

DEATH BY ABUSE: ONE DEATH IS TOO MANY

“The death of a baby is like a stone cast into the stillness of a quiet pool; the concentric ripples of despair sweep out in all directions, affecting many, many people.”

John DeFrain, Ph.D., 1991

SUMMARY

Every day in America, three children are murdered by their parents or caregivers.

In Orange County (OC), the employees of Social Services Agency (SSA) including Children and Family Services Division (CFS), Health Care Agency (HCA), and law enforcement are charged with keeping our children safe when their own parents are the danger.

The Orange County Grand Jury has a unique observation point in society. In its role as civic watchdog over county government, the Grand Jury has the opportunity to view all facets of those agencies from an up-close perspective. These OC agencies have the mandate to address the ever changing needs and solutions to the ills in society that place children at risk in their own homes.

Children who are victims of abuse or neglect can be removed from their parents for their safety when allegations are substantiated and at imminent risk. At all times during this process, including interviews, investigation, and court hearings, the safety of the child is the primary priority. At the same time, SSA works to create a safe home environment for those children or to find a permanent home when the risk is too great to return a child to the parents.

Community education and communication could reduce the risk to children through the promotion of the Child Abuse Registry (CAR).

REASON FOR INVESTIGATION

When a child under the jurisdiction of OC SSA dies, the immediate reaction is to try to understand how it happened; could that death have been prevented and are the procedures in place to make sure that it is not repeated? This topic has been covered by several reports of Grand Juries in the past few years. Understandably, there is a veil of confidentiality by law that is applicable to all matters relating to juveniles that is difficult to penetrate.

METHOD OF INVESTIGATION

The Grand Jury observed and toured:

- the Child Abuse Registry (CAR);
- immediate response calls to allegations of abuse that required an emergency response;
- Child Abuse Services Team (CAST) where children who have been sexually abused are interviewed and examined in the most child-friendly environment possible;
- Orange County’s emergency shelter and the Orangewood Children’s Home (OCH);

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- Juvenile Justice Commission (JJC) meetings;
- the Dependency Court;
- the Truancy Court; and
- the Drug Court.

The Grand Jury interviewed:

- SSA personnel;
- SSA County Counsel;
- Non-relative caregivers; and
- Child Welfare care providers.

BACKGROUND

The role of government in families, particularly Child Protective Services (CPS), is exactly what the name implies – protecting children. Every year in the United States, CPS agencies investigate thousands of child abuse and neglect reports. On average, in California, according to the State Child Death Review Council, about 500 children are hospitalized each year for documented child maltreatment.

According to the Welfare and Institutions Code, the legal reasons to remove a child from the family home are:

- Physical abuse
- Corporal punishment that inflicts injury or is not age appropriate
- Sexual abuse
 - By adult (living in home or caregiver)
 - By another child with significant age difference
- General neglect
 - Basic needs such as food, shelter, clothing, safety
- Emotional abuse
 - Connection between the behavior of parent resulting in psychological problems, school problems, and depression
 - Exposure to domestic violence
- Incapacitation/abandonment
 - Illness
 - Incarceration

CHILD ABUSE REGISTRY

Most referrals to the Child Abuse Registry (CAR) are made by mandatory reporters such as law enforcement officers, hospital and school personnel. Other mandatory reporters include, but are not limited to:

- Employees of childcare institutions

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- Administrators and employees of public or private day camps, youth centers, youth recreation programs, or youth organizations
- Social workers, probation officers, or parole officers
- State or county public health employees
- Commercial film and photographic print processors
- Clergy members

When a report of any kind of abuse is made to CAR, a social worker (SW) takes the information and a decision is made depending on the level of abuse and whether or not it requires an immediate response. This decision is based on a risk assessment with Senior Social Workers.

A referral may be considered an emergency, but if the child is in a safe place, the SW must balance risk versus exposure in terms of being able to contact the child without the perpetrator being present or able to influence what the child says to the SW. Under that scenario, a child could be contacted at school or in a more neutral environment. The SW interviews the victim and siblings, if any. If there is abuse, law enforcement is called. Under the penal code, a SW is not allowed to remove the child from a home, only law enforcement officers have that authority. Under the Welfare and Institutions Code, with the approval of the CFS Program Manager, children can be taken into the custody of SSA.

The CAR Response Levels:

- Immediate (I) Response/Emergency
 - Allegation of imminent danger
 - Within two hrs
- Next day response
- See by (certain date) - some imminent danger, but child is not in contact with perpetrator
- 10 day response – no immediate danger to child

On an Immediate Response, if it is determined by the SW that there is no imminent risk to the children, the SW will identify resources for the family and offer voluntary family services.

