CHILD ABUSE REPORTING PROCEDURES

REASON FOR INVESTIGATION

The Grand Jury received a citizen’s complaint concerning the possible mishandling of a Suspected Child Abuse Report (SCAR) by the Nevada County Child Protective Services (CPS). The Grand Jury conducted an investigation into practices and procedures followed in suspected child abuse cases by Nevada County agencies charged with protecting our children.

PROCEDURE FOLLOWED

The Grand Jury reviewed files pertaining to two child abuse cases, one of which was the basis for the citizen’s complaint, and court transcripts of one case. California Penal Code Sections 11164-11174.4, and Child Welfare Services Program Intake Chapter 31-101 and 105 were reviewed, along with CPS activity sheets and police logs. The complainant was interviewed. Employees of CPS, the Grass Valley Police Department, Nevada City Police Department, Truckee Police Department, and Nevada County Sheriff’s Department were interviewed, along with the District Attorney.

LEGAL FRAMEWORK

• Certain individuals and employees are mandated by law to report any instance of suspected child abuse to a designated agency. A “mandated reporter”, as defined in California Penal Code Section 11165.7, includes, among others: an administrative officer or supervisor of child welfare, a social worker, a physician, a police officer, a teacher, a licensed nurse, and a licensed day care provider.

• California Penal Code Section 11165.9, states: “Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff’s department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Any of those agencies shall accept a report of suspected child abuse or neglect. . . .”

• California Penal Code Section 11166(a) states: “A mandated reporter shall make a report to an agency whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter shall make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.”
• **California Penal Code Section 11165.9(3)(b)** states: “Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect as required by this section is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or by both that fine and punishment.”

• **California Penal Code Section 11166(h)** states: “A county probation or welfare department shall immediately, or as soon as practically possible, report, by telephone, fax, or electronic transmission to the law enforcement agency having jurisdiction over the case, to the agency given the responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code, and to the district attorney’s office every known or suspected instance of child abuse or neglect . . .”

**FINDINGS**

1. The Grand Jury found that while there are legal definitions and written procedures regarding reporting of suspected child abuse cases, there are misunderstandings and failures to follow proper procedures.

   a. Until the Grand Jury investigation got underway, local CPS officials took the position that since they were one of the agencies to whom others reported suspected child abuse, they themselves were not also mandated reporters. Therefore, they were not obligated to adhere to the same reporting requirements as other designated reporters. In fact, CPS is a mandated reporter.

   b. For the last two years and up until March of 2003, CPS sent suspected child abuse reports in batches to one police department, resulting in some reports reaching the department as much as three weeks (and up to six weeks in one case) after the alleged incidents.

   c. Some law enforcement agencies confirmed they conduct their own, separate investigations before contacting CPS staff and relating their findings. This occurred even though the law enforcement agencies understood that they were mandated reporters.

   d. One police department was aware that CPS was failing to send SCAR forms to them in a timely manner for the last two years. No action was taken to communicate their concern to CPS or to insist upon timely cross-reporting of these cases.

2. There were three serious cases of child abuse in the county during the last several years. However, the Grand Jury was only able to access the information concerning two cases.
a. All cases involved escalating child abuse with one child dying of injuries and another one suffering irreparable brain damage.

b. In the fatality case, both a licensed child-care provider and a physician failed to file a report alleging abuse of a three-year-old child to officials. Within months, the child was subjected to further, more serious abuse, and died of those injuries.

c. In another case of child abuse, CPS did not report the initial suspected child abuse hospital referral to the appropriate law enforcement agency until two weeks later, after the second, more serious incident occurred. The initial report by CPS was in the process of being prepared, when the second referral was made to CPS.

d. At the time of the initial report to CPS as outlined in 2.c above, a hospital report prepared by an emergency room nurse indicated the fracture in the infant’s arm was not “spiral.” However, a doctor’s report prepared the following day stated that it was clearly a “spiral fracture.” CPS records do not show when or whether staff had obtained or understood the implications of that report. According to some interviewees, a spiral fracture is a sign of child abuse. UC Davis Medical Center personnel later confirmed this to the case investigators.

e. Two weeks later the child, referred to in 2c above, suffered permanent brain damage. According to CPS staff and local law enforcement officials, staff at UC Davis Medical Center felt that all local officials, including city and county agencies and the local hospital personnel, mishandled the first incident. This included a failure to identify clear evidence of previous, multiple injuries to the infant from earlier abuse that took place over a period of time.

f. State reporting requirements identify the types of information that are to be obtained in the course of an investigation. Such information includes a check of the family’s background to determine whether there is a history of abuse or neglect, alleged or unfounded, in the system. In this case, there was information about the family already in the system. The failure of the agencies to cross-report the alleged abuse, prevented CPS staff from learning that the family did have a history, something that would have raised red flags concerning the family’s ability to care for its children.

g. Conflicting information from the hospital, CPS and the law enforcement agency regarding dates, times, types of injuries sustained, and sequence of events was found throughout this case file. CPS officials acknowledged that while their internal system of reporting case investigation activities works for them, they are unable to provide the Grand Jury with a log that documents when calls concerning suspected abuse are received or when reports of those calls are forwarded to law enforcement agencies. Further, there is no system in place that enables the Grand Jury to determine when staff received medical
reports or what activities, if any, were undertaken to obtain all related reports in a timely fashion. In one of the two cases reviewed, medical reports prepared one day apart for the first incident of suspected abuse provide conflicting information concerning the nature of the injuries. Additionally, law enforcement and CPS officials disagreed as to whether certain reported injuries are always, or only sometimes, associated with child abuse.

h. Several mandated reporters failed to refer a suspected child abuse incident to CPS or a law enforcement agency. A second incident involving the same child then occurred and, again, mandated reporters failed to make a SCAR referral to CPS or law enforcement. As a result of the second incident, the child died. The physician who earlier treated the child amended the report, after the child’s death, to reflect that the doctor had previously counseled the mother about the textbook child abuse injuries sustained by the child and the need to keep the child away from the boyfriend. The licensed daycare provider, who acknowledged having status as a mandated reporter, testified at trial that perhaps the earlier abuse should have been reported. The District Attorney’s office made a decision not to prosecute the mandatory reporters in this case.

i. The individual convicted of the crime had been suspected of a prior charge of child abuse. Interviewees stated that, if the mandated reporters had notified a law enforcement agency, that information would have been revealed and intervention for this family could have been provided.

3. Following is a table showing the frequency of child abuse referrals to Nevada County CPS, as taken from the Child Welfare System/Case Management System and emergency response data.

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<th>General Neglect</th>
<th>Combined Total</th>
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4. Nevada County has a multi-disciplinary team (MDT) in place that reviews policies and procedures and actions taken related to reports of alleged abuse, including those involving children. However, following the two cases reported herein, no action has been taken to bring concerns about these incidents to the members of the MDT. Further, it was reported to the Grand Jury that attendance at the MDT meetings is not mandatory and meetings frequently are sparsely attended.

5. In all agencies in which interviews occurred, budget and staffing issues were the reasons given for why cracks in the child abuse prevention system are not being repaired or are simply overlooked. No agency identified itself as being the agency accountable for ensuring that mandatory reporters understand and adhere to legal reporting requirements.
6. The law enforcement community has access to both the California Law Enforcement Tracking System (CLETS), and the Department of Justice Central Index, databases of criminal history. Child Protective Services staff has access to a Child Welfare System/Case Management System database in which names of families may be entered any time an investigation is conducted concerning abuse, even if no conviction results. CPS has limited access to the law enforcement CLETS if a child has been detained, or if they are looking at whether a child’s relative would be an appropriate person with whom to place that child. In the event the child is not detained, however, as in at least one of the cases researched, CPS has not routinely forwarded the SCAR form to the appropriate law enforcement agency for their own search of the criminal database systems. Thus, potential flags concerning a family’s history of abuse were not found until further, more serious abuse occurred, resulting in a criminal investigation by law enforcement officials, and irreparable injuries to the child.

7. Law enforcement personnel are provided regular, mandated training through the California Police Officers Standards and Training programs. CPS staff is provided 40-80 hours of training every year, at a cost of about $25,000. Training covers a variety of mandated subject areas including the detection and diagnosis of child abuse. Although they are independently trained to detect and diagnose signs of child abuse, both law enforcement officials and CPS rely on information obtained by medical professionals to determine whether abuse has occurred. For example, one official indicated that even if a bone was found to be sticking out of the child’s arm and it appeared to be broken, if the medical professional reported that it was “internal injuries,” that is what the investigator would put in the final report. However, as shown in the two cases reviewed, medical professionals erred either in their initial statement of injuries sustained or in their ability to provide accurate and complete information in a timely manner.

8. Job descriptions developed for the social worker series used by CPS identify different levels of classification for positions (I, II, III, and IV) based on the required knowledge, degree of task difficulty, and type of tasks assigned. CPS assigns social workers at all levels to handle cases such as suspected child abuse on a rotational on-call basis. The justification given for doing this is that the supervisor closely monitors the cases and each social worker at all times. Minimal requirements for appointment to a social worker position include a specified number of college credits in related classes such as social work, plus experience as a homemaker or office assistant. Once appointed to the general social worker classification, staff moves up in level of appointment from I to II to III, based on a period of time in the job. The IV level is the only one which requires possession of a college degree. The social worker first assigned to investigate the suspected abuse case that involved the “spiral fracture” is classified at the II level. The second social worker assigned, following the escalating abuse and irreparable injuries to the child, is classified at the III level.
9. Neither CPS officials nor law enforcement officials in the cases reviewed filed complaints with the District Attorney’s office seeking prosecution of the mandatory reporters who failed in their obligation to protect these children by meeting either initial or cross-reporting requirements.

CONCLUSIONS

Clearly, our local agencies failed to protect the children in the cases reviewed by the Grand Jury.

If practiced in a collaborative setting, California’s legislative framework provides an effective system to protect children and infants. The dramatic increase of reported cases suggests that a system for quickly evaluating and sharing information about suspected abuse cases must be implemented. Only a results-oriented partnership between agencies focusing on the protection of our children can prevent further incidents like these from occurring.

Agencies must stop trying to justify their failure to protect children with the excuse they lack staff and funding. They must find and develop solutions. They must accept responsibility for each and every incident in which a child is further abused and for every mandated reporter who fails to act responsibly to protect our children.

Possible solutions must not be discounted because these might result in more work for existing staff or because of legal limits on the cross-sharing of some types of information.

CPS and law enforcement agencies must take a more aggressive approach when presented with a SCAR referral. If all of the agencies involved in the cases reviewed had been given information - and shared it - sooner, the chances are strong that these children would not have been subject to an escalation of abuse that led to irreparable injuries and death.

All technological resources must be explored to provide communication between agencies and reporters with regard to child abuse cases. Consistent, ongoing training of agencies and reporters must be implemented. All of our government agencies must work to ensure that our children do not continue to “fall through the cracks” and become victimized by failures of the system created to protect them.

RECOMMENDATIONS

1. All county and city officials should take responsibility to ensure that their personnel is trained to swiftly and thoroughly investigate incidents of alleged child abuse (whether suspected, founded or unfounded).

2. All mandated agencies should maintain an easily accessed database of logs and records that identify the receipt of, and attempts made to obtain and include, all relevant medical, criminal or family history, and investigative records in their child abuse cross-reference files.
3. All mandated agencies, CPS staff, and law enforcement investigators should at all times utilize cross-reporting and cross-investigation procedures to better assist in the investigation of cases.

4. In keeping with legal reporting requirements, all reporters must inform both CPS and the appropriate law enforcement agency of a suspected case of child abuse/neglect in the manner prescribed, and as soon as possible. CPS and the law enforcement agencies must then deliver a copy of a completed SCAR form to the counterpart agency and the District Attorney’s office in the time frame provided by law.

5. All mandated agencies and reporters within Nevada County should be required to file complaints with the District Attorney’s office to seek prosecution of any mandated reporter who fails to report an alleged or suspected case of child abuse. Reporters and their agencies should be put on notice that those who fail to report possible child abuse to other mandated agencies in a timely manner are in violation of the law and a misdemeanor complaint could be filed with the District Attorney’s office.

6. All persons hired in Nevada County into positions designated as mandated reporters whether as child care providers, medical personnel, teachers, CPS staff, law enforcement agents, or others should receive written notification of their obligations for reporting suspected cases of child abuse, and of the penalties for their failure to do so. The County of Nevada should take the leadership role in ensuring that this is done.

7. The County of Nevada, and its incorporated cities, should develop and implement a training program (with the assistance of medical personnel) to educate all mandated reporters within the county concerning the physical injuries or signs and family behaviors typically associated with the abuse of children.

8. Given the County’s budget constraints, CPS should consider utilizing local college students majoring in sociology or child psychology for office internships to supplement and assist regular staff.

**REQUIRED RESPONSES**

Board of Supervisors – by September 26, 2003
Nevada County Sheriff – by August 27, 2003
City Council of Grass Valley – by September 26, 2003
City Council of Nevada City – by September 26, 2003
Truckee Town Council – by September 26, 2003
September 24, 2003

The Honorable Judge Ersel Edwards
Presiding Judge of the Nevada County Courts
Nevada County Court House
Nevada City CA 95959

Subject: Board of Supervisors Responses to the 2002-2003 Nevada County Civil Grand Jury Early Response Report No. 11, dated June 27, 2003 regarding Child Abuse Reporting Procedures

Dear Judge Edwards:

The attached responses by the Board of Supervisors to the 2002-2003 Nevada County Civil Grand Jury Early Response Report No. 11, dated June 27, 2003, are submitted as required by California Penal Code §933.

These responses to the Grand Jury’s Findings and Recommendations were approved by the Board of Supervisors at their regular meeting on September 23, 2003. Responses to Findings and Recommendations are based on either personal knowledge, examination of official County records, information received from the Sheriff-Coronors, the City Councils and Police Chiefs for Grass Valley, Nevada City, and the Town of Truckee, or the Board of Supervisors and County staff members.

Submission of this response completes the required Board of Supervisors’ responses to Findings and Recommendations in the 2002-2003 Grand Jury Report. The Board of Supervisors would like to thank the members of the 2002-2003 Grand Jury for their participation and effort in preparing their Reports, and their participation in the Grand Jury process.

Sincerely,

Sue Horne
Chair of the Board

Attachment
cc: Foreman, Grand Jury
    HSA
    Rick Haffey, County Executive Officer
    County Counsel
    City Councils: Grass Valley, Nevada City, Town of Truckee
I. GRAND JURY INVESTIGATION:

Child Abuse Reporting Procedures.

A. RESPONSE TO FINDINGS & RECOMMENDATIONS:

Findings:

1. The Grand Jury found that while there are legal definitions and written procedures regarding reporting of suspected child abuse cases, there are misunderstandings and failures to follow proper procedures.

   a. Until the Grand Jury investigation got underway, local CPS officials took the position that since they were one of the agencies to whom others reported suspected child abuse, they themselves were not also Mandated Reporters. Therefore, they were not obligated to adhere to the same reporting requirements as other designated reporters. In fact, CPS is a mandated reporter.

Disagree.

The Human Services Agency reported to the Board of Supervisors that there may be a misunderstanding of the terminology used in the child welfare system. "Mandated Reporters" refers to more than 30 categories of individuals, including county child welfare workers, who are identified in the Penal Code as having responsibility to report known or suspected child abuse. Child Protective Service (CPS) staff understands their role as "Mandated Reporters," which includes reporting to law enforcement as appropriate. The law also identifies CPS as a Child Protection Agency (CPA) responsible for receiving and evaluating reports of alleged abuse. Law enforcement agencies are also Child Protection Agencies. It is not clear which "CPS officials" the Grand Jury understood to have taken the position described in this Finding. However, it is likely that some misunderstanding may have arisen over the use of this terminology.
b. For the last two years and up until March of 2003, CPS sent suspected child abuse reports in batches to one police department, resulting in some reports reaching the department as much as three weeks (and up to six weeks in one case) after the alleged incidents.

Agree.

This practice of batching reports was initiated at the request of law enforcement and was stopped in early 2003, concurrent with the Grand Jury investigation and upon filling a long-vacant staff position. It should be noted that this practice was only followed for cases in which the allegation of abuse was determined to be unfounded. Abuse cases have always been, and will continue to be, immediately forwarded to the responsible law enforcement agency. A memorandum of agreement between CPS and all the local law agencies to formalize protocols for cross reporting and information sharing is presently in development and is expected to be fully executed and in place by October 15, 2003.

c. Some law enforcement agencies confirmed they conduct their own, separate investigations before contacting CPS staff and relating their findings. This occurred even though the law enforcement agencies understood that they were Mandated Reporters.

Agree.

Law enforcement agencies often conduct their own, separate investigations before contacting CPS. Their role as a Child Protection Agency provides that they may conduct their own investigation. In some cases this is acceptable, as there are no apparent child protection issues. Other times, CPS is not informed until after the investigation is complete and it may have been appropriate to make a joint response because of protection issues. The memorandum of understanding mentioned in the response to Finding No. 1b. is intended to address this issue as well.

d. One police department was aware that CPS was failing to send SCAR forms to them in a timely manner for the last two years. No action was taken to communicate their concern to CPS or to insist upon timely cross-reporting of these cases.

Agree.

