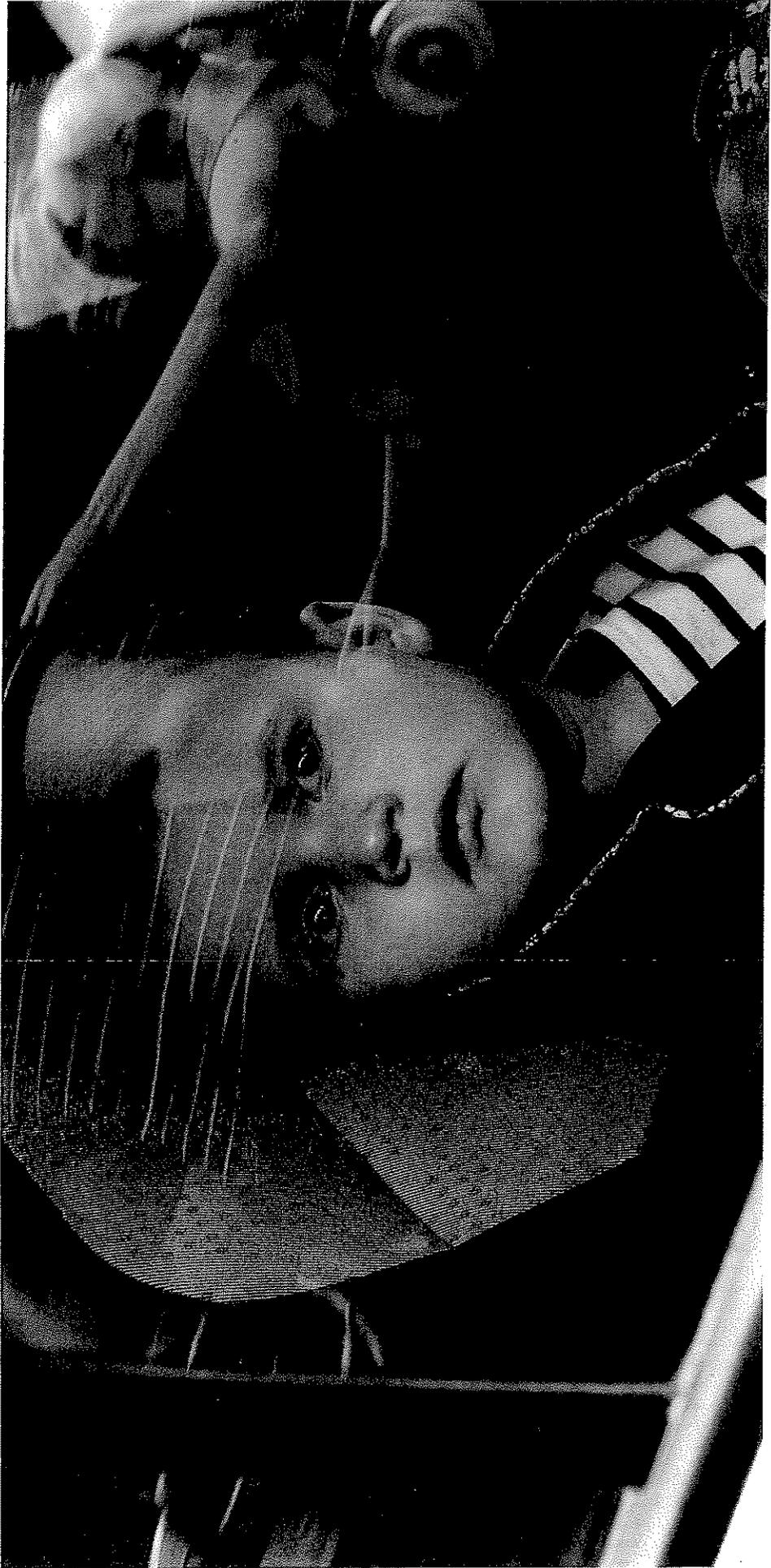


**Inter-Agency Council on
Child Abuse and Neglect**

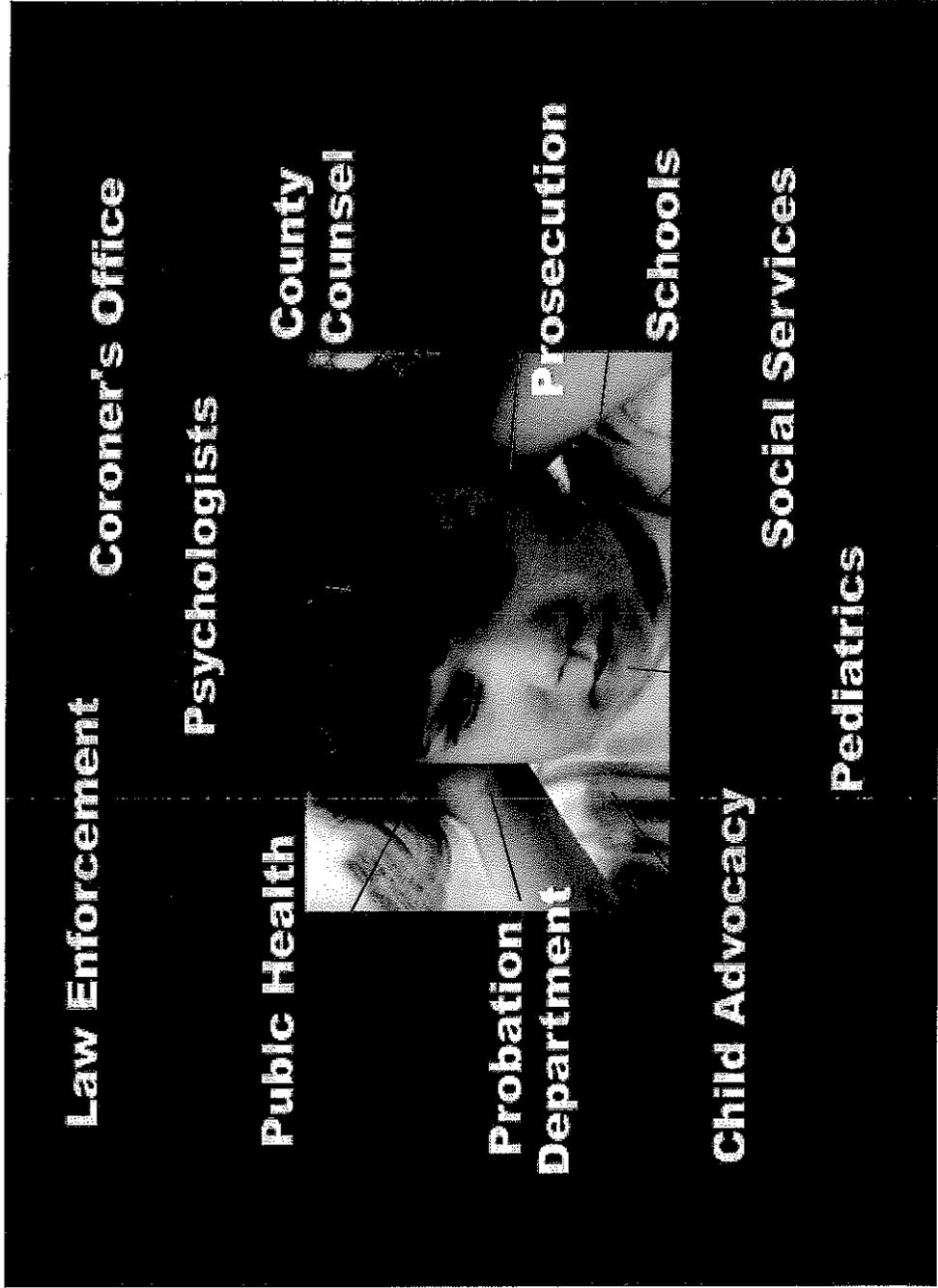
ICAN

- Established in 1977 by Board of Supervisors
 - Official county Agent to coordinate services for prevention, identification and treatment of child abuse and neglect
 - 32 County, City, State and Federal agencies