The TDM is one of the most effective tools used in the delivery of services to the family in terms of contact and flow of information among the caregivers, family, and case managers. The areas of concern are discussed and plans to address them are developed. The team could consist of:

- Emergency Social Worker
- SW Supervisor
- Parents
- Relatives
- Friends
- Neighbors
- Contracted caregivers

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- Foster parents, if applicable
- Cal-Works Social Worker, if applicable
- HCA personnel

If abuse or neglect is substantiated and the child is taken into protective custody, the child could go to OCH or to an emergency foster home. A TDM occurs the next day in either instance. The SW asks parents to have family, friends, counselors or anyone else who has had a positive contact with the child to attend the meeting for input on the best placement options available. Resources for the child and parents are discussed and those options that best meet the needs of the child are determined with the safety of the child given the greatest consideration. Day two is a detention hearing in the court and a court appointed attorney represents the child in all court hearings. The parents are represented by a private attorney or public defender. SSA has an attorney present to represent the agency and support the staff recommendations.

An Investigation SW prepares a detailed report for the court within 30 days. It can be delayed up to 60 days while the child is in out-of-home placement. The length of time involved depends on the orders of the court, time to obtain assessments, testing, or evaluations to identify the needs of the child and family.

A Family Reunification (FR) plan is developed by the SW in conjunction with the family. An Integrated Continuing Services (ICS) Social Worker manages the case and communicates with the court and family on the FR plan, which is submitted to the court for approval and, or modification. FR requires 6, 12, and 18 month reviews by the court and includes court-ordered services. The main question addressed is whether it is likely that the child could be returned to the parents. Concurrently, a permanency plan is developed that includes adoption, legal guardianship, or long term foster care for the child if the reunification plan is not successful. At 18 months, there is a determination by the TDM and ultimately by the court whether the permanency plan is enacted.

COUNTY PROCEDURES

In 2000, SSA updated the 1998 Child Welfare Services Strategic Plan and identified the most recent internal changes and external factors. They developed new strategies and choices to provide emergency shelter and care resources that would be adequate for abused children up to year 2010. There was a decided shift in Best Known Practices (BKP) from that of professionally centered to family centered. Instead of the experts determining needs, the family identified their needs. Instead of fitting a family to professional services, services became tailored to the unique family needs with flexible roles and service provisions. In-home support services became available to maintain children in their family homes as an alternative to group home care. These services are provided to increase the number of families that are able to care for their children in homes that are safe and nurturing.

An examination of several child deaths and the procedures in place at the time of those deaths, along with current procedures, reflects a system that evaluates itself and makes recommendations for change to meet the challenge of keeping children safe.

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Male Victim 1 (MV1) became a dependent child after his birth. Upon the Mother's release from the hospital, she was arrested on criminal charges. MV1 was in placement because his mother was incarcerated. He was first placed at OCH as an emergency shelter. With no relative able to care for him, he was placed with a foster parent in a neighboring county at two months of age. The foster parent wanted to adopt him as a part of the permanency plan, but because the Mother completed her jail sentence and decided she wanted custody, he was released to her at six months of age. This child was not removed from his mother's care because of abuse or neglect, but because of abandonment due to incarceration; therefore, the services given to the Mother and child were voluntary. After being returned to his mother he died four months later as a result of abuse. His mother was convicted of his homicide and is now in prison.

During the criminal trial of the Mother, CFS became aware of neighbors who reportedly told county SSA and/or HCA workers that the child cried constantly and might be abused; however, no one ever filed a report or notified CAR. The only mention of concern was a month before the death when an HCA employee expressed concerns regarding the Mother's lack of understanding of child development and bonding. At the same time, services, such as parenting classes, ceased at the request of the Mother.

It is not exactly clear who the neighbors talked to about the child's constant crying, and on how many occasions. A neighbor gave an investigator information the day before the child died, but the investigator did not call or refer the neighbor to CAR. That investigator was looking into welfare fraud by the Mother.

SSA conducted a child death review after this child's homicide that was very thorough and complete. Areas of concern were identified by the Agency and recommendations made that included:

- improve and establish communication among the various social workers;
- establish a time frame for sharing of information;
- inputting information into the state's Child Welfare Services/Case Management Systems (CWS/CMS) in a timely manner; and
- retraining of staff based on the assessment and issues of concern raised in the child death review.

Female Victim 2 (FV2) became a dependent child at birth because she tested positive for drugs. She had three older siblings who were not declared dependents of the court at that time. According to Penal Code § 11165.13, drug abuse by a parent is not in and of itself grounds for the removal of a child from the family home; general neglect or abuse must be documented as well.