The memorandum of understanding presently in development between CPS and local law agencies to formalize protocols for cross reporting and information sharing will improve communication and strengthen child abuse reporting procedures. (See response to Finding No. 1b.)

Nevada County CPS also has had discussions with local law enforcement agencies to clarify current procedures and protocols and to identify any actions needed to improve timely communication and information exchange until the MOU is developed.
2. There were three serious cases of child abuse in the county during the last several years. However, the Grand Jury was only able to access the information concerning two cases.

As to the third case, it is the understanding of CPS that County Counsel advised the Grand Jury to follow the process outlined in Section 827 of the Welfare & Institutions Code in order to gain access to the information they sought. This existing law was clarified by an appellate decision (People v. Superior Court [Fifth Dist.; Tulare; 3/26/03] 2003 Cal. App. LEXIS 455.) that was issued during the Grand Jury investigation. This appellate case clarified the scope of the law specifically with respect to a Grand Jury inquiry.

a. All cases involved escalating child abuse with one child dying of injuries and another one suffering irreparable brain damage.

Agree

b. In the fatality case, both a licensed child-care provider and a physician failed to file a report alleging abuse of a three-year-old child to officials. Within months, the child was subjected to further, more serious abuse, and died of those injuries.

Agree

c. In another case of child abuse, CPS did not report the initial suspected child abuse hospital referral to the appropriate law enforcement agency until two weeks later, after the second, more serious incident occurred. The initial report by CPS was in the process of being prepared, when the second referral was made to CPS.

Partially agree

Because a number of the Grand Jury’s Findings and Recommendations refer to this case, it is summarized here to provide a reference for the specific responses that follow.

Nevada County CPS received a call from Sierra Nevada Memorial Hospital indicating that an infant was being treated in the emergency room for injuries that were suspected to be child abuse. CPS immediately dispatched Social Worker A to the hospital. While en-route to the hospital, Social Worker A was informed that the child had been released home with the parents. The hospital had informed CPS that the child had suffered an arm fracture that was consistent with the parents’ description of the accidental circumstances under which the parents claimed the injury had occurred.

Social Worker A, instead of proceeding to the hospital, went to the child’s home, arriving shortly after the parents and child had themselves arrived home from the hospital. Social Worker A found the parents to be cooperative and asked them to describe how the alleged accident occurred. Social worker A counseled the parents on how they could prevent such accidents, and discussed with the mother the importance of scheduling a follow-up visit with the treating doctor. The child’s mother agreed to notify Social Worker A of the date and time of the follow-up doctor’s appointment.
Three days later, the child’s mother left a message with CPS for Social Worker A, stating that an appointment had been scheduled with the doctor for later that week. On the same day that this message was left, Social Worker A, accompanied by a colleague, visited the mother and child at home, obtained the mother’s authorization of release of medical information from the doctor to CPS, and confirmed the scheduled doctor appointment. Also on that day, Social Worker A confirmed with the doctor’s office by telephone the scheduled appointment and asked that the doctor contact Social Worker A if he had any concerns.

CPS is required by Penal Code section 11166(h) to report to law enforcement and the District Attorney “every known or suspected instance of child abuse or neglect…” Penal Code section 11165.6 defines “child abuse or neglect” as “physical injury inflicted by other than accidental means…” This referral was determined less than an hour after the initial report to be an unfounded allegation of abuse, as the medical diagnosis of the child’s injury and the social worker’s assessment were consistent with the mother’s explanation of how the “accident” had occurred. No cross reporting to law enforcement or the District Attorney was initiated at this time by CPS.

Twelve days following Social Worker A’s last contact with the family, the child was again brought to the local hospital emergency room, this time with life threatening injuries that required that the child be transferred to UC Davis Medical Center for treatment. CPS opened a new case and assigned Social Worker B to this new case. Social Worker A, recognizing that the case that she had handled would likely be relevant to law enforcement’s investigation of the second case, forwarded a report to the Grass Valley Police Department and the District Attorney before closing her case.

d. At the time of the initial report to CPS as outlined in 2.c above, a hospital report prepared by an emergency room nurse indicated the fracture in the infant’s arm was not “spiral.” However, a doctor’s report prepared the following day stated that it was clearly a “spiral fracture.” CPS records do not show when or whether staff had obtained or understood the implications of that report. According to some interviewees, a spiral fracture is a sign of child abuse. UC Davis Medical Center personnel later confirmed this to the case investigators.

Partially agree

CPS did not receive the hospital report indicating that the initial injury was a spiral fracture until after the second, more serious, injury occurred. During the two weeks between the first and second injuries, the CPS social worker was in contact with the parents to ensure that proper care was taken of the first injury. As the medical professionals were of the opinion that the injury was not a spiral fracture and was, consistent with the mother’s statement, accidental, CPS did not refer the case to law enforcement.

CPS staff clearly understand the potential implications of a “spiral” fracture.

e. Two weeks later the child, referred to in 2c above, suffered permanent brain damage. According to CPS staff and local law enforcement officials, staff at UC Davis Medical Center felt that all local officials, including city and county agencies and the local hospital personnel, mishandled the first incident. This included a failure to identify clear evidence
of previous, multiple injuries to the infant from earlier abuse that took place over a period of time.

Partially agree

UC Davis (UCD) staff did indicate to a Nevada County Community Health nurse that UCD believed that the first injury had been handled incorrectly. However, following further communication between Nevada County staff and UCD staff, it is our understanding that the UCD staff no longer hold that critical opinion after reviewing the documentation related to the first injury. The only prior injury of which CPS is aware is the one described above that was deemed to have been accidental.

f. State reporting requirements identify the types of information that are to be obtained in the course of an investigation. Such information includes a check of the family’s background to determine whether there is a history of abuse or neglect, alleged or unfounded, in the system. In this case, there was information about the family already in the system. The failure of the agencies to cross-report the alleged abuse, prevented CPS staff from learning that the family did have a history, something that would have raised red flags concerning the family’s ability to care for its children.

Partially agree

CPS did not cross-report the first injury because the allegation of abuse was determined to be unfounded when the medical professionals determined that the injury was not the result of abuse and released the child into the custody of the parents. It is not certain that the outcome would have been different even if there had been cross reporting and the family member’s history had been known. The social worker made two visits to the home following the first visit and did not observe anything that suggested that the parents were unable to care for their children.

g. Conflicting information from the hospital, CPS, and the law enforcement agency regarding dates, times, types of injuries sustained, and sequence of events was found throughout this case file. CPS officials acknowledged that while their internal system of reporting case investigation activities works for them, they are unable to provide the Grand Jury with a log that documents when calls concerning suspected abuse are received or when reports of those calls are forwarded to law enforcement agencies. Further, there is no system in place that enables the Grand Jury to determine when staff received medical reports or what activities, if any, were undertaken to obtain all related reports in a timely fashion. In one of the two cases reviewed, medical reports prepared one day apart for the first incident of suspected abuse provide conflicting information concerning the nature of the injuries. Additionally, law enforcement and CPS officials disagreed as to whether certain reported injuries are always, or only sometimes, associated with child abuse.

Partially agree

The internal system of reporting case investigation activities (CWS/CMS) is mandated by the
California Department of Social Services. Additional information that cannot be entered into CWS/CMS is maintained in a paper file, as is the practice statewide. Documents are "date stamped" when they arrive at CPS and may be placed in the paper file. All information obtained in the course of an investigation is included in CWS/CMS or the paper file. This includes any and all medical reports that are received on any specific child. In the case described here, although the reports were prepared on the same day (not one day apart as stated), neither report was provided to CPS until after the subsequent injury. There was no conflicting information at the time of the CPS investigation of the first incident; the case was treated in a manner consistent with the physician's report at the time the child was released from the hospital. Subsequent to this case, CPS has entered into an agreement with UC Davis to obtain medical review of cases where there is conflicting information. Because the conflicting information was not provided by the local hospital until after the second injury occurred, there is no indication that UC Davis review would have been sought in this case even if that agreement had been in place at that time.

ii. Several Mandated Reporters failed to refer a suspected child abuse incident to CPS or a law enforcement agency. A second incident involving the same child then occurred and, again, Mandated Reporters failed to make a SCAR referral to CPS or law enforcement. As a result of the second incident, the child died. The physician who earlier treated the child amended the report, after the child's death, to reflect that the doctor had previously counseled the mother about the textbook child abuse injuries sustained by the child and the need to keep the child away from the boyfriend. The licensed daycare provider, who acknowledged having status as a mandated reporter, testified at trial that perhaps the earlier abuse should have been reported. The District Attorney's office made a decision not to prosecute the mandatory reporters in this case.

Agree

The District Attorney indicated a decision to not prosecute two Mandated Reporters was made because their cooperation was needed as witnesses in the child abuse case. The District Attorney successfully prosecuted the child abuser for murder and related child abuse statutes.

