



**Los Angeles County
Blue Ribbon Commission on Child Protection**

**Interim Report
December 30, 2013**

On June 25, 2013, the Los Angeles County Board of Supervisors (Board) created the Blue Ribbon Commission on Child Protection (Commission), following the tragic death of eight year-old Gabriel Fernandez. The horrific killing of this young boy, allegedly at the hands of his caregivers, was seen as another failure by Los Angeles County (County) to protect children under its supervision. In its motion, the Board charged the Commission to:

- Review previously delayed or failed efforts to implement reforms and provide recommendations for a feasible plan of action to expeditiously implement needed reforms;
- Review the systemic, structural and organizational barriers to effective performance. These may include such factors as the current structure, scope of the Department of Children and Family Services (DCFS) and relevant County departments, including the departments of Health Services, Mental Health, Public Health, and Sheriff, the District Attorney, the Dependency Court and commissions, various memoranda of understanding, and the relationship of DCFS to the Board; and
- Review, at its discretion, the child protection failures, including DCFS policies and cases.

The Board instructed the Commission to provide an Interim Report by December 31, 2013, and to issue its Final Report by April 18, 2014. While most of the Commission's findings and recommendations will be provided in April, this Interim Report describes the information-gathering process to date, sets forth initial key findings, and makes a limited set of preliminary recommendations for immediate implementation.

The Commission fully recognizes the urgent need to reform the County's child protection system, as well as the direct request by the Board to provide "a feasible plan of action to expeditiously implement needed reforms." **To improve child safety and prevent child maltreatment fatalities, the Commission urges the Board to adopt the concrete steps proposed in this Interim Report to begin immediate reform of the current "dysfunctional"**

County child protection system. These proposals, set forth in Section II below, provide an opportunity to make children safer *now*.

I. INFORMATION GATHERING

Given the gravity of the task and the multitude of recommendations for reform the Board has received over the years, the Commission determined that the Board deserves more than a cursory review leading to prejudged conclusions. **A multi-system, comprehensive assessment is warranted to fundamentally improve child safety.** The effort had to be more than a compilation or repetition of previous recommendations. Therefore, the Commission has pursued a fresh perspective and process that is comprehensive, inclusive, and transparent, including:

- **Eleven public hearings** at which the following Los Angeles County departments and nonprofit organizations provided testimony: Department of Children and Family Services (DCFS); Sheriff's Department (LASD); Department of Mental Health (DMH); District Attorney's Office (DA); Department of Health Services (DHS); Department of Public Health (DPH); Department of Coroner; Department of Public Social Services (DPSS); the Inter-Agency Council on Child Abuse and Neglect (ICAN); First 5 LA; the Commission for Children and Families; Dependency Court; Domestic Violence Council; LAC+USC Medical Center; University of Southern California School of Social Work; Children's Law Center of California; Alliance for Children's Rights; Public Counsel; Child Welfare Initiative; Stuart House; relative caregiver organizations, including Kinship in Action, Community Coalition, Grandparents as Parents, and ROCK; representatives from the Countywide Community Child Welfare Coalition, including SHIELDS for Families, Project IMPACT, Bienvenidos, Para Los Niños, and Children's Institute, Inc.; and members of the Association of Community Human Service Agencies, including Optimist Youth Homes & Family Services, David and Margaret Youth and Family Services, and Penny Lane Centers. The Commission also received important comments from many members of the public.
- **Interviews with close to 300 stakeholders** across all program areas related to child safety. Under the direction of a Commission work group, the University of Southern California School of Social Work took primary responsibility for organizing and conducting these interviews. Interviews were conducted in each Supervisorial District and included conversations with representatives of DCFS, the Dependency Court, DHS, DPH, the Commission for Children and Families, Service Employees International Union leadership, selected local hospitals and community health services, Los Angeles and Long Beach Unified School Districts, faith-based organizations, and community nonprofit programs contracting with DCFS, DMH, and the Department of Probation. Interviews were conducted with providers representing a complete spectrum of services, ranging from prevention, early diagnosis and investigation, to foster care, intensive treatment, residential care, and transitional support. A total of 298 persons provided input in one of either 32 focus groups or 34 in-person meetings.
- **Focus groups with the people most impacted by the policies and practices of the child welfare system.** Under the direction of another Commission work group with significant support from Casey Family Programs and the USC School of Social Work,

focus groups and interviews are underway with the following client populations: children and youth 13-17 years old; transition age youth 18-25 years old; formal and informal kinship caregivers; birth parents; and foster and adoptive parents.

- **Review of relevant previous recommendations made to DCFS and other County agencies.** In consultation with Walter R. McDonald & Associates, Inc. (WRMA), a database was created to organize and categorize prior recommendations related to child protection and safety dating back to 2008. An initial review and analysis of over 700 recommendations contained in 29 documents was completed. Additional analysis is planned to inform the Final Report.
- **One-on-one, in-depth interviews with leaders in the child welfare field, conducted by Commissioners and Commission staff.** These include extensive interviews with members of law enforcement, DCFS, DHS, DMH, and the District Attorney's Office, as well as education and community leaders.
- **Review of best practices and relevant reports on child abuse.** The Commission is reviewing promising practices and reports considered and/or utilized in other jurisdictions to assess what can be learned and applied in Los Angeles County.
- **Constituent correspondence received by the Commission.** Constituent letters and email inquiries were received and reviewed.

II. KEY FINDINGS AND PRELIMINARY RECOMMENDATIONS

Of one thing the Commission is certain: The children of Los Angeles County must be safer than they are at present. The Blue Ribbon Commission on Child Protection will issue a complete set of recommendations in its April 18, 2014, Final Report to the Board of Supervisors. The Commission has decided to present in this Interim Report ten recommendations that lend themselves to immediate action.

Accountability

Hundreds of child welfare-related recommendations have been offered to the Board over the past eight years. **Before any set of recommendations can be effectively implemented, a fundamental change in County structure and culture must occur.**

The failure to protect children cannot be attributed to one agency or department. DCFS is not and cannot be viewed as solely responsible for all aspects of child protection. Under its current structure, the County child welfare system is comprised of multiple departments and agencies that struggle to communicate effectively, plan jointly for children and families at risk, combine funding resources, and work together on integrated planning to improve child outcomes. While some advances have been made through partnership initiatives, such as the Violence Intervention Program at LAC+USC Medical Center and Stuart House at UCLA Medical Center, these collaborative models are the exception rather than the rule.

The County’s current siloed approach often re-victimizes children and fails to strengthen family caregiving. There must be a fundamental cultural and structural shift to a multi-disciplinary system of County departments with common priorities, shared responsibilities, and collaborative problem solving. Child safety must become a priority across these departments coupled with mechanisms to work collaboratively. The Board should hold departments accountable for developing structured inter-agency partnerships that reflect a County-wide systemic approach to improve child safety. Multi-sector and multi-agency strategies are essential components of a comprehensive system that protects children.

Currently, the County has no system for managing, vetting, implementing, and assessing recommendations related to child safety and well-being. This includes process and outcome assessments for child protection. These are essential in the management of any system of care and to the provision of consistent and meaningful information about the effectiveness of implemented reforms.

In response to the Board’s direction that the Commission review “structural and organizational barriers to effective performance,” the Commission proposes that one coordinating entity be identified to work with the Board to ensure that all relevant departments are accountable for improved child safety. That entity should oversee the development of joint strategic plans, including the combining of resources. It also should be charged with consolidating, prioritizing, implementing, and evaluating reforms mandated by the Board. In its Final Report, the Commission will highlight the important components of such an entity and recommend a streamlined system for vetting and implementing needed reforms. Ultimately, the Board of Supervisors and County leadership should be able to answer confidently the question of whether the adopted strategies are improving child safety.

Recommendations:

- 1. All previous recommendations undergoing implementation by DCFS should be reviewed and prioritized to ensure that implementation will improve child safety and/or contribute to the effectiveness of DCFS’s mission.**
- 2. The Board and County leadership must develop additional finely-tuned process and outcome measures, other than tragic child fatalities, to assess system performance.**

Children Age Five and Under

The Commission believes that improved child safety depends on identifying children who are at the greatest risk for a serious or fatal injury and providing them and their families with high-quality, accessible, and appropriate services. Dr. Emily Putnam Hornstein, Director of the Children’s Data Network in the School of Social Work at the University of Southern California, provided the Commission with crucial information about children at risk:

- Children under five years old are at the greatest risk of death as a result of abuse or neglect. Fatality rates are highest among infants under age one.

- A report to a child protection hotline is the single best predictor of a child’s injury-related death before age five, including both deaths due to maltreatment and deaths due to unintentional injury. This is true regardless of whether DCFS legally substantiates the abuse or neglect.
- The rate of death is highest during infancy (under 12 months).
- More than three quarters of the roughly 8,000 infants who are reported to DCFS each year remained with their families of origin after the first hotline report – and 50% were subsequently reported for a second report of maltreatment before age five.

National child fatality trends indicate that very young children (ages four and younger) are the most frequent victims of child fatalities. National Child Abuse and Neglect Data System (NCANDS) data for 2011 demonstrated that children younger than one year accounted for 42.4% of fatalities and children younger than four years accounted for four-fifths (81.6%) of fatalities. A recent report by the Inter-Agency Council on Child Abuse and Neglect (ICAN) and other reports suggest similar trends in Los Angeles County.

Given that fatality risks are most pronounced for children reported to child protective services during their first year of life, this is likely a period during which service interventions are most impactful and protective. Unfortunately, among these infants, there is very little data from which to determine how many families were successfully engaged in services.

Recommendation:

- 3. The County can measurably and immediately improve child safety by requiring all departments to target combined resources and high quality services, including prevention services, toward children under the age of five.**

Law Enforcement

In addition to DCFS, an independent, second set of eyes assessing the well-being of a child can be the difference between a safe child and one who is seriously injured or dies. **The mandated obligation of law enforcement to investigate possible criminal behavior related to child safety should be more aggressively and consistently enforced.**

Allegations originating from DCFS through the Electronic Suspected Child Abuse Reporting System (E-SCARS) should be treated with equal importance as calls made directly to a law enforcement agency from a resident or mandated reporter. E-SCARS is the County’s innovative information sharing system available for use by DCFS, every law enforcement agency in the County, and by City and County prosecutors.

The District Attorney’s Office can play a major role in improving law enforcement policies and practices. The DA’s Office regularly interacts with all of the County’s 46 law enforcement agencies, prosecuting appropriate criminal cases. It also tracks the response of these agencies to child abuse cases, including the number of cases referred for prosecution, how each entity utilizes E-SCARS, varying methods of retrieving Suspected Child Abuse Reports (SCARs), and the documented/reported amount of time it takes to begin to investigate SCARs. The DA’s Office could ensure appropriate cross-reporting by all LA County law enforcement entities and

provide needed training about their responsibilities and best practices. The Office could help address the following:

- Failure by some law enforcement entities to cross-report SCARs to DCFS and the DA's Office and document their actions;
- Different standards among law enforcement agencies for investigating reports of alleged abuse;
- Insufficient support for updating and maintaining E-SCARS and for needed oversight by the DA's Office;
- Inadequate methods of retrieving cross-reported SCARs so that some are not seen for days; and
- The need for mandatory and continuing training for all levels of law enforcement personnel on handling child safety cases and on their respective responsibilities. The Commission also is looking into the effectiveness of cross-training law enforcement with social work and mental health personnel.

Recommendations:

- 4. All Sheriff's deputies and local law enforcement agencies within the County of Los Angeles must cross-report every child abuse allegation to DCFS, as required by State law. In addition, it should be documented that a cross-report was made, for example, in a police report or law enforcement log.**
- 5. E-SCARS should be utilized fully by all relevant agencies and receive the necessary support to be well-maintained and enhanced.**
- 6. The District Attorney's Office should increase its oversight of the law enforcement response and sharing of information, including cross-reporting between DCFS and law enforcement agencies, to ensure that each agency carries out its mandated investigative response.**
- 7. To avoid placement delays and improve child safety, law enforcement and DCFS staff should be co-located, or otherwise collaborate closely, to increase the speed of background checks for relatives and other potential care providers.**

Health Services

Medical or developmental issues may be symptoms of child abuse or neglect. When those signs are missed or not addressed, the risk of repeat abuse, serious injury or even death occurs. In 2006, DHS, DCFS, and DMH partnered to develop the County-wide Medical Hub Program to build a system of medical and mental health care that, in partnership with DCFS, would guarantee that every child detained or at risk for detention had access to expert medical/mental health evaluations to promote appropriate interventions and child safety. Ultimately, the Hubs were designed to provide the foundation for building a medical/mental health home for children in foster care.

Currently, six Hub clinics provide a limited number of medical and other services under the auspices of the DHS. All of them have out-stationed DCFS workers as partners and provide expert forensic evaluations, as well as initial medical evaluations of children detained by DCFS and placed in out-of-home care. However, only one, the Hub at LAC+USC Medical Center, provides comprehensive services supported by a number of departments and 24-hour, 7-day a week inter-agency services.

The Hubs need immediate support to align them with the original goals of providing the following services in each Supervisorial District:

- Expert forensic, medical, and mental health evaluations for every child detained or at risk for detention;
- Expert forensic, medical, and mental health assessments for children at the time their families receive preservation or reunification services;
- Re-evaluation for children who were in foster care or who had unsuccessful foster placements, remained in group homes for longer than six months, or returned home either through family preservation programs or reunification;
- A mandated “medical home” and ongoing services for children who are in foster care; and
- A “re-entry” service for children who were followed by both the probation and the child welfare systems.