FV2 lived in a foster home for 18 months while the family received Family Reunification services. This included monitored visits with the child and regular drug testing of the parents. Records reflect that the parents tested positive for amphetamines four months into the case plan. The social worker found that the child was responsive to the parents and them to her. The parents continued to be randomly checked for drugs, with negative, drug-free results, so the social worker gradually liberalized visits to include overnights. At the 18

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Month Review, which was actually 22 months after her birth, SSA recommended that the child be placed in Long Term Foster Care because the parents did not have adequate housing for the family. The Mother, Father and three full siblings, (one born drug free 14 months after FV2's birth) were living in a motel; however, the court ordered a 60 day trial stay which turned out to be successful. The child's attorney conveyed confidence that the parents would be able to care for her and the court ordered Family Maintenance services at the recommendation of SSA since Long Term Foster Care was not ordered by the court.

Records reflect that the policies and procedures of CFS in place at that time were adequate in the care of the child. There were no recommendations made in the death review of this child, in fact, most of the workers involved felt that they had provided best practice efforts on her behalf because there were no indicators or "early red flags" that abuse would occur. The recommendation for Long Term Placement was based on the housing situation, and the court did not agree, and instead, returned the child to the parents. The siblings of this child were not removed from the parents while FV2 was in out-of-home placement until after her death at the hands of her father.

The child's death was caused by severe blunt head trauma. Bruising and bite marks on her may have been inflicted by her siblings, two of whom are developmentally delayed.

Male Victim 3 (MV3) was not a dependent child. The first contact CAR had with the family was a report made regarding the Mother's thoughts of suicide and killing her child as well. Based on this information reported to CAR, an unannounced visit was made to the family home. The Mother was not as depressed as she had been when she made those statements. The Father was a full time student who also held a job. According to contacts with the SW, the Mother was depressed because she had no friends and little contact with her husband because of his schedule. She did not have transportation within OC, and did not want to take the child back to their home country. The child was healthy and happy and the Mother accepted voluntary services that included counseling and assistance with transportation needs.

The Mother and Father were from another continent, and the Mother was concerned about her immigration status if she were to divorce. The Mother started working and the child did not appear to be at risk with her. In her home culture, according to the Mother, domestic violence by the husband is an acceptable behavior. Eventually the Mother made a report to her local law enforcement officials charging her husband with domestic abuse and filed for divorce. At that time, the child was not at risk with the Father based on the risk assessment tools that are a part of current Best Known Practices (BKP). The system was working with in-home services to the Mother, information and counseling services were offered to both parents, and a child who appeared to be loved by both parents. The policies, procedures, and BKP were in place and appeared to be effective.

By his own admission, the Father attempted a suicide/murder with his son nine months prior to the murder, and has been charged accordingly. In his confession, the Father stated that he was upset with divorce proceedings and decided to kill the child and himself by setting his car on fire with both of them in the trunk. A law enforcement officer/mandatory reporter discovered the Father's sedan at the side of a freeway in a rural area outside OC during daylight hours. The car was not locked and the keys to the car along with the

Father's wallet were in the car. When the back of the car was inspected, the law enforcement officer touched the lid of the trunk which opened and found the Father and son inside. According to the Father, the trunk lid was opened before he could ignite the gasoline he had poured in the trunk. Even though the law enforcement officer smelled gasoline, he did not file a CAR report.

If other reports had been made to CAR against the Father, the outcome might have been different. Based on then known information, little could be done by OC SSA to change the outcome of the death of this child at the hands of his father.

CONCLUSION

An important part of preventing child abuse and death is to have a means of reporting potential child abuse issues to the appropriate authorities. OC CAR is an anonymous Automated Call Distribution Service (ACDS), staffed 24 hours per day, seven days per week by the OC Social Services Agency. Fortunately for OC residents, the CAR system will be upgraded by June, 2007, with many new features that will allow staff and management to act upon and preserve important information. The new system enables law enforcement to get a priority response from CAR staff and CAR management access to monitor calls is increased. Also, the phone system has the ability to record all incoming calls, and save them indefinitely by time and date.

It is increasingly difficult to protect children from their parents. One parent may be a functional mentally ill person, and another may be a drug abuser who has impaired brain function through chronic abuse or alcoholism. Unfortunately, the experts are not always able to predict behavior, but can analyze the aftermath.

Under AB 458, the California legislature authorized counties to officially establish interagency death review teams. SSA participates, but is not required under law to conduct a Client Death and Serious Incident Review (CDSIR) within the agency.

SSA conducts a CDSIR as a tool that evaluates the case decisions and circumstances related to a serious incident or death in a non-judgmental manner. SSA's Child Death Review team includes members of the Juvenile Justice Commission (JJC). This policy has been in place since 1994, documented in the CFS Operations Manual Number B-0104. It directs CFS management staff:

1. "to provide Children's Services management staff with the most complete and timely information about the circumstances of the incident or death;
2. to evaluate in a non-judgmental manner the case decisions and circumstances related to the incident or death;
3. to recommend modifications, updates or implementation of new policies and procedures, if needed, in an organized, long-term response to prevent similar incidents in the future;
4. to maintain a central data base of all serious incidents or deaths in cases where Children's Services was involved in order to identify trends and problems."