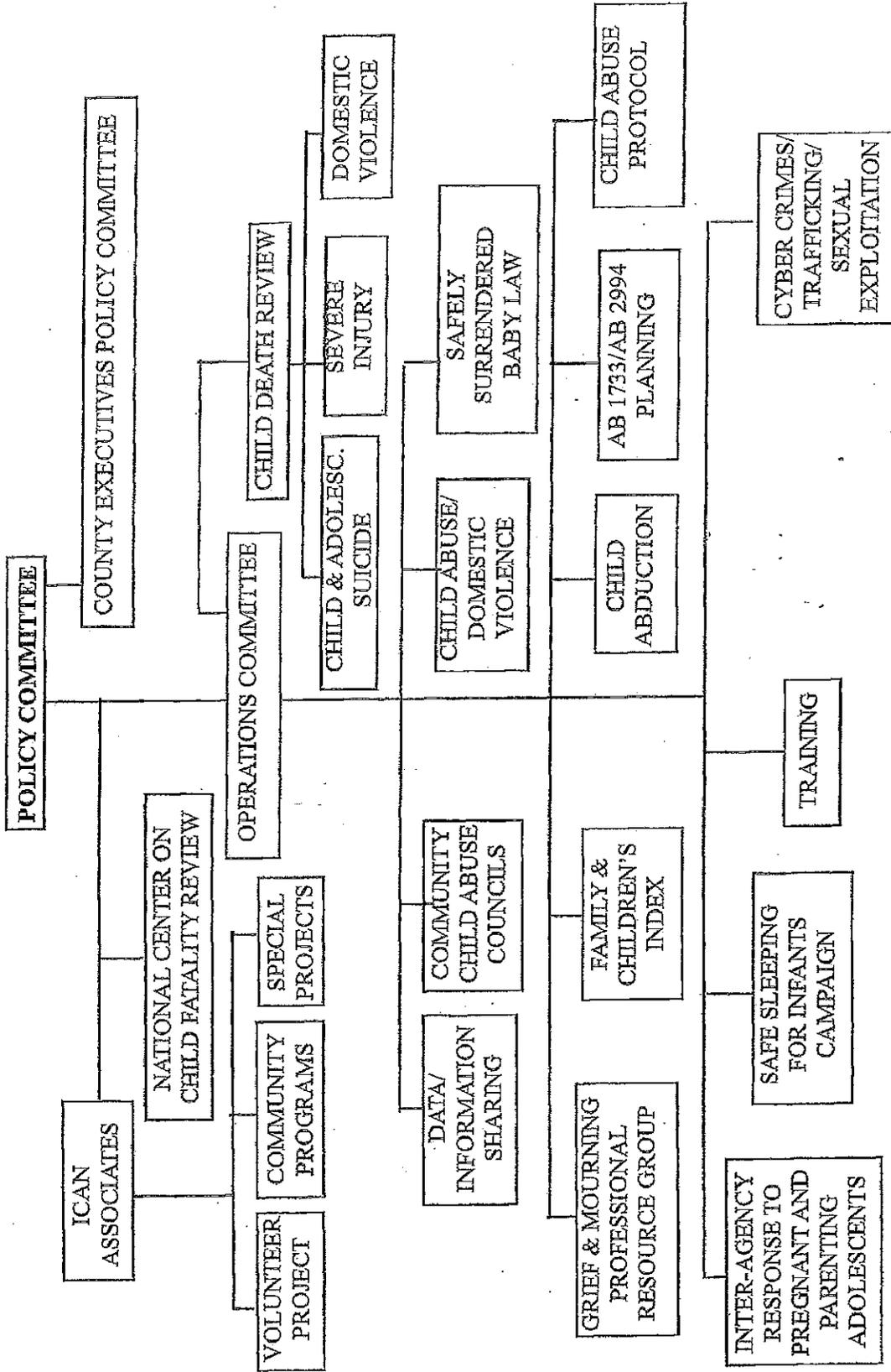
Bringing agencies together...



ICAN Organization

- Policy Committee
- Operations Committee
- 20 Subcommittees
- ICAN Associates
- Community Councils

Inter-Agency Council on Child Abuse and Neglect (ICAN)



Inter-Agency Council on Child Abuse and Neglect (ICAN)
 4024 N. Durfee Avenue
 El Monte, CA 91732
 (626) 455-4585 ~ (626) 444-4851 (FAX)