Expansion of this Hub system will help save children’s lives and enable DCFS to better evaluate and appropriately place children.

Assessments should be conducted to identify each Hub’s strengths and weaknesses and devise strategies to meet the needs of their geographic area. For example, Martin Luther King Medical Center (MLK) is the perfect site to assess immediately and then expand services to meet the pressing needs of high-risk families in Service Planning Area 6 and address the needs of sexually exploited girls found predominantly close to MLK clinics.

In addition to expanding Hub involvement, the skills and expertise of Public Health Nurses should be used to improve and enhance DCFS’s investigative processes. Their participation would immediately improve decision-making. This approach has been utilized successfully in several communities around the country.

The Department of Public Health’s evidence-based home visiting program has reduced the risk of subsequent abuse and neglect. These critical services should be expanded to reach all children under age one who are seen at a Medical Hub. DCFS must remain in continuous contact with these medical personnel to facilitate appropriate detention and placement decisions, as well as service referrals.

Recommendations:

- 8. All children entering placement and children under age one whose cases are investigated by DCFS should be screened at a Medical Hub. Children placed in out-**

of-home care or served by DCFS in their homes should have ongoing health care provided by physicians at the Medical Hubs.

9. A Public Health Nurse should be paired with a DCFS social worker in child abuse or neglect investigations of all children from birth to at least age one.

10. The Department of Public Health’s evidence-based home visit service should be made available to all children under age one who are seen at a Medical Hub.

III. IMPLEMENTATION OF LAW ENFORCEMENT AND HEALTH SERVICES RECOMMENDATIONS

Even at this early juncture, the Board and the County collectively have an opportunity to demonstrate their commitment to improve child safety by initiating implementation of the Commission’s preliminary recommendations. Ultimately, the Commission will be recommending that one entity oversee implementation of the Final Report’s recommendations, as set forth in the Accountability section. In the meantime, in concert with the Board’s direction that the Commission review “structural and organizational barriers to effective performance,” the Commission proposes the following implementation steps:

- The Board should consider and endorse the law enforcement and health services recommendations through a Board vote.
- In health services and in law enforcement, one agency, department or stakeholder should be designated by the Board to bring relevant decision-makers together and lead the development of a concrete plan for implementation of the recommendations. The Commission further recommends that the Board designate a lead entity by the end of January 2014.
- The lead agency must be empowered by the Board to have the ability to transcend structure and propose the movement of financial and staff resources without regard to department lines.
- In each area, the lead entity should develop an implementation plan that includes timelines, projected improvements in safety outcomes for children, and milestones to indicate whether implementation is on track. The implementation plans should be completed and presented to the Board by mid-March 2014.

The Commission believes that the District Attorney’s Office should have lead responsibility for implementation of the law enforcement recommendations, with the participation of the Sheriff’s Department, DCFS, and the Chief Executive Office (CEO). With respect to the health services recommendations, the leadership from the Violence Intervention Program at LAC+USC Medical Center (VIP), in conjunction with the Department of Health Services, should oversee an assessment of the current capacity of all Hubs and work with the CEO, Departments of Public Health and Mental Health, as well as DCFS, to implement needed reforms and propose cross-sector funding for new initiatives to the Board. VIP is the most comprehensive Hub that is closest to meeting articulated goals and has the greatest ability to conduct a neutral assessment.

The Commission will remain closely involved with these initiatives to support this restructuring process and monitor the implementation of the recommendations. The progress made and obstacles encountered will inform the Commission's Final Report. If adopted, the coordinating structure that the Commission will define in its Final Report would play a major role in the final implementation of these recommendations.

IV. CONCLUSION

Immediate implementation of the Commission's preliminary law enforcement and health services recommendations will improve child safety. The Commission will continue to develop a roadmap for making the County's generally fragmented child protection system into an integrated, interdisciplinary, and effective network to help all children reach their full potential.

In its ongoing work, the Commission is investigating a wide range of important issues that could reduce the risk of future abuse and neglect to children. Topics will include, but not be limited to: DCFS culture, workload, and training; foster care practices; support for relative caregivers; legislative impediments to child safety; the accessibility and quality of mental health services; the role of technology to facilitate cross-department communication and collaboration; programs for transition age youth; domestic violence and substance abuse programs; and the roles of the Dependency Court, the educational system, community-based organizations, prevention services, and group homes.

The Commission thanks the Board of Supervisors for the opportunity to examine the obstacles to creating an effective child safety system in Los Angeles County and provide a Final Report in April with comprehensive recommendations for reform.