(See response to recommendation No. 5)

i. The individual convicted of the crime had been suspected of a prior charge of child abuse. Interviewees stated that, if the Mandated Reporters had notified a law enforcement agency, that information would have been revealed and intervention for this family could have been provided.

Agree.

Certainly, it is an objective of the mandated reporter network that information be made available in order to provide services to prevent injury to children. Whether a different form of intervention would have occurred if the prior allegations were known is speculation.
3. Following is a table showing the frequency of child abuse referrals to Nevada County CPS, as taken from the Child Welfare System/Case Management System and emergency response data.

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Partially agree

The figures presented in the table above relate to allegations of child abuse, not referrals, and are a subset of the CPS emergency response data for the years presented. The table below summarizes all of the CPS emergency response activity for those years, from which the table prepared by the Grand Jury was excerpted.

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<thead>
<tr>
<th>Year</th>
<th># of Referrals</th>
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</tr>
<tr>
<td>2000</td>
<td>1244</td>
<td>392</td>
<td>695</td>
</tr>
<tr>
<td>2001</td>
<td>1446</td>
<td>382</td>
<td>1035</td>
</tr>
</tbody>
</table>

Following are definitions of terms used in the table:

- **Referral**: a report of child abuse received by CPS. A referral may include more than one allegation and may relate to more than one child.
- **Allegation**: the nature of the abuse being reported in a referral. Again, a referral may include one or more allegations.
- **Other Allegations** include sexual abuse, severe neglect, emotional abuse, exploitation, and caretaker absence or incapacitation. These “other” categories are summarized here to reflect their general relationship to the two categories singled out by the Grand Jury. The detailed figures for these other categories are available.
- **Case Closed** means that the reported allegations are evaluated and determined to not require a face-to-face contact.
- **In-Person Response** refers to allegations in which a face-to-face contact is conducted.
- **Service Cases** are those that remain open for thirty days, requiring multiple face-to-face contacts.

Depending on the outcome of the emergency response services, a case may or may not continue to receive other, non-emergency, CPS services, either on a voluntary basis or by Court order. Those services may include long-term or short-term foster care, family maintenance services, family re-unification services, guardianship, or adoption.

As the table indicates, the number of referrals has nearly doubled over the past five years. That there has not been a corresponding increase in the number of allegations reflects a trend toward the screening process for referrals becoming more specific, resulting in fewer allegations per referral.
4. Nevada County has a Multi-Disciplinary Team (MDT) in place that reviews policies and procedures and actions taken related to reports of alleged abuse, including those involving children. However, following the two cases reported herein, no action has been taken to bring concerns about these incidents to the members of the MDT. Further, it was reported to the Grand Jury that attendance at the MDT meetings is not mandatory and meetings frequently are sparsely attended.

Partially agree

The Special Multidisciplinary Assessment and Referral Team (SMART) is the official MDT in Nevada County related to child welfare. It does not review policies, procedures and actions taken related to reports of alleged abuse. Rather, it reviews cases that may come to the attention of CPS, Probation, the schools, Community Health, Behavioral Health, or other SMART participants, where collaboration among these agencies is appropriate for providing information as to the family situation and exploring potential solutions for a positive intervention with the family. Meetings are held approximately weekly. Over the past year, there were 41 SMART meetings held, at which 94 cases were discussed. The average attendance was 13 people per meeting.

There is a separate MDT in Nevada County for elder abuse cases. Because the child welfare MDT is commonly referred to as “SMART” and the elder abuse MDT is commonly referred to as “MDT,” there has been some misunderstanding among some of the participants that the term “MDT” only refers to elder abuse.

Nevada County also has a Child Death Review Team that meets quarterly to review all child deaths. CPS is an active member of this team. In the case highlighted by the Grand Jury in which the child died, the team sent letters to the Mandated Reporters who had been in positions where they could have reported earlier signs of abuse. The letters explained how those signs should have been taken seriously and been reported, and reminded the Mandated Reporters of their duty to report.

5. In all agencies in which interviews occurred, budget and staffing issues were the reasons given for why cracks in the child abuse prevention system are not being repaired or are simply overlooked. No agency identified itself as being the agency accountable for ensuring that mandatory reporters understand and adhere to legal reporting requirements.

The Board can neither agree nor disagree with what testimony was given to the Grand Jury by other agencies. The Board does not agree that problems with the child abuse prevention system are being ignored or overlooked in Nevada County.

Recruitment and retention of qualified social workers has historically been a challenge for CPS. The County’s recent personnel classification and compensation studies have addressed this issue and CPS is presently fully staffed. We continue to have fewer Master’s degree level social workers than state standards require, and have a temporary waiver from those requirements. As vacancies occur, we expect the revised compensation structure will enhance our ability to hire more highly trained social workers, though there is a shortage statewide in this field.
Training of Mandated Reporters is the responsibility of the State of California as described in Welfare & Institutions Code 12606. The State, under contract with the University of California, Davis, provides such training. CPS also provides training, as do other local agencies.

6. The law enforcement community has access to both the California Law Enforcement Tracking System (CLETS), and the Department of Justice Central Index, databases of criminal history. Child Protective Services staff has access to a Child Welfare System/Case Management System database in which names of families may be entered any time an investigation is conducted concerning abuse, even if no conviction results. CPS has limited access to the law enforcement CLETS if a child has been detained, or if they are looking at whether a child's relative would be an appropriate person with whom to place that child. In the event the child is not detained, however, as in at least one of the cases researched, CPS has not routinely forwarded the SCAR form to the appropriate law enforcement agency for their own search of the criminal database systems. Thus, potential flags concerning a family's history of abuse were not found until further, more serious abuse occurred, resulting in a criminal investigation by law enforcement officials, and irreparable injuries to the child.

Partially agree

CPS has access to CLETS for investigations of child abuse or neglect. In one of the cases cited by the Grand Jury, medical professionals told CPS that the injuries were not indicative of abuse, so no further investigation, which may have included a CLETS search, was indicated. In the other case, CPS received no referral. Access to Department of Justice information is restricted and monitored. It can only be accessed when there is reasonable suspicion that a child is at risk of abuse or neglect. (Penal Code Section 11105, W&I Section 272 and 16504.5.)

In the past year, as CPS staffing has become more stable, additional staff have been trained on the CLETS system.

7. Law enforcement personnel are provided regular, mandated training through the California Police Officers Standards and Training programs. CPS staff is provided 40-80 hours of training every year, at a cost of about $25,000. Training covers a variety of mandated subject areas including the detection and diagnosis of child abuse. Although they are independently trained to detect and diagnose signs of child abuse, both law enforcement officials and CPS rely on information obtained by medical professionals to determine whether abuse has occurred. For example, one official indicated that even if a bone was found to be sticking out of the child's arm and it appeared to be broken, if the medical professional reported that it was "internal injuries," that is what the investigator would put in the final report. However, as shown in the two cases reviewed, medical professionals erred either in their initial statement of injuries sustained or in their ability to provide accurate and complete information in a timely manner.

Partially agree
Although CPS relies on information provided by medical professionals, staff are intelligent and sufficiently concerned about children’s welfare that the extreme situation described here would certainly not happen. If CPS does not have confidence in a medical opinion, a second opinion is sought. The ability to obtain a second opinion has been enhanced within the past year by the creation of a contractual relationship with UCD Medical Center.

8. Job descriptions developed for the social worker series used by CPS identify different levels of classification for positions (I, II, III, and IV) based on the required knowledge, degree of task difficulty, and type of tasks assigned. CPS assigns social workers at all levels to handle cases such as suspected child abuse on a rotational on-call basis. The justification given for doing this is that the supervisor closely monitors the cases and each social worker at all times. Minimal requirements for appointment to a social worker position include a specified number of college credits in related classes such as social work, plus experience as a homemaker or office assistant. Once appointed to the general social worker classification, staff moves up in level of appointment from I to II to III, based on a period of time in the job. The IV level is the only one which requires possession of a college degree. The social worker first assigned to investigate the suspected abuse case that involved the “spinal fracture” is classified at the II level. The second social worker assigned, following the escalating abuse and irreparable injuries to the child, is classified at the III level.

Partially agree

Social workers are assigned cases based on their experience and expertise, and are closely supervised. Social workers may move up in classification, not based on their period of time on the job, but on their experience and the quality of their work. Social workers must demonstrate knowledge of law, regulations, policies and procedures, as well as “good practice” in social work. The Social Worker II referred to in the report has had substantial training and experience on the job, and has demonstrated knowledge of the regulations and good decision-making skills. The change in assignment was not due to the first worker’s decision, but due the stress that very often occurs when a social worker has had contact with a child and the child is subsequently re-injured. The outcome would have been the same had the worker been a II, III, or IV.

9. Neither CPS officials nor law enforcement officials in the cases reviewed filed complaints with the District Attorney’s office seeking prosecution of the mandatory reporters who failed in their obligation to protect these children by meeting either initial or cross-reporting requirements.

Agree that CPS did not file complaints against the two mandatory reporters who failed to report suspected child abuse incidents described by the Grand Jury in Finding No. 2. The complaints were not filed for the reasons stated below. The District Attorney indicated he did not prosecute because the Mandated Reporters were witnesses in the murder case of the convicted child abuser.

(See responses to Finding No. 2h and recommendation No. 5.)
Child Protective Services is only required by law to report to the appropriate law enforcement agency any Mandated Reporters who fail to report suspected child abuse incidents. The role of CPS in the child welfare system is not to seek prosecution of Mandated Reporters who fail to report. Law enforcement agencies are in a better position to conduct the type of investigation that might result in such a complaint. Further, the District Attorney attends the Child Death Review Team meetings at which the facts and circumstances are provided that might result in a compliant.
Recommendations:

The Board of Supervisors fully supports the need to have a strong and effective child abuse reporting system and will continue to work with Nevada County Child Protective Services through the County Executive Officer to ensure we are fully compliant with all state laws and regulations and are taking a proactive approach to improving the system wherever possible. The Board will also continue to work with other agencies involved in child protective services to ensure there is a common understanding of child abuse reporting requirements and that inter-agency procedures are fully coordinated towards achieving common goals.

1. All county and city officials should take responsibility to ensure that their personnel are trained to swiftly and thoroughly investigate incidents of alleged child abuse (whether suspected, founded or unfounded).

The recommendation has been implemented and is on-going.

County officials responsible for the provision of Child Protective Services, including the Board of Supervisors, have consistently accepted their responsibility to ensure all CPS staff are trained to swiftly and thoroughly investigate incidents of alleged child abuse (whether suspected, founded or unfounded). The proper training of CPS staff social workers to ensure they are qualified to recognize and thoroughly investigate alleged incidents of child abuse is a fundamental requirement and responsibility of the Child Protective Services program.

Nevada County Child Protective Services (CPS) contracts with the University of California at Davis to provide ongoing training. Training curriculum is focused on increasing social workers' knowledge of child abuse issues and the development of skills to provide positive social work outcomes. In addition to the UC Davis training, weekly staff meetings are utilized to review and maintain current competency with pertinent regulations and procedures. The department maintains all training records and ensures staff members receive necessary training on a regular basis.

2. All mandated agencies should maintain an easily accessed database of logs and records that identify the receipt of, and attempts made to obtain and include, all relevant medical, criminal or family history, and investigative records in their child abuse cross-reference files.

The recommendation has been partially implemented. At the present time, it is not feasible or cost-effective to merge law enforcement and other related agency databases in order to cross reference common files.

All information needed by CPS to meet its child abuse reporting responsibilities may be found either in CWS/CMS or in department files. Documentation is stamped with the date of receipt. Information regarding client families may be accessed as necessary.
If “cross-reference files” refers to the desire to have a database that could be shared by all the various law enforcement entities and CPS, the cost implications would be considerable. CPS is required by the State to use the CWS/CMS system. To establish a separate system would be a very expensive and duplicative undertaking. There are multiple databases of information maintained by law enforcement and other community agencies. At this time it is not possible to merge these systems.

3. All mandated agencies, CPS staff, and law enforcement investigators should at all times utilize cross-reporting and cross-investigation procedures to better assist in the investigation of cases.

The recommendation has not yet been implemented but will be by October 15, 2003.

A memorandum of understanding is presently being developed that will establish agreements between CPS, all local law enforcement agencies, the Probation Department, and the District Attorney to ensure that cross-reporting practices are not only consistent with the law, but provide for information to be shared in a manner that best serves to respond to alleged abuse and to prevent abuse. This agreement is expected to be fully executed and in place by October 15, 2003.

(See responses to Findings No 1b. & 1c)

4. In keeping with legal reporting requirements, all reporters must inform both CPS and the appropriate law enforcement agency of a suspected case of child abuse/neglect in the manner prescribed, and as soon as possible. CPS and the law enforcement agencies must then deliver a copy of a completed SCAR form to the counterpart agency and the District Attorney’s office in the time frame provided by law.

The recommendation cannot be fully implemented as stated.

State law requires that Mandated Reporters must contact either CPS or law enforcement within time frames and under circumstances prescribed by law. Mandated Reporters are encouraged to contact either CPS or the appropriate law enforcement agency but cannot be compelled to do so by the County.

Responsibilities for cross reporting between Child Protection Agencies, such as CPS and law enforcement, are also prescribed by law.
5. All mandated agencies and reporters within Nevada County should be required to file complaints with the District Attorney’s office to seek prosecution of any mandated reporter who fails to report an alleged or suspected case of child abuse. Reporters and their agencies should be put on notice that those who fail to report possible child abuse to other mandated agencies in a timely manner are in violation of the law and a misdemeanor complaint could be filed with the District Attorney’s office.

The recommendation will not be implemented as stated. As required by the California Penal Code, suspected violations of Mandated Reporting requirements will be reported to the appropriate law enforcement agency for investigation and not directly to the District Attorney.

The District Attorney has the sole discretion to prosecute any mandated reporter who fails to report an alleged or suspected case of child abuse.

As required by Section 11166(b) of the Penal code, “Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect as required by this section is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or by both that fine and imprisonment.”

In the specific case referenced by the Grand Jury in this report, complaints were not filed against the two Mandated Reporters who failed to report suspected child abuse incidents because they were witnesses in the murder case of the child abuser.

(See responses to Finding No. 2h.)

6. All persons hired in Nevada County into positions designated as Mandated Reporters whether as child care providers, medical personnel, teachers, CPS staff, law enforcement agents, or others should receive written notification of their obligations for reporting suspected cases of child abuse, and of the penalties for their failure to do so. The County of Nevada should take the leadership role in ensuring that this is done.

The recommendation has been implemented and is ongoing.

Mandated Reporters are required to sign a document upon starting employment that indicates their understanding of their responsibilities. CPS has provided mandated reporter training in the past and is available to do so upon request. In collaboration with CPS, Court Appointed Special Advocates (CASA) has also provided training locally. The State of California Department of Social Services provides mandated reporter training statewide.

Nevada County Child Protective Services will continue to work with county Mandated Reporters and other agencies and organizations to assist with training and statutory child abuse reporting procedures and requirements.
7. The County of Nevada, and its incorporated cities, should develop and implement a training program (with the assistance of medical personnel) to educate all Mandated Reporters within the county concerning the physical injuries or signs and family behaviors typically associated with the abuse of children.

The recommendation has been implemented.

Training is already available from a variety of sources. Medical professionals receive training relating to their specialty. UC Davis has a catalog of classes that are available to Mandated Reporters. The Child Abuse Prevention Councils also provide training.

8. Given the County’s budget constraints, CPS should consider utilizing local college students majoring in sociology or child psychology for office internships to supplement and assist regular staff.

The recommendation has not yet been implemented but will be as qualified interns are identified and trained.

This has been aggressively pursued in the past. Unfortunately, students have been unable to commute to this area to pursue their internships, and the local community college does not offer the types of programs that would provide appropriately trained interns.

By this response, the Human Services Agency (HSA), through the County Executive Officer, is directed to continue the effort to recruit qualified interns to supplement and assist CPS staff to the extent they can do so. The HSA Director will report on the effort to recruit interns and the potential for using them to augment staff as part of their budget proposal for FY 2004-2005.

REQUIRED RESPONSES
Board of Supervisors – by September 26, 2003
Nevada County Sheriff – by August 27, 2003
City Council of Grass Valley – by September 26, 2003
City Council of Nevada City – by September 26, 2003
Truckee Town Council – by September 26, 2003
August 20, 2003

Honorable Ersel L. Edwards
Presiding Judge of the Superior Court of Nevada County
201 Church Street
Nevada City, CA 95959

RE: Response to the Grand Jury Report as to Child Abuse Reporting Procedures

Your Honor,

This letter is a response to the 2002-2003 Grand Jury Report regarding Child Abuse Reporting Procedures from the Grass Valley City Council. The Grand Jury's interest in Child Abuse Reporting Procedures is appreciated.

As you know, the Grand Jury conducted a comprehensive investigation into the practices and procedures followed in suspected child abuse cases by Nevada County agencies charged with protecting our children. Thus the findings, conclusions and recommendations of their report are sometimes agency specific and/or specific to one or more agencies charged with protecting our children in Nevada County. Nevertheless, Grass Valley Police Chief John Foster and Captain Greg Hart were directed to take the lead and assist with the City of Grass Valley’s response to the Grand Jury's report. We have reviewed Chief Foster’s and Captain Hart’s efforts and concur with their findings and recommendations that relate to the City of Grass Valley. Thus, the following are the City Council’s responses to the Grand Jury Report on Child Abuse Reporting Procedures in the areas of findings and recommendations:

FINDINGS

We agree with all the report’s Findings, except for 1.c, 2.e., f., g. and 4.

- **1.c. Disagree.** The Grass Valley Police Department (GVPD) does not conduct Child Abuse investigations independent of CPS knowledge or involvement.

- **2.e. Disagree.** Upon receipt of this child’s injury, our officers responded immediately. The responding officer immediately notified our investigators and the Investigative Captain, all three of which responded. Both investigators (and an experienced supervisor who was temporarily removed from patrol) were assigned to work exclusively on this case (being relieved of their work on all other cases) for 3 weeks until the investigation was complete.

- **2.f. Partially Agree.** We had no information about previous contacts with this family.

- **2.g Disagree.** GVPD was able to provide the Grand Jury copies of the incoming case log, which identifies the receipt date of the CPS report. GVPD's case report already provides all information as to “dates, times, types of injuries
sustained and sequence of events..." as stated in the Grand Jury report.

- 4. Disagree. The Nevada County MDT deals with Elder-Abuse cases only. There is agreement, however, that there is a need for a similar program for child abuse cases. This area is currently under review by the affected agencies.

RECOMMENDATIONS

- 1. Previously implemented with ongoing training.

- 2. Previously implemented with incoming case logs and investigative reports.

- 3. Previously implemented with cross reporting pursuant to current law and cooperative investigations.

- 4. Implemented on child abuse cases only. This will not apply to cases, which, on their face, do not constitute child abuse, but rather poor parenting skills, etc.

- 5. Will not be implemented. As with any criminal offense, each case will be reviewed individually to determine if a crime has been committed.

- 6. Previously implemented. Notification is already made upon hiring.

- 7. Yet to be implemented. Representatives of all child protection agencies in Nevada County have been meeting to discuss a training and implementation plan that should be completed during this fiscal year. In addition these meetings have also been productive in taking other proactive steps to ensure all agencies are working in a collaborative and effective manner.

- 8. Does not apply to the City of Grass Valley.

This response was reviewed and approved by City Council at its August 26, 2003 meeting. Thank you for your consideration.

Sincerely,

Patti Ingram
Mayor

DeVere "Dee" Mautino
Vice Mayor

cc: City Council
John Foster, Chief of Police
Keith Royal, Sheriff Nevada County
Lou Trovato, Chief of Police, Nevada City
Dan Boone, Chief of Police, Truckee
Mike Ferguson, District Attorney, Nevada County
Robert Erickson, Director of Behavioral Health, Nevada County
Pat Ward, Nevada County BOS Analyst
August 20, 2003

Honorable Ersel L. Edwards
Presiding Judge of the Superior Court of Nevada County
201 Church Street
Nevada City, CA 95959

RE: Response to the Grand Jury Report as to Child Abuse Reporting Procedures

Your Honor,

This letter is a response to the 2002-2003 Grand Jury Report regarding Child Abuse Reporting Procedures from the Grass Valley City Council. The Grand Jury’s interest in Child Abuse Reporting Procedures is appreciated.

As you know, the Grand Jury conducted a comprehensive investigation into the practices and procedures followed in suspected child abuse cases by Nevada County agencies charged with protecting our children. Thus the findings, conclusions and recommendations of their report are sometimes agency specific and/or specific to one or more agencies charged with protecting our children in Nevada County. Nevertheless, Grass Valley Police Chief John Foster and Captain Greg Hart were directed to take the lead and assist with the City of Grass Valley’s response to the Grand Jury’s report. We have reviewed Chief Foster’s and Captain Hart’s efforts and concur with their findings and recommendations that relate to the City of Grass Valley. Thus, the following are the City Council’s responses to the Grand Jury Report on Child Abuse Reporting Procedures in the areas of findings and recommendations:

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- 1 c. **Disagree.** The Grass Valley Police Department (GVPD) does not conduct Child Abuse Investigations independent of CPS knowledge or involvement.

- 2 e. **Disagree.** Upon receipt of this child’s injury, our officers responded immediately. The responding officer immediately notified our investigators and the Investigative Captain, all three of which responded. Both investigators (and an experienced supervisor who was temporarily removed from patrol) were assigned to work exclusively on this case (being relieved of their work on all other cases) for 3 weeks until the investigation was complete.

- 2 f. **Partially Agree.** We had no information about previous contacts with this family.

- 2 g **Disagree.** GVPD was able to provide the Grand Jury copies of the incoming case log, which identifies the receipt date of the CPS report. GVPD’s case report already provides all information as to “dates, times, types of injuries
sustained and sequence of events..." as stated in the Grand Jury report.

- 4. **Disagree.** The Nevada County MDT deals with Elder-Abuse cases only. There is agreement, however, that there is a need for a similar program for child abuse cases. This area is currently under review by the affected agencies.

RECOMMENDATIONS

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- 5. Will not be implemented. As with any criminal offense, each case will be reviewed individually to determine if a crime has been committed.
- 6. Previously implemented. Notification is already made upon hiring.
- 7. Yet to be implemented. Representatives of all child protection agencies in Nevada County have been meeting to discuss a training and implementation plan that should be completed during this fiscal year. In addition these meetings have also been productive in taking other proactive steps to ensure all agencies are working in a collaborative and effective manner.
- 8. **Does not apply to the City of Grass Valley.**

This response was reviewed and approved by City Council at its August 26, 2003 meeting. Thank you for your consideration.

Sincerely,

Patti Ingram
Mayor

Devere "Dee" Mautino
Vice Mayor

cc: City Council
John Foster, Chief of Police
Keith Royal, Sheriff Nevada County
Lou Trovato, Chief of Police, Nevada City
Dan Boone, Chief of Police, Truckee
Mike Ferguson, District Attorney, Nevada County
Robert Erickson, Director of Behavioral Health, Nevada County
Pat Ward, Nevada County BOS Analyst
CITY OF NEVADA CITY
CALIFORNIA

September 3, 2003

Honorable Ersel L. Edwards
Presiding Judge of the Superior Court of Nevada County
201 Church Street
Nevada City, CA 95959

RE: Response to the Grand Jury Findings on Child Abuse Reporting Procedures

Your Honor:

This report is provided as the required response to the Grand Jury by the City Council of Nevada City to the Grand Jury investigation into child abuse reporting procedures. Police Chief Louis Trovato and Sergeant Lorin Gage reviewed the Grand Jury report and presented this Council with the following responses. We concur with their conclusions and submit them in accordance with the Grand Jury request for a response from the City Council of Nevada City.

Grand Jury Findings

1. Paragraphs a, b, and d do not pertain to Nevada City.

Paragraph c states, “Some law enforcement agencies confirmed they conduct their own, separate investigations before contacting CPS staff and relating their findings. This occurred even though the law enforcement agencies understood that they were mandated reporters.”

Response – Respectfully Disagree

2. Does not pertain to Nevada City.

3. Does not pertain to Nevada City.

4. Report states: “Nevada County has a multi-disciplinary team (MDT) in place that reviews policies and procedures and actions taken related to reports of alleged abuse, including those involving children. However, following the two cases reported herein, no action has been taken to bring concerns about these incidents to the members of the MDT. Further, it was reported to the Grand Jury that attendance at the MDT meetings is not mandatory and meetings frequently are sparsely attended.”
Nevada City Response to Grand Jury
September 3, 2003
Page 2 of 4

Response – Respectfully Disagree
The MDT is a coalition for the prevention and investigation of Elder Abuse. There is an
MDIC Advisory Committee. The MDIC/MDIT is in place for the investigation and
interview of child abuse cases. This Department participates fully with both the MDT and
the MDIC committees.

5. Does not pertain to Nevada City.
6. Does not pertain to Nevada City.
7. Does not pertain to Nevada City.
8. Does not pertain to Nevada City.
9. Does not pertain to Nevada City.

Grand Jury Recommendations

1. "All county and city officials should take responsibility to ensure that their personnel is
trained to swiftly and thoroughly investigate incidents of alleged child abuse (whether
suspected, founded or unfounded.)"

Response – Currently implemented
All officers and supervisors of this Department have previously received, and will continue
to receive, timely training in this area. Legal updates, bulletins, and participation in various
law enforcement organizations provides up-to-date information on legal changes.
Participation in the MDIC committee ensures we are aware of County trends and current
cases.

2. "All mandated agencies should maintain an easily accessed database of logs and records that
identify the receipt of, and attempts made to obtain and include, all relevant medical,
criminal or family history, and investigative records in their child abuse cross-reference
files."
Response - Currently implemented
This Department maintains an automated index of all reports and follow-up investigations.

