

A CHILD AT RISK: MISSED OPPORTUNITIES TO SAVE A LIFE

“What we got here is a failure to communicate.”
Cool Hand Luke, 1967

SUMMARY

The 2003-2004 Orange County Grand Jury reviewed the procedures of the Orange County Social Services Agency as they pertain to child-abuse recognition and reporting. The Grand Jury investigated the roles of the Anaheim Police Department, certain medical providers and Children and Family Services, a division of Social Services, in the death of a child. Several employees of Orange County agencies, and citizens associated with the case, were interviewed. Dozens of records and reports indicated that the death of the child could have been prevented. The Grand Jury’s findings include:

- The child died at the hands of a neglectful mother as a result of starvation complicated by physical injuries. The death occurred despite three contacts by senior social workers, three contacts by the Anaheim Police Department, contacts by counselors of a child-advocacy facility, and numerous treatments by medical doctors for physical injuries.
- There is no effective protocol to share information among agencies associated with child abuse in Orange County.
- At the time of the child’s death the Child Abuse Registry did not have a policy of logging all incoming calls, as is the case in other counties in California. Such a log might have disclosed patterns of abuse.
- The medical personnel for this child failed to report physical injuries to those authorities responsible for overseeing incidents of potential child abuse.
- Mandated reporters of child abuse need periodic retraining in recognizing and reporting child abuse.

The Orange County Grand Jury has outlined several recommendations that will help prevent a recurrence of the lack of communication that resulted in tragic consequences.

PURPOSE

The purposes of this study were to:

1. Determine the extent to which Children and Family Services, the Anaheim Police Department and medical providers shared information on potential child abuse in this case.
2. Determine if further intervention could have saved this child's life.
3. Determine if a public-health nurse is available at the Child Abuse Registry (CAR) to provide assistance.
4. Investigate whether CAR logs all incoming calls to their database.
5. Determine if the Anaheim Police Department records all calls to addresses where possible child abuse occurs.
6. Determine if the state-mandated reporters who deal with child abuse are trained by Social Services to follow the required protocol.
7. Investigate the need for forum-style Child Death Reviews.

BACKGROUND

Individuals in certain professions are required to report suspected cases of child abuse. Referred to as "mandated reporters," they include teachers, police officers, firefighters, probation officers, social workers, the clergy, medical providers and child-care providers. State law requires that mandated reporters immediately report any suspected negligent treatment or abuse of children and must follow up with a written report within 36 hours. Penalties can be assessed for non-compliance.

Upon discovery of abuse, the reporter usually calls "911" or the CAR Hotline. The Orange County CAR is the primary point of entry for reporting child abuse. The CAR Hotline is staffed by senior social workers 24 hours a day, seven days a week. They receive some 40,000 calls per year and record some 26,000 calls related to child abuse. Eight percent of the 26,000 result in responses by Social Services workers. The balance of reports do not rise to the level of state-mandated requirements for intervention. Once CAR receives a call and evaluates it, social workers decide if an immediate response is required. They also assess the risk to the child and determine if the child is to be removed and placed into protective custody.

The Grand Jury studied the death of a female child, born on March 1, 2001, who lived with her parents and another family in Anaheim. She died March 26, 2002, as a result of abuse and neglect at the hands of her mother. This tragic fatality occurred despite checks by Anaheim police officers, investigations by the Orange County Social Services Agency (SSA) and many treatments of physical injuries by local medical doctors.

METHOD OF STUDY

Pursuant to the civil or “watchdog” responsibility of the Grand Jury to examine all aspects of public agencies to ensure efficiency of operations, the 2003-2004 Orange County Grand Jury investigated Orange County agencies involved with child abuse.

The Grand Jury studied the process by which agencies involved with children recognize and act on child-abuse allegations and the way that such information is exchanged among agencies. In the case of this female child victim (FCV), the Grand Jury reviewed mandated reporters’ responses to allegations of her abuse and the roles the Anaheim Police Department, Social Services and the medical providers played. For the purpose of gathering data, the Grand Jury conducted 18 interviews with members of the following Orange County agencies and organizations:

- Social Services Agency
- Children and Family Services, a division of SSA
- Child Abuse Registry
- Child Abuse Services Team (CAST)
- Suspected Child Abuse/Neglect (SCAN) Team
- A child advocacy home
- Orangewood Children’s Home
- Juvenile Court
- Anaheim Police Department
- District Attorney’s Office
- County Counsel’s Office

The Grand Jury also interviewed several non-mandated reporters and other individuals associated with this case.

In addition, the Grand Jury studied the following reference documents:

- California Penal Code, Child Abuse and Neglect Reporting Act - §11165 et seq.
- California Education Code §48906

- California Welfare and Institutions Code 300 et seq.
- “Child Death Review,” Children and Family Services
- 9th Annual Report of Conditions of Children in Orange County, Social Services Agency
- “Child Maltreatment 2001,” U.S. Dept. of Health & Human Services
- “Reporting Child Abuse and Neglect,” U.S. Department of Justice
- “Possible Abuse Case Under Fire” by Vik Jolly and Eleeza Agopian, *The Orange County Register*, 4-30-02
- “Chance to Save Baby is Missed” by John McDonald and Aldrin Brown, *The Orange County Register*, 11-30-02
- “Probe of Girl’s Death Urged” by Eleeza Agopian, *The Orange County Register*, 5-1-03
- “Plea Reached in Starvation Death” by Vik Jolly, *The Orange County Register*, 12-17-03
- “No One to Blame for Her Death?” by Daniel Yi, *Los Angeles Times*, 11-10-02
- “Justice Pending in Death of Child” by Daniel Yi, *Los Angeles Times*, 5-11-03
- “An Infant’s Death Unsolved” by Daniel Yi, *Los Angeles Times*, 9-3-03
- Records from Orange County Social Services Agency’s Children and Family Services:
- “Child Abuse Registry and Emergency Response 2001,” County of Orange Social Services Agency
- Computer records from the Anaheim Police Department for response to FCV home on N. Harbor from October 2001 through March 2002
- Medical records from local hospital for FCV from October 2001 through March 2002
- *Child Abuse — An American Epidemic*, Elaine Landau
- *8% Solution*, M. Schumacher

DISCUSSION

According to State law, a child-abuse allegation must first meet the definition of abuse or neglect. The Social Services Agency then needs to assess if the alleged victim needs to be placed into protective custody or can safely remain in the home. Although a single or specific incident may not rise to that level, several instances of injuries may constitute a pattern of abuse that leads to intervention. Unfortunately, in the case of this 1-year-old victim, Social Services was not made aware of all the medically treated injuries that would have allowed for an in-depth assessment. If such a pattern had been recognized, Children and Family

Services would doubtless have responded in their normal, conscientious and effective manner.

There was a serious problem related to the ability to share information among the Child Abuse Registry, the Anaheim Police Department and a medical provider. State law requires that law-enforcement and child-welfare agencies develop and implement procedures that address the cooperation of these agencies in the investigation of suspected child abuse or neglect. The law also requires these agencies to share data and information and create a body of information to prevent child death.

On separate occasions, medical personnel who treated this child and her sibling found numerous injuries that were not reported to CAR. The injuries to the children should have warranted telephone calls to CAR.

An abused child is often sent to the Child Abuse Services Team (CAST), an Orange County multidisciplinary investigative team. The components of CAST include child advocates and victim specialists, deputy district attorneys, investigators, patrol officers, pediatricians, nurse practitioners, social workers and registered therapists. At CAST, both paid professionals from several agencies and volunteers assist children. This "one stop" site is for victims of child abuse to tell their story in a child-friendly environment. The child is encouraged to speak with trained forensic interviewers while other professionals observe the interaction through a one-way mirror. Also, the child is given a medical examination, often including the genital area. The Grand Jury noted that CAST employees and volunteers are highly effective in putting the children at ease in order to gain critical information in the investigation of child abuse.

CAR receives more than 26,000 calls per year for possible child abuse. Prior to July 2003, CAR did not document all telephone calls regarding suspected child abuse, as other State child-abuse reporting agencies do. Such information is valuable in establishing a historical pattern of child abuse.

On or about Jan. 22, 2002, the Child Abuse Registry failed to record a report by the child-advocacy home of new injuries to the FCV. No response was made to the home. An internal investigation by CAR failed to indicate that any such call was received.

A substantial number of the calls received by CAR involve children with modest to severe medical conditions. In these cases, social workers must seek outside assistance for medical information and interpretation that takes considerable time to accomplish.

The Child Abuse Registry currently has a vacant position for a public-health nurse. If such a person were on the staff, the nurse would be available to review reports of child abuse or neglect, provide medical consultation and field assistance, provide expertise in pediatric health needs and resources, interface with medical professionals, consult during the data-entry process and assist in educating mandated reporters and citizens in recognizing child abuse and reporting it.

Officers with the Anaheim Police Department responded twice to the FCV's house during October 2001 but did not acknowledge those calls. Documentation of responses by the Anaheim police officers would have been important in establishing a pattern of child abuse at the FCV's address.

The Anaheim Police Department experiences difficulties in obtaining information about prior reports of child abuse due to communication delays in dealing with CAR. CAR believes the reason this occurs is that police call in on the telephone line used by the public rather than the dedicated line for use solely by law-enforcement agencies.

The Social Services Agency was aware of the following signs that might have indicated the FCV was being abused (for more information see Appendix):

- Fractured arm with unknown cause
- Senior social worker's declaration of general neglect
- Hospital personnel comments to a senior social worker alleging parental neglect, reinforced by observations of the mother's negative attitude as an unbonded and uncaring provider
- Three contacts by a senior social worker
- Several contacts and reports to CAR by the child-advocacy home's counselors
- Reports by hospital personnel that the mother had an anger problem, disliked female children and was glib and manipulative in blaming injuries on siblings

Because investigatory techniques and child-abuse laws are constantly evolving, periodic retraining of involved personnel is essential. The child-advocacy home did not adequately train new and existing employees, as mandated by State law. Also, it is important that agencies document visits by their employees to homes where child abuse is suspected. Such documentation assists Social Services in developing a historical background for patterns of abuse.

Mandated reporters are required by State law to immediately contact an agency such as CAR when child abuse is suspected. The reporters must make a written report within 36 hours after reporting the suspected abuse. Training by Social Services is imperative so mandated reporters recognize suspected child abuse and are cognizant of the consequences of failing to report abuse.

The Social Services Agency has conducted Child Death Review forums in the past, but did not do so in this child's case. These fact-finding reviews involving all persons associated with a child's death, such as social workers, police, firefighters, medical personnel and relatives, assist agencies to improve their procedures for future child-abuse cases.

FINDINGS

Under *California Penal Code* §933 and §933.05, responses are required to all findings. The Orange County Grand Jury arrived at 10 findings:

1. Few mechanisms exist in Orange County to share information among agencies involved with child abuse that would help those agencies to discern patterns of abuse.
2. At the time of this child's death, the Child Abuse Registry had no policy to document all incoming calls on child abuse.
3. The Anaheim Police Department failed to acknowledge two prior responses to the female child victim's address on Oct. 17, 2001, and Oct. 18, 2001, and no reports of those responses were written.
4. The Child Abuse Registry and Emergency Response Programs have a vacant position for a public-health nurse to gather, evaluate and interpret medical information.
5. Mandated reporters failed to contact the Child Abuse Registry to report injuries to the FCV and a sibling, delayed in reporting those injuries to CAR and did not follow up with written reports.
6. The child-advocacy home made a call to the Child Abuse Registry on or about Jan. 22, 2002, reporting new injuries to the FCV, but no documentation of that telephone call exists.
7. Despite the inability of the Social Services Agency and the Anaheim Police Department to confirm abuse of the FCV, an aggregation of facts/observations might have revealed a pattern of abuse.

8. Children and Family Services failed to conduct an internal Child Death Review involving a meeting of parties/agencies associated with this case.
9. In lieu of a roundtable gathering, a single senior social worker was assigned to prepare a written report. A social worker who visited the home and examined the child was never interviewed for the report.
10. Because law-enforcement agencies frequently call in on the public phone line rather than the dedicated line at the Child Abuse Registry, they experience delays in getting information on prior reports for child abuse.

Responses to Findings 1, 2 and 4-10 are requested from the Orange County Social Services Agency.

Responses to Findings 3 and 7 are required from the City Council of the City of Anaheim and requested from the Police Chief of the Anaheim Police Department.

A response to Finding 4 is required from the Board of Supervisors.

RECOMMENDATIONS

In accordance with *California Penal Code* §933 and §933.05, each recommendation requires a response from the government entity to which it is addressed. These responses are to be submitted to the Presiding Judge of the Superior Court. Based upon the findings, the 2003-2004 Orange County Grand Jury recommends that:

1. The Child Abuse Registry expand its database capability to include all incoming calls. Add sufficient resources to accommodate this additional workload. (Findings 2 and 6)
2. The Social Services Agency assume a leadership role in establishing a mechanism for gathering and disseminating information among the Social Services Agency, medical providers, law enforcement and other agencies involved with children. (Finding 1)
3. The Social Services Agency work more closely with larger medical institutions that use Suspected Child Abuse/Neglect (SCAN) teams in detecting child-abuse injuries and developing procedures for recording and reporting abuse. The Social Services Agency should

also include those medical providers that do not use SCAN teams. (Findings 1 and 7)

4. The Social Services Agency provide timely updates to law enforcement on changes in laws that reflect the release of confidential information for cases covering child abuse. (Finding 1)
5. The Social Services Agency increase its education of mandated reporters, with an emphasis on state-mandated requirements, penalties for non-compliance and guidance on recognizing and reporting child abuse. (Findings 1, 3 and 5)
6. Children and Family Services conduct a forum-type Child Death Review in every case where the child dies from abuse or under suspicious circumstances. Involved in the review would be all participants associated with the case, such as social workers, police officers, relatives or teachers. (Findings 8 and 9)
7. The Anaheim Police Department increase the training of its personnel in recognizing child abuse. The department should avail itself of the training opportunities offered by the Social Services Agency in child- abuse recognition and reporting responsibilities of mandated reporters. (Finding 3)
8. The Child Abuse Registry add a public-health nurse to assist social workers at CAR in interpreting and evaluating medical information on children who come to the attention of Children and Family Services. (Finding 4)
9. When investigating a child's death and documenting the findings, Social Services Agency ensure that all social workers who have been in contact with the child are interviewed. (Finding 9)
10. The Child Abuse Registry publicize to all Orange County law-enforcement agencies that a dedicated phone line exists solely for use by police departments. Ensure that incoming calls on the dedicated line are given prompt attention. (Finding 10)

Responses to Recommendations 1-6 and 8-10 are requested from the Orange County Social Services Agency.

Response to Recommendation 7 is required from the City Council of the City of Anaheim and requested from the Police Chief of the Anaheim Police Department.

A response to Recommendation 8 is required from the Board of Supervisors.

APPENDIX

Chronology of Events

- 3-1-01 The female child victim (FCV) is born at hospital.
- 10-16-01 FCV treated at medical clinic for bruised left cheek, sprained left leg, foot injury; doctor makes no referral to Child Abuse Registry (CAR).
- 10-17-01 Adult, non-English-speaking friend of family makes 911 call to report abuse; wants to remain anonymous; police respond to FCV home; referral unfounded.
- 10-18-01 Second call by friend; police respond to report of a “child screaming”; police speak to mother; referral unfounded; no report; no referral.
- 11-8-01 Friend contacts counselor of the child advocacy home who contacts CAR to report bruising on FCV’s face. CAR sends senior social worker who cannot confirm injury; senior social worker (SSW) attempts to interview sibling, is unsuccessful; SSW asks mother for name of pediatrician, but does not follow up; SSW unable to contact father; SSW aware of friend but makes no attempt to contact; referral unfounded.
- 11-21-01 FCV taken to medical clinic; medical report indicates “child fell out of crib”; scar on nose; no referral made.
- 11-23-01 FCV taken to medical clinic; report states: “blood from ear due to a punctured eardrum”; cause unknown; no referral made.
- 12-16-01 FCV taken to medical clinic with injured arm; child cannot use arm; doctor refers to hospital emergency room; mother reluctant to take child there; no referral was made.
- 12-22-01 Mother takes FCV to hospital; diagnosis is fractured arm; CAR contacted by hospital personnel; SSW responds; doctors do not suspect child abuse; other medical personnel concerned with mother’s neglect due to child’s poor hygiene and the mother being belligerent, uncaring and unbonded toward the child. Cause of fracture unknown; SSW confirms general neglect due to mother’s delay in seeking treatment.
- 12-23-01 Same SSW responds to home of FCV; unsuccessful interview of sibling; interviewed friends who stated they saw no injuries to the children; offers assistance to mother who declines; no referral made for further action; this was last visit by a social worker.
- 1-17-02 Friend makes another contact with counselor of the child-advocacy home (wants to remain anonymous due to fear of retaliation from mother); states FCV has new bruises on face. Counselor contacts CAR. Anaheim PD is contacted and

- sends a police officer to home; cannot find new bruises; referral unfounded; no report made; no referrals made. Anaheim Police Department acknowledges this response as only response made to home.
- 1-18-02 Friend again calls counselor, insisting old injuries still evident: bruises and scratches to face. Counselor fails to contact CAR and fails to follow up with required written report.
- 1-22-02 Counselor and associate counselor of child-advocacy home visit FCV's home; confirm new injuries, i.e. bruise on face, scratches over eye and fading old bruises; child advocacy claims a telephone report was made to CAR; claims statement by social worker, "case is under investigation." No follow-up with written report by child advocacy. CAR cannot find record or log of this call, but acknowledges possibility that worker erroneously may not have logged this call.
- 2-14-02 Mother of FCV makes phone call to medical-clinic doctor about 2-year-old sibling with injury to head. Medical report states, "mother hit child's head on metal frame of bed; has one-inch laceration on forehead, but bleeding is under control." On-duty Registered Nurse advises mother to bring child in only if child has further complications; no referral is made.
- 3-4-02 FCV taken to medical clinic; report states, "underweight, has swollen face"; no referral made.
- 3-18-02 FCV taken to medical clinic; report states, "facial bruising, liver inflammation, failure to thrive, underweight"; no referral made.
- 3-19-02 FCV taken to medical clinic; report states, "face still swollen"; no referral made.
- 3-21-02 FCV taken to medical clinic; report states, "new facial bruising noted, no weight gain"; no referral made.
- 3-25-02 FCV taken to clinic; report states, "healing bruises on left side of face, bruises on right side resolved, weight loss"; no referral made.
- 3-26-02 FCV found dead in crib; siblings removed from home.
- 3-27-02 Child Abuse Services Team (CAST) interviews 5-year-old sibling who displays 2-inch bite bruise on leg caused by the father; child also states parents beat all children with a belt and that mother touched his genitals.
- 8-12-02 Orange County Sheriff/Coroner declares death is a homicide due to starvation; other conditions: scalp contusions (had been hit over head 15 times in hours before death), cerebral edema, repeated fractures of right elbow, injury to colon due to blow to abdomen, vaginal bleeding and clinical failure to thrive.

3-27-04 Mother of FCV convicted and sentenced to state prison for eight years for child abuse and the death of FCV.