ICAN Associates

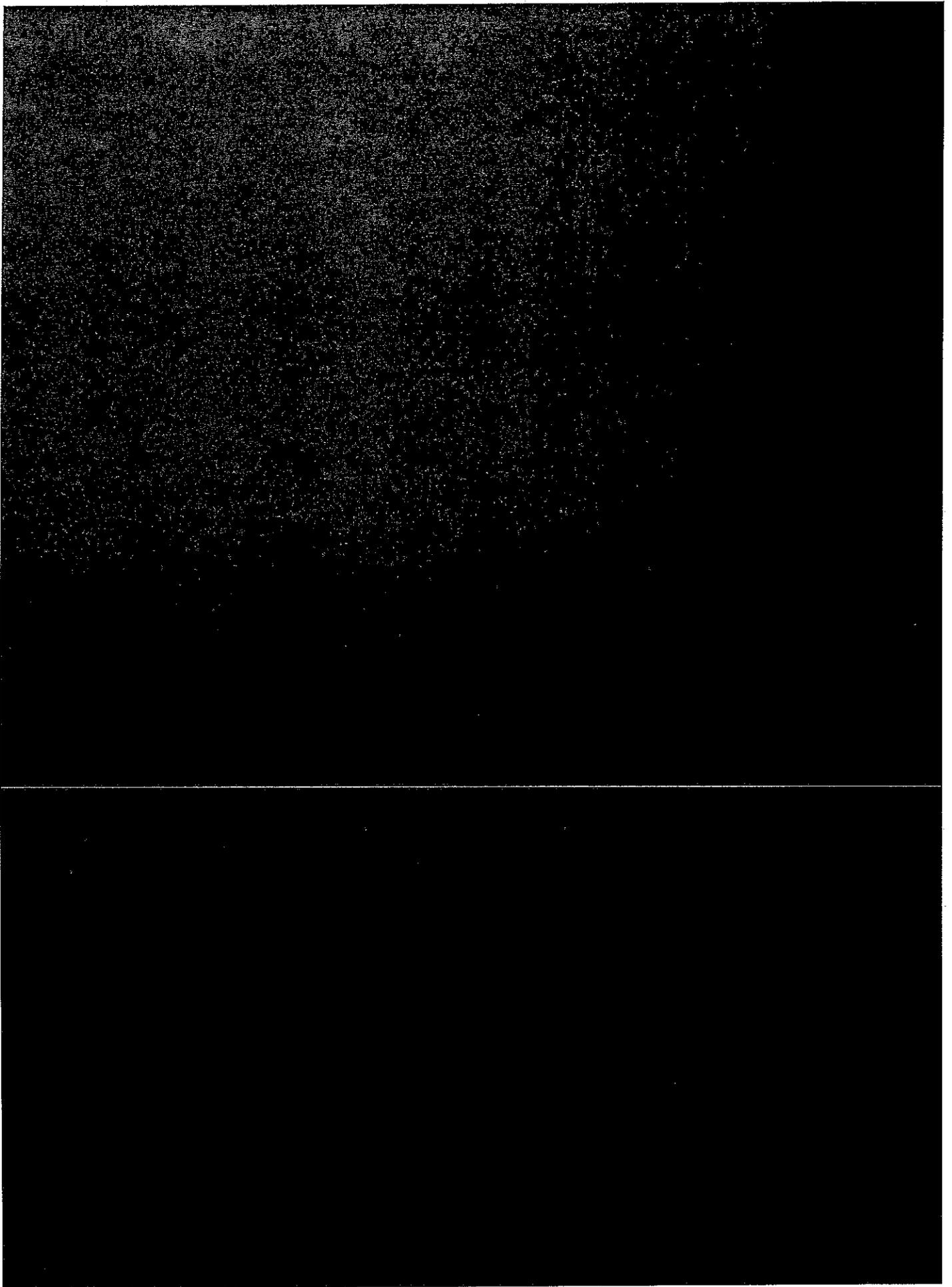
- Partnership with 501(c)3 nonprofit ICAN Associates

STOP



CHILD

ABUSE



ICAN

- Child and Adolescent Suicide Review (CASRT)
- Child Abduction and Reunification
- Commercial Sexual Exploitation of Children (CSEC)
- Cyber Crime Prevention
- Safe Sleep for Baby Campaign
- Nexus Conference

ICAN (continued)

- Childhood Grief Conference
- Safely Surrendered Baby Law (SSBL) Speaker's Bureau and Website
- ICAN California Hospital Network
- Community Child Abuse Councils

ICAN Legislation

- AB1733 – \$10 million state funds (CAN)
- AB2994 – Trust Fund/birth certificate fees
- CAN Reporting Act – Child Death Review Teams
- SB525 – Tracking Child Fatalities
- AJR22 – Sharing school info with CDRs
- AB3305 – Swimming Pool Safety Act

ICAN Legislation (Continued)

- AB2229 – Two-person MDT for FCI
- AB1687 – Sharing Medical Info with CPS
- SB647 – Requires Inter-Agency Protocol (CAN)
- SB1745 – Inter-Agency Protocol (CA/DV)
- AB2258 – Sentence Enhancement (Fatal CA*)
*Under 8 years, reasonable person standard
- AB3391 – Family and Children’s Index

FCI is ...

- a **computerized interagency data information system** which is designed to better identify children and families who may be at risk of abuse and neglect;
- **stores basic demographic data about families and children** that have had contacts with public agencies and have been identified as at risk for abuse or neglect. Participating departments identify these "at-risk" families and children and update FCI with basic identifying information; and
- an additional resource for participating departments to **receive and provide pertinent information about "at-risk" families** that have had contact with other agencies.

ICAN-NCFR

- National Center on Child Fatality Review
(NCFR)



Inter-Agency Council on Child Abuse and Neglect

Home Admin ▾ Events ▾ ICAN Associates ▾ NCFR ▾ Other ▾ Resources ▾ Calendar ▾ Donate

ICAN Kids Only Search

Every Ten Seconds



0:00 / 3:16

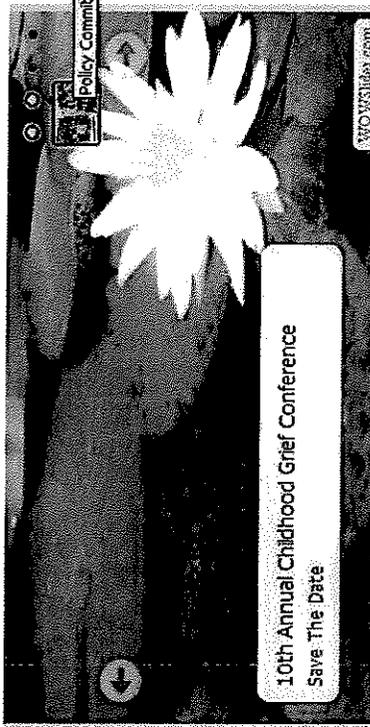
ICAN 2012 Annual Reports
Los Angeles County

State of Child Abuse

Child Death
Review Report

ICAN California
Hospital Network

Safe Sleep For Baby
Don't wake up to a tragedy.



10th Annual Childhood Grief Conference
Save The Date

The Inter-Agency Council on Child Abuse and Neglect is comprised of Los Angeles County City, State and Federal Agencies, as well as community organizations, and individuals from the private sector. ICAN's mission is to coordinate the development of services for the prevention, identification and treatment of child abuse and neglect throughout Los Angeles County.

ICAN is involved in numerous Programs and Committees such as the Safe Sleeping for Infants Campaign, Youth Mentoring Collaborative, and the California Hospital Network Project dedicated to improving the well being of children. ICAN also sponsors two annual conferences: The Childhood Grief Conference and Nexus: Violence Within the Home and its Effects on Children. ICAN also creates and publishes numerous reports, guidelines and training materials such as the Child Death Review Team Report, the Child Abuse and Neglect Protocol, and the CalEMA Severe Injury Investigation Guidelines, which encourage inter-agency cooperation between county agencies in the quest to eliminate child abuse.

Administration

- Staff
- Policy Committee
- Operations Committee
- Policy Committee and News Conference

Hot Button Topics

- Children Exposed to Violence
- Safe Sleeping for Infants
- Victim Services
- Cyber Crime Prevention
- Childhood Grief

Inter-Agency

- Youth Suicide Review
- Data & Information Sharing
- Family & Children's Index
- Child Death Review

ICAN Associates

- Associates Board
- Foster Kids Holiday Party
- Student Poster Art Contest
- Youth Mentoring Collaborative

NCFR

History

Advisory Board

Virtual Library

State Teams

California Hospital Directory

CDR Curriculum

Severe Injury Guidelines

Miscellaneous

Infants at Risk



CHILD ABUSE PREVENTION NETWORK



A NATION'S BRAND



CALIFORNIA HOSPITAL DIRECTORY



YOUTH SUICIDE REVIEW



SAFE SLEEP FOR BABY



ICAN CALIFORNIA HOSPITAL NETWORK



STATE OF CHILD ABUSE



CHILD DEATH REVIEW REPORT



ICAN 2012 ANNUAL REPORTS

Subscribe to email updates



OTDR
CHILD ABUSE
PREVENTION
NETWORK



A NATION'S BRAND



YOUTH SUICIDE REVIEW



CALIFORNIA HOSPITAL DIRECTORY



SAFE SLEEP FOR BABY



ICAN CALIFORNIA HOSPITAL NETWORK



STATE OF CHILD ABUSE



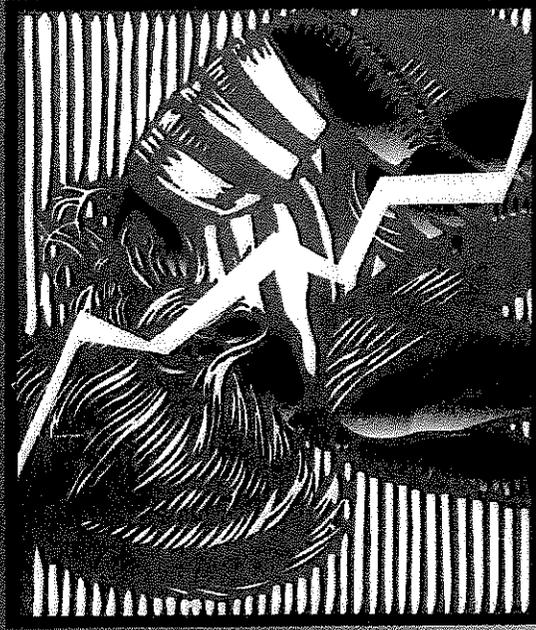
CHILD DEATH REVIEW REPORT



ICAN 2012 ANNUAL REPORTS

U.S. DEPARTMENT
OF HEALTH
AND HUMAN
SERVICES
Administration for
Children and
Families

A Nation's Shame: Fatal Child Abuse and Neglect in the United States



A Report of the U.S.
Advisory Board on Child
Abuse and Neglect



Los Angeles

WIREIMAGE.COM
JULY 16, 2005

THEY HAVE THE WORLD'S WORST JOB

L.A. County's Child

Death Review

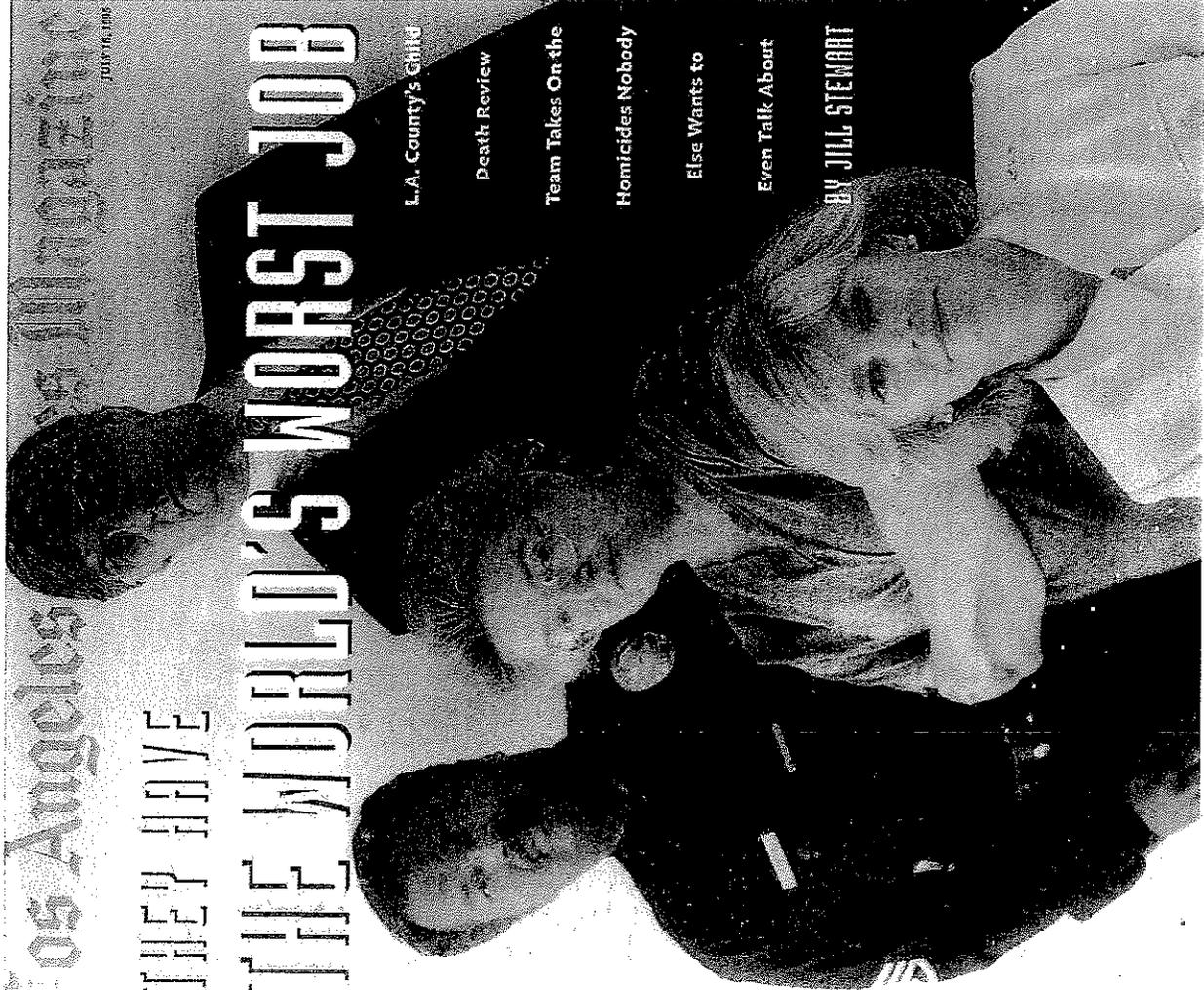
Team Takes On the

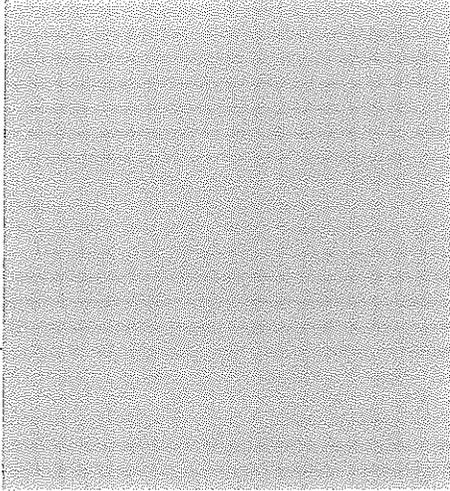
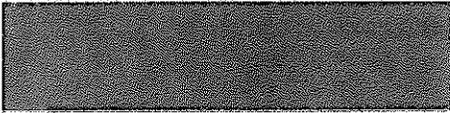
Homicides Nobody

Else Wants to

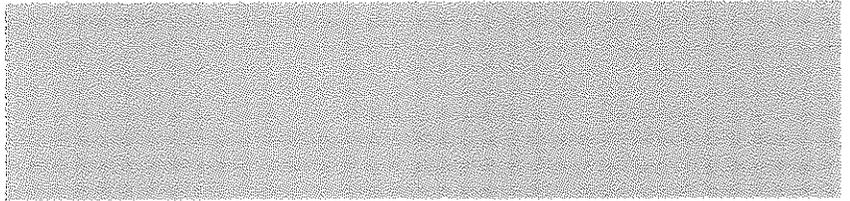
Even Talk About

BY JILL STEWART





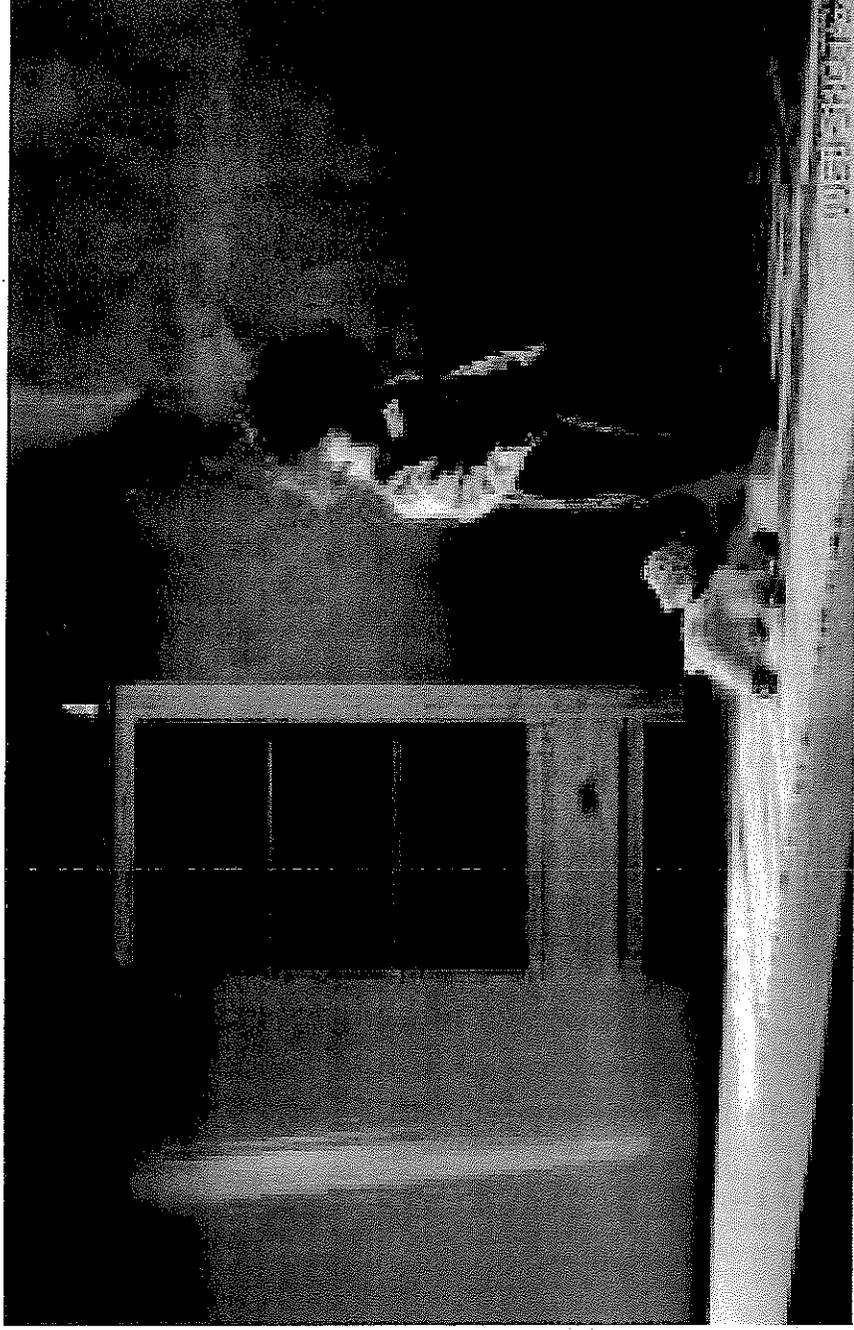
**DEFENDING
CHILDHOOD**
PROTECT HEALTHRIVE



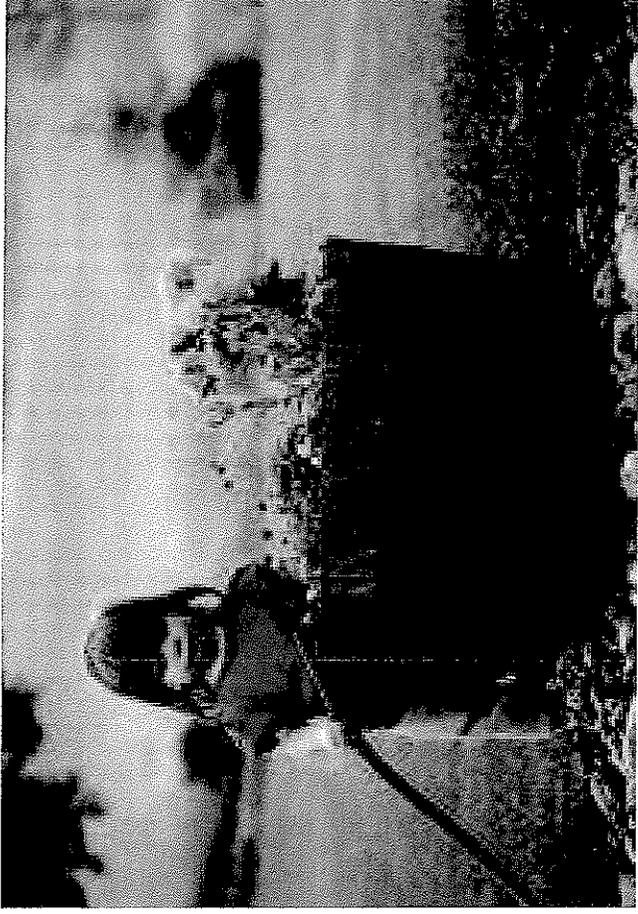
Report of the Attorney General's National Task Force on
Children Exposed to Violence



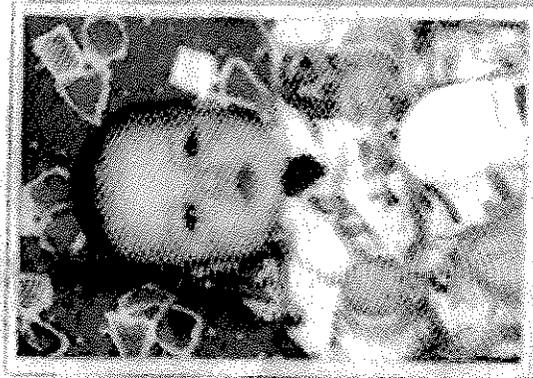
**In Los Angeles County alone, DCFS responded to
over 181,827 child abuse and neglect reports
last year...**



More children under age five die each year from child abuse and neglect than from falls, choking on food, drowning, house fires or auto accidents.



Why are these children dead?



◀ **Dominique Hayes** (3 years)
Birmingham

Kiefer Serna (15 months)
Birmingham

Adjua Sims (3 months)
Birmingham

Haley Davis (16 months)
Heflin

Alicia Lawson (13 months)
ARTISTOP

Their stories. Page 6A

Five little victims battered in six-week period

child abuse homicides

**90% OF CHILD ABUSE AND NEGLECT
FATALITY VICTIMS ARE UNDER
AGE FIVE**

**Over HALF ARE INFANTS ONE YEAR
AND UNDER**

Child Death Review Findings

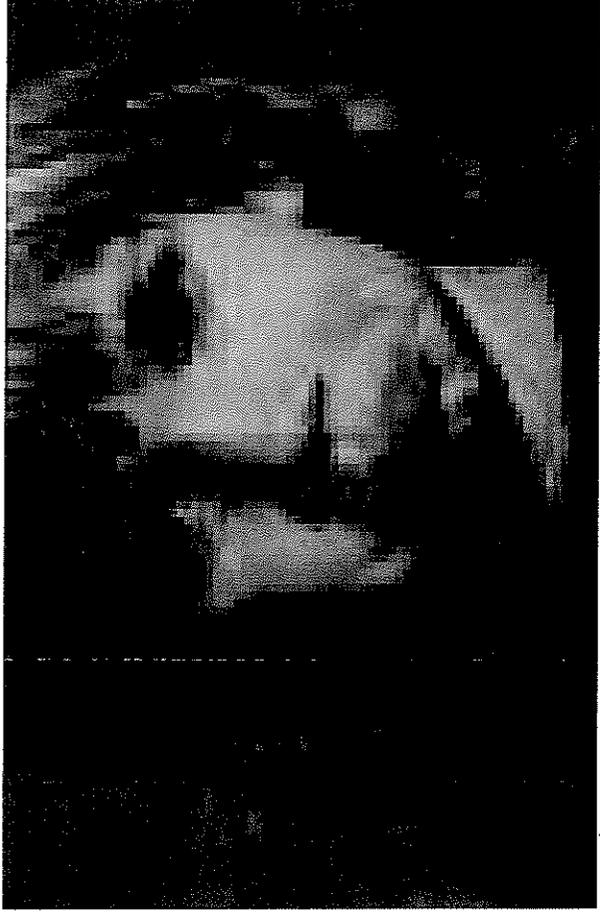
- Agency Involvement
- 40% had current or previous Child Welfare Agency involvement
- Most had been seen by a medical professional
- Law enforcement may not have documented presence of child in DV responses
- Information was not exchanged among agencies that had previous contact with the child or family

Risk Factors

- Young age of child
- Cycle of Abuse
- Lack of bonding; poor attachment
- Mental illness
- History of substance use
- Previous CPS or law enforcement contacts
- CPS contact as a minor
- Young parents
- Social isolation
- Domestic violence

Domestic Violence and Child Abuse...

Child Abuse is three times more likely in homes where there is domestic violence.



NEXUS XVIII

TRAINING CONFERENCE

Violence Within the Home and its Effects on Children

PROGRAM GUIDE



WEDNESDAY, OCTOBER 16, 2013

Pasadena Convention Center
300 East Green Street
Pasadena, CA 91101



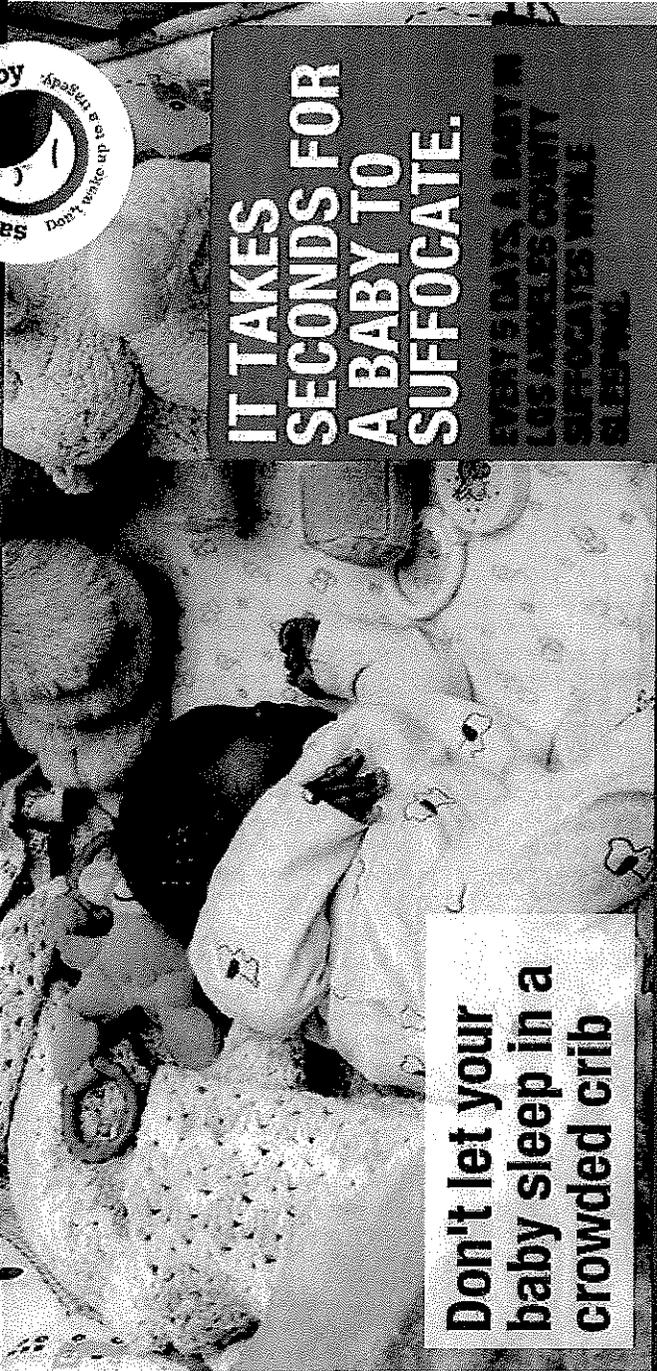
Center for Prevention of
Public-Use Incidents

ICAN Associates

**Approximately 70 infants
die from unsafe sleep
related deaths in
Los Angeles County
each year.**

en Español

HOME A PROBLEM IN L.A. HOW TO KEEP YOUR BABY SAFE GET EDUCATED



Don't let your baby sleep in a crowded crib

IT TAKES SECONDS FOR A BABY TO SUFFOCATE.

EVERY 5 DAYS, A BABY IN LOS ANGELES COUNTY SUFFOCATES WHILE SLEEPING



IS YOUR BABY SLEEPING SAFELY?



Get Safe Sleep Tips



Watch the PSA



Take the E-Learning Course

Like us on Facebook for the latest updates.  Like  Like

Contact
ICAN Associates

Safe Sleep Task Force

The Infant Safe Sleeping Task Force oversees the



FIRST5
LA



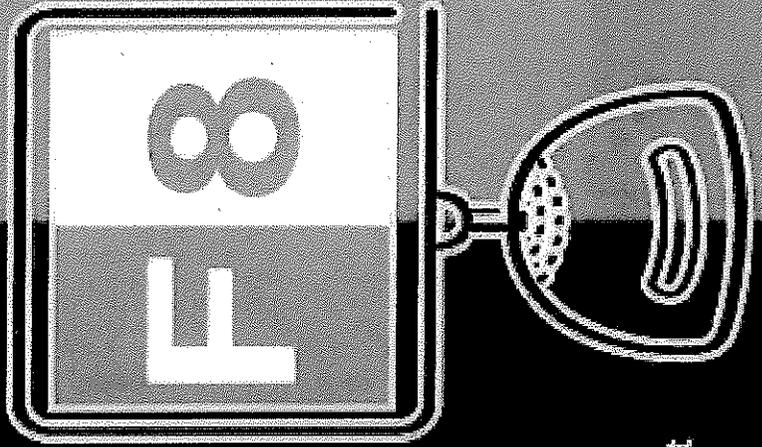
Safe Sleep for Baby PSA (:30) English



Champions For Our Children
www.First5LA.org



Cyber Crime Prevention Symposium



September 30, 2011

The California Endowment

**SAFELY SURRENDERED AND
ABANDONED INFANTS IN
LOS ANGELES COUNTY - 2002-2012**



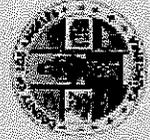
Prepared by

**The Inter-Agency Council on
Child Abuse and Neglect (ICAN)**

4024 Durfee Ave

El Monte, CA 91732

Deanne Tilton, Executive Director



**FIRST 5
LA**

Cooperator for Our Children
www.first5la.org



Ninth Annual California Conference

CHILDHOOD GRIEF AND TRAUMATIC LOSS

Restoring Joy to Children and Families



March 19, 2013

The Pasadena Convention Center
300 East Green Street
Pasadena, CA 91101

ICAN 2012

Inter-Agency Council on Child Abuse and Neglect

Los Angeles County & ICAN Data/Information Sharing Subcommittee
(626) 453-4585 & Fax (626) 444-4851 & Website: www.ican-ncl.org



ICAN

Report Compiled From 2011 Data

THE STATE OF CHILD ABUSE IN LOS ANGELES COUNTY



Inter-Agency Council on Child Abuse and Neglect

Michigan: Theron Charles, Executive Director
Lisa Rogerson Caskey, Co-DA, Health Agency Child Death Review Team
10240 422nd Ave. #200, Grand Rapids, MI 49503-1024

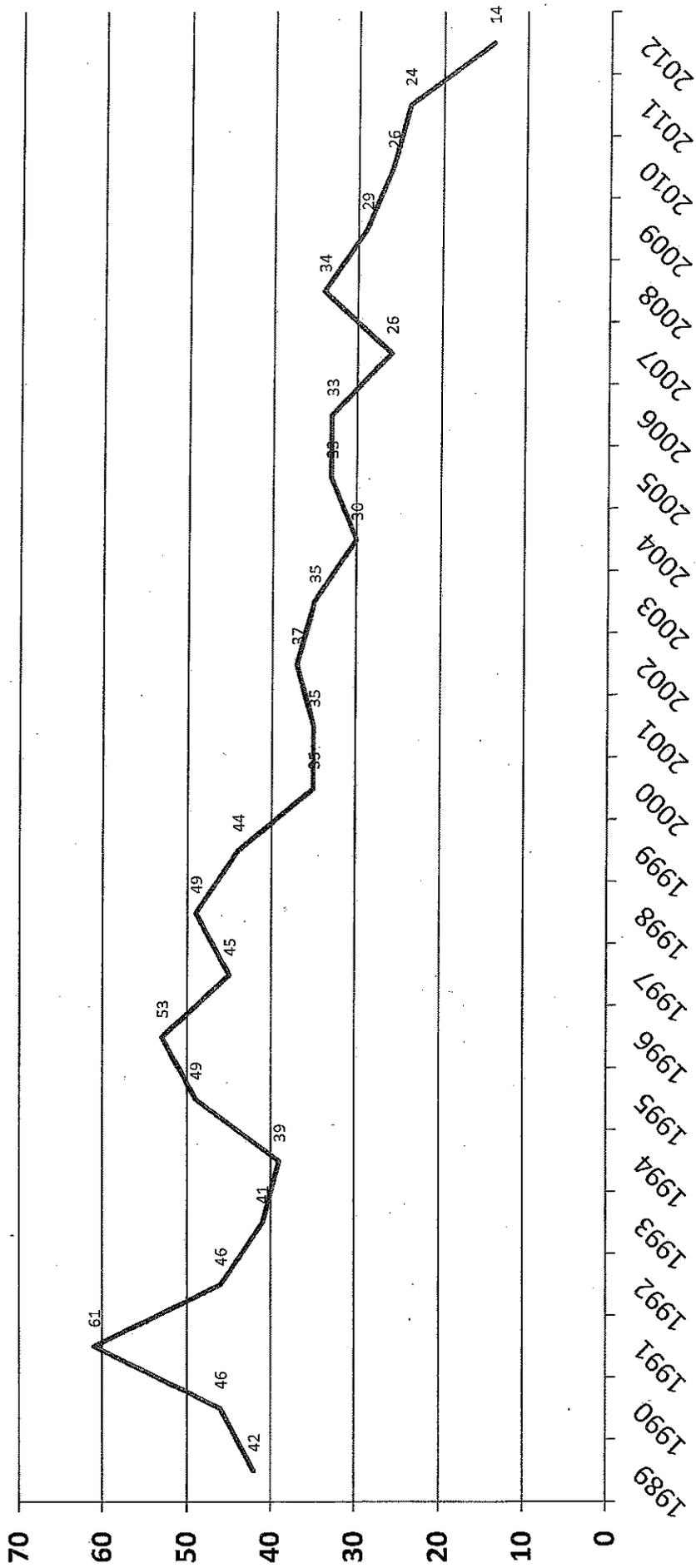


Child Death Review Team Report 2012

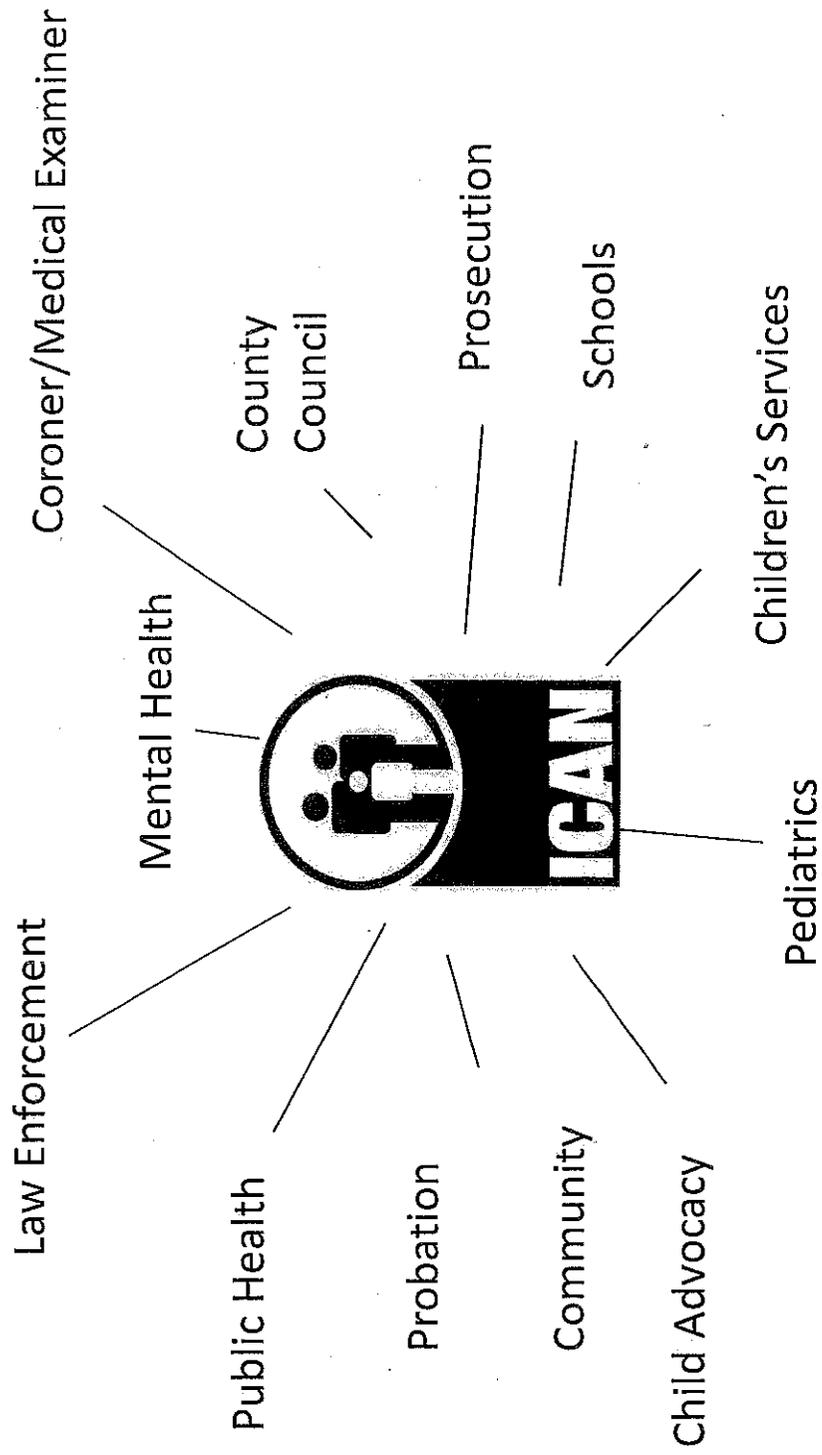
Report Compiled from 2011 Data

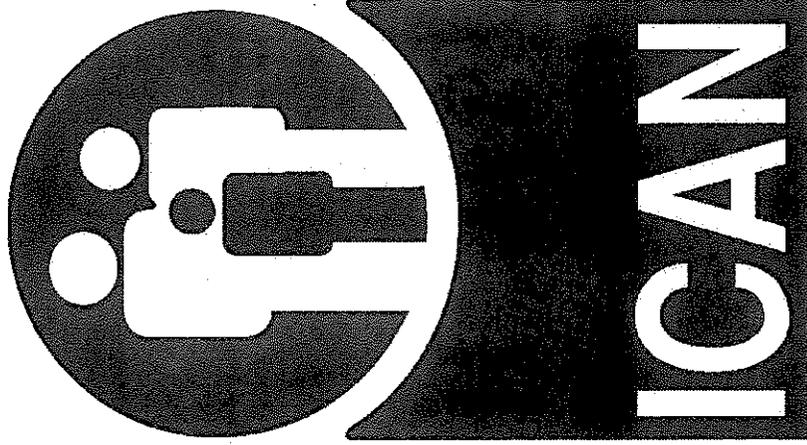
Child Abuse Homicides

(In which the perpetrator