3. "All mandated agencies, CPS staff, and law enforcement investigators should at all times utilize cross-reporting and cross-investigation procedures to better assist in the investigation of cases."

Response - Currently implemented
This Department adheres to Penal Code section 11166 mandates. Investigators conduct thorough and timely follow up investigations and coordinate with all adjunct agencies. Our participation with the MDIC committee provides additional cross-agency coordination.

4. "In keeping with legal reporting requirements, all reporters must inform both CPS and the appropriate law enforcement agency of a suspected case of child abuse/neglect in the manner prescribed, and as soon as possible. CPS and the law enforcement agencies must then deliver a copy of a completed SCAR form to the counterpart agency and the District Attorney's office in the time frame provided by law."

Response - Currently implemented as pertains to Nevada City law enforcement
This Department adheres to all Penal Code section 11166 mandates.

5. "All mandated agencies and reporters within Nevada-County should be required to file complaints with the District Attorney's office to seek prosecution of any mandated reporter who fails to report an alleged or suspected case of child abuse. Reporters and their agencies should be put on notice that those who fail to report possible child abuse to other mandated agencies in a timely manner are in violation of the law and a misdemeanor complaint could be filed with the District Attorney's office."

Response - Currently implemented as pertains to Nevada City law enforcement
This Department files with the District Attorney on all cases in which investigation determines criminal conduct. Notifying other mandated reporters of their role and responsibilities would best be handled by the licensing agencies.
Nevada City Response to Grand Jury
September 3, 2003
Page 4 of 4

6. "All persons hired in Nevada County into positions designated as mandated reporters whether as child care providers, medical personnel, teacher, CPS staff, law enforcement agents, or others should receive written notification of their obligations for reporting suspected cases of child abuse, and of the penalties for their failure to do so. The county of Nevada should take the leadership role in ensuring that this is done."

Response – Currently implemented as pertains to Nevada City law enforcement
By virtue of their training and legal mandates law enforcement personnel are aware of their responsibilities in this area.

7. "The County of Nevada, and its incorporated cities, should develop and implement a training program (with the assistance of medical personnel) to educate all mandated reporters within the county concerning the physical injuries or signs and family behaviors typically associated with the abuse of children."

Response – Future implementation planned
A program specific to this recommendation has been under development through the auspice of the MDIC committee.

8. Does not pertain to Nevada City.

This response was reviewed and approved by the City Council on September 8, 2003.

Respectfully submitted,

Kerry Arnett
Mayor
August 8, 2003

Honorable Ersel L. Edwards
Presiding Judge of the Superior Court
201 Church Street
Nevada City, CA 95959

Re: Response to Grand Jury Report Child Abuse Reporting Procedures

Dear Judge Edwards:

This letter constitutes the response of the Town of Truckee to the report of the Grand Jury regarding Child Abuse Reporting Procedures as it relates to the Town Police Department.

With regard to Findings 1 through 9 the facts related therein, to the best of the Town's knowledge, occurred prior to the creation of the Truckee Police Department and without direct Town involvement.

With regard to the stated Conclusions the Town agrees that child protective services are best done in a collaborative manner. The Town and its Police Department are committed to that principle and are actively implementing it with all involved agencies.

With regard to the Grand Jury Recommendations the Town responds as follows:

The Town agrees with Recommendations 1 to 4 and is implementing them now. That process is expected to be completed within one year. With regard to Recommendation 5 the Town agrees that all mandated reporters should be made fully aware of their reporting responsibilities and their legal exposure if they fail to do so. The Town has implemented that policy. Deciding how to proceed if that policy is not followed is a
management decision to be made on a case by case basis. A blanket policy in that respect is not appropriate and will not be implemented.

Item 6 involves Nevada County employees and therefore a response by the Town is not appropriate.

The Town agrees with Recommendation 7 and is now actively working with Nevada County and the other cities in the County to implement the recommendation. It is anticipated implementation will be complete within one year.

Item 8 involves Nevada County personnel policies so a response by the Town is not appropriate.

If there are any questions regarding these responses please contact Police Chief Dan Boon or Town Manager Steve Wright.

Sincerely,

Ted Owens
Mayor
August 27, 2003

Presiding Judge Al Dover
Superior Courts of Nevada County of Nevada
201 Church Street
Nevada City, CA 95959


Dear Judge Dover:

This correspondence is prepared in response to the Grand Jury's Eleventh Early Release Report, dated July 9, 2003, relative their findings, conclusions, and recommendations as they pertain to the Nevada County Sheriff's Office and our policies, procedures, and past practices in relation to child abuse reporting.

FINDINGS:

1. "The Grand Jury found that while there are legal definitions and written procedures regarding reporting of suspected child abuse cases, there are misunderstandings and failures to follow proper procedures."

   a. "Until the Grand Jury investigation got underway, local CPS officials took the position that since they were one of the agencies to whom others reported suspected child abuse, they themselves were not also mandated reporters. Therefore, they were not obligated to adhere to the same reporting requirements as other designated reporters. In fact, CPS is a mandated reporter."

   Response: CPS is not under direction of the Sheriff's Department and therefore we are unaware of the position taken by CPS.

   b. "For the last two years and up until March of 2003, CPS sent suspected child abuse reports in batches to one police department, resulting in some reports reaching the department as much as three weeks (and up to six weeks in one case) after the alleged incidents."
Response: The Sheriff's Department CAPP Unit has not experienced batches of late child abuse reports from CPS.

c. "Some law enforcement agencies confirmed they conduct their own, separate investigations before contacting CPS staff and relating their findings. This occurred even though the law enforcement agencies understood that they were mandated reporters."

Response: We have no knowledge of other law enforcement agency's practices in this regard. It is neither the policy or practice of the Nevada County Sheriff's Office to delay reporting investigations of suspected child abuse to CPS.

d. "One police department was aware that CPS was failing to send SCAR forms to them in a timely manner for the last two years. No action was taken to communicate their concern to CPS or to insist upon timely cross-reporting of these cases."

Response: The Nevada County Sheriff's Office has not experienced late reporting by CPS relating to child abuse.

2. "There were three serious cases of child abuse in the county during the last several years. However the Grand Jury was only able to access the information concerning two cases."

Response: The Sheriff's Office supplied copies of any documentation it possessed when requested by the Grand Jury.

   a. "All cases involved escalating child abuse with one child dying of injuries and another one suffering irreparable brain damage."

Response: Agree.

   b. "In the fatality case, both the licensed child-care provider and a physician failed to file a report alleging abuse of the three-year-old child to officials. Within months, the child was subjected to further, more serious abuse, and died of those injuries."

Response: The documentation we have in our possession does indicate this to be true.

   c. "In another case of child abuse, CPS did not report the initial suspected child abuse hospital referral to the appropriate law enforcement agency until two weeks later, after the second, more serious incident occurred. The initial report by CPS was in the process of being prepared, when the second referral was made to CPS."

Response: Cannot comment; the Sheriff's Office was not involved with this case.
d. "At the time of the initial report to CPS as outlined in 2.c. above, a hospital report prepared by an emergency room nurse indicated the fracture in the infant's arm was not "spiral." However, a doctor's report prepared the following day stated that it was clearly a "spiral fracture." CPS records do not show when or whether staff had obtained or understood the implications of that report. According to some interviewees, a spiral fracture is a sign of child abuse. UC Davis Medical Center personnel later confirmed this to the case investigators."

Response: I have no independent knowledge of these matters.

e. "Two weeks later the child, referred to in 2c. above, suffered permanent brain damage. According to CPS staff and local law enforcement officials, staff at UC Davis Medical Center felt that all local officials, including city and county agencies, and the local hospital personnel, mishandled the first incident. This included a failure to identify clear evidence of previous, multiple injuries to the infant from earlier abuse that took place over a period of time."

Response: The Sheriff's Office was not involved in this case. I do not know what the opinion of the UC Davis Medical Center was in regard to the handling of this incident.

f. "State reporting requirements identify the types of information that are to be obtained in the course of an investigation. Such information includes a check of the family's background to determine whether there is a history of abuse or neglect, alleged or unfounded, in the system. The failure of the agencies to cross-report the alleged abuse, prevented CPS staff from learning that the family did have a history, something that would have raised red flags concerning the family's ability to care for its children."

Response: Again, we were not involved with this particular case.

g. "Conflicting information from the hospital, CPS and the law enforcement agency regarding dates, times, types on injuries sustained, and sequence of events was found throughout this case file. CPS officials acknowledged that while their internal system of reporting case investigation activities works for them, they are unable to provide the Grand Jury with a log that documents when calls concerning suspected abuse are received or when reports of those calls are forwarded to law enforcement agencies. Further, there is no system in place that enables the Grand Jury to determine when staff received medical reports or what activities, if any, were undertaken to obtain all related reports in a timely fashion. In one of the two cases reviewed, medical reports prepared on day apart for the first incident of suspected abuse provide conflicting information concerning the nature of the injuries. Additionally, law enforcement and CPS officials disagreed as to whether certain reported injuries are always, or only sometimes, associated with child abuse."

Response: The Sheriff's Office was not involved in the cited case.
h. "Several mandated reporters failed to refer a suspected child abuse incident to CPS or a law enforcement agency. A second incident involving the same child then occurred and, again, mandated reporters failed to make a SCAR referral to CPS or law enforcement. As a result of the second incident, the child died. The physician who earlier treated the child amended the report, after the child’s death, to reflect that the doctor had previously counseled the mother about the textbook child abuse injuries sustained by the child and the need to keep the child away from the boyfriend. The licensed daycare provider, who acknowledged having status as a mandated reporter, testified at trial that perhaps the earlier abuse should have been reported. The District Attorney’s office made a decision not to prosecute the mandatory reporters in this case.

Response: Please refer to the response from the District Attorney.

3. "Following is a table showing the frequency of child abuse referrals to Nevada County CPS, as taken from the Child Welfare System/Case Management System and emergency response data." (See table on original report.)

Response: None.

4. "Nevada County has a multi-disciplinary team (MDT) in place that reviews policies and procedure and actions taken related to reports of alleged abuse, including those involving children. However, following the two cases reported herein, no action has been taken to bring concerns about these incidents to the members of the MDT. Further it was reported to the Grand Jury that attendance at the MDT meetings is not mandatory and meetings frequently are sparsely attended."

Response: Partially agree. A representative of the Sheriff’s Office regularly attends MDT meetings. This team deals with elder abuse cases.

5. "In all agencies in which interviews occurred, budget and staffing issues were the reasons given for why cracks in the child abuse prevention system are not being repaired or are simply overlooked. No agency identified itself as being the agency accountable for ensuring that mandatory reporters understand and adhere to legal reporting requirements."

Response: Partially agree. Budget and staffing issues are a concern. We do ensure that the Sheriff’s Office employees who are mandatory reporters, do understand and adhere to legal reporting requirements.

6. "The law enforcement community has access to both the California Law Enforcement Tracking System (CLETs) and the Department of Justice Central Index, databases of criminal history. Child Protective Services Staff has access to a Child Welfare System/Case Management System Database in which names of families may be entered any time an investigation is conducted concerning abuse, even if no conviction results. CPS has limited access to the law enforcement CLETs if a child has been detained, or if they are looking at whether a child’s relative would be an appropriate person with whom to place that child. In the event the child is not detained, however, as in at least one of the cases researched, CPS has not routinely forwarded the SCAR form to the appropriate law enforcement agency for their own search of the criminal database systems. Thus, potential flags concerning a family’s history of abuse were not found until
Response: Partially agree. The Sheriff’s Office does have access to CLETS and the DOJ Central Index. I am not certain whether or not CPS is referring the SCAR form to the appropriate law enforcement agencies with expediency and regularity. There is no indication that we have a particular problem with CPS in this regard.

7. “Law Enforcement personnel are provided regular, mandated training through the California Police Officers Standards and Training Programs. CPS staff is provided 40-80 hours of training every year, at a cost of about $25,000. Training covers a variety of mandated subject areas, including the detection and diagnosis of child abuse. Although they are independently trained to detect and diagnose signs of child abuse, both law enforcement officials and CPS rely on information obtained by medical professionals to determine whether abuse has occurred. For example, one official indicated that even if a bone was found to be ticking out of the child’s arm and it appeared to be broken, if the medical professional reported that it was “internal injuries,” that is what the investigator would put in the final report. However, as shown in the two cases reviewed, medical professionals erred either in their initial statement of injuries sustained or in their ability to provide accurate and complete information, in a timely manner.”

Response: Partially agree. I can state that Nevada County Sheriff’s deputies receive regular, mandated training through California Peace Officer Standards and Training (POST), which includes the detection and diagnosis of child abuse. We do rely on medical professionals to determine whether abuse has occurred in most instances.

8. “Job descriptions developed for the social worker series used by CPS identify different levels of classification for position (I, II, III, and IV) based on the required knowledge, degree of task difficulty, and type of tasks assigned. CPS assigns social workers at all levels to handle cases such as suspected child abuse on a rotational, on-call basis. The justification given for going this is that the supervisor closely monitors the cases and each social worker at all times. Minimal requirements for appointment to a social worker position include a specified number of college credits related classes such as social work, plus experience as a homemaker or office assistant. Once appointed to the general social worker classification, staff moves up in level of appointment from I to II to III, based on a college degree. The social worker first assigned to investigate the suspected abuse case that involved the “spiral fracture" is classified at the II level. The second social worker assigned, following the escalating abuse and irreparable injuries to the child, is classified at the III level.”

Response: None.

9. “Neither CPS officials nor law enforcement officials in the cases reviewed, filed complaints with the District Attorney’s Office seeking prosecution of the mandatory reporters who failed in their obligation to protect these children by meeting either initial or cross-reporting requirements.”

Response: I would agree that the Nevada County Sheriff’s Office did not seek prosecution by the District Attorney’s Office of the mandatory reporters who failed in their obligation.
1. “All county and city officials should take responsibility to ensure that their personnel is trained to swiftly and thoroughly investigate incidents of alleged child abuse (whether suspected, founded, or unfounded.)”

Response: It is extremely important that alleged child abuse be swiftly and thoroughly investigated. Training for mandatory reporters to understand their responsibilities as well as training for personnel involved in detection, diagnosis, and investigation should be provided regularly. When a sworn officer is assigned to our Investigations Division, and assigned to the Crimes Against Persons and Property (CAPP) Unit, they are required to attend training in Child Abuse Investigation. Officers are trained not only to investigate child abuse, but also to cross-report their findings to CPS and the DOJ.

2. “All mandated agencies should maintain an easily accessed database of logs and records that identify the receipt of, and attempts made to obtain and include, all relevant medical, criminal or family history, and investigative records in their child abuse cross-reference files.”

Response: All cases investigated by the Sheriff’s Office are entered and tracked using the TAZ computer system. All information related to these cases is maintained using this system and updated as cases are brought to conclusion.

3. “All mandated agencies, CPS staff, and law enforcement investigators should at all times utilize cross-reporting and cross-investigation procedures to better assist in the investigation of cases.”

Response: Cross-reporting with CPS is a state mandated procedure and is accomplished using forms provided under PC 11169 (form SS85583) or PC 11166 (form SS8572.)

4. “In keeping with legal reporting requirements, all reporters must inform both CPS and the appropriate law enforcement agency of a suspected case of child abuse/neglect in the manner prescribed, and as soon as possible. CPS and the law enforcement agencies must then deliver a copy of a completed SCAR form to the counterpart agency and the District Attorney’s Office in the time frame provided by law.”

Response: Agree

5. “All mandated agencies and reporters within Nevada County should be required to file complaints with the District Attorney’s Office to seek prosecution of any mandated reporter who fails to report an alleged or suspected case of child abuse. Reporters and their agencies should be put on notice that those who fail to report possible child abuse to other mandated agencies in a timely manner are in violation of the law and a misdemeanor complaint could be filed with the District Attorney’s Office.”

Response: The Nevada County Sheriff’s Office will file complaints whenever a mandated reporter is in violation of PC 11166(b).
6. All persons hired in Nevada County into positions whether as child care providers, medical personnel, teachers, CPS staff, law enforcement agents, or others should receive written notification of their obligations for reporting suspected cases of child abuse, and of the penalties for their failure to do so. The County of Nevada should take the leadership role in ensuring that this is done.

Response: All Nevada County deputy sheriffs are mandated to abide by Sheriff's General Order #32 (attached) that spells out their obligation to report and investigate cases of child abuse.

7. "The County of Nevada, and its incorporated cities, should develop and implement a training program (with the assistance of medical personnel) to educate all mandated reporters within the county concerning the physical injuries or signs and family behaviors typically associated with the abuse of children."

Response: We appreciate the need for training for mandated reporters. We are not familiar with this type of training for non-law enforcement personnel. Additional training would be beneficial. Deputies receive training in the recognition of signs of abuse both in the academy and during regular update training classes.

8. "Given the County's budget constraints, CPS should consider utilizing local college students majoring in sociology or child psychology of office internships to supplement and assist regular staff."

Response: No response.

Sincerely,

Keith Royal
Sheriff-Coroner

KR/dn

cc: Dieter Juli, Grand Jury Foreman; Pat Ward; Rick Haffey