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Clearly this procedure was followed in 2001 when MV1 died. The recommendations addressed problems with case management decisions, communication among the care providers, and reporting in a timely manner.

The U.S General Accounting Office (GAO) reported in 2006 (GAO-07-75), “ In response to a GAO survey, state child welfare agencies identified three primary challenges as most important to resolve to improve outcomes for children under their supervision: providing an adequate level of services for children and families, recruiting and retaining caseworkers, and finding appropriate homes for certain children.”

In the same document GAO addressed caseloads of SWs from a previous report: “For example, we reported that high caseloads, poor supervision, and the burden of administrative responsibilities have, in some cases, prompted caseworkers to voluntarily leave their employment with welfare agencies.” The GAO conducted this study because “the states have not been able to meet all outcome measures for children in their care”. The difficulty of recruiting, training, and retaining employees in child welfare is nationwide. It may well exacerbate poor outcomes for children in the states’ care.

A very disturbing aspect of the MV1 case not addressed in the SSA recommendations is that during the criminal trial of the Mother, neighbors said that they expressed concerns about the child to care providers, and/or the SW, and as well as an investigator. There were no CAR reports or mention of complaints against the Mother in contact logs. If, in fact, neighbors did report suspected abuse, the SW procedure would have been to conduct an investigation and examination of the child. Perhaps the outcome could have been different had the neighbors been aware of CAR and how to report suspected child abuse.

In the case of FV2, the SW made a recommendation to the court not to reunify this child. When a situation occurs where the agency’s recommendation is not followed by the court, the agency has no recourse.

MV3’s case, five years after MV1, followed Best Known Practices (BKP) to the letter, and yet, the Father confessed to the murder of his son.

SSA’s role in the protection of children and attempting to change the root causes of abuse is a national goal. The current Best Known Practice focuses on the best interests of the child, which is removing the harm from the child, either through reunification, adoption, or guardianship.

According to the OC Child Death Review Team 2006 Annual Report from the office of the Sheriff-Coroner, in calendar year 2005, five children under the age of six died as a result of homicide.

In 2000, the statewide Fatal Child Abuse and Neglect Surveillance (FCANS) program established a matrix to collect data on causes and circumstances surrounding child deaths. The broad scope of the matrix includes those deaths that may not have abuse and neglect as a contributing factor; however, that child may have had abuse and neglect as a part of his or

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her life history. In 2005, 31 children in OC under six years of age were reported under the FCANS matrix.

FINDINGS

In accordance with California Penal Code sections 933 and 933.05, each finding will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2006-2007 Orange County Grand Jury has arrived at the following findings:

- F-1 CDSIRs have been effective in improving procedures within the agency.
- F-2 Brochures, pamphlets, and public service announcements about CAR are not widely distributed or displayed.
- F-3 The current Automated Call Distribution telephone system at CAR was purchased in 1998 and has reached its end-of-life.

Responses to Findings F-1 through F-3 are requested from the Orange County Social Services Agency.

RECOMMENDATIONS

In accordance with to California Penal Code sections 933 and 933.05, each recommendation will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. Based on the findings of this report, the 2006-2007 Orange County Grand Jury makes the following recommendations:

- R-1. SSA should continue Quality Assurance investigation and procedural review based on best practice along with the CDSIR.
- R-2. SSA should conduct an aggressive public service campaign to educate the general public about child abuse. The anonymity of reporting to CAR needs to be publicized throughout Orange County, including radio and TV public service announcements in English and Spanish.
- R-3. SSA should ensure that the new phone system at CAR is operational by June, 2007.

Responses to Recommendations R-1 through R-3 are requested from the Orange County Social Services Agency.

RESPONSE REQUIREMENTS

The California Penal Code specifies the required permissible responses to the findings and recommendations contained in this report. The specific sections are quoted below:

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§933.05(a) For purposes of subdivision (b) of Section 933, as to each grand jury finding, the responding person or entity shall indicate one of the following:

- (1) The respondent agrees with the finding.
- (2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefore.

(b) For purposes of subdivision (b) of Section 933, as to each grand jury recommendation, the responding person or entity shall report one of the following actions:

- (1) The recommendation has been implemented, with a summary regarding the implemented action.
- (2) The recommendation has not yet been implemented, but will be implemented in the future, with a timeframe for implementation.
- (3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a timeframe for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This timeframe shall not exceed six months from the date of publication of the grand jury report.
- (4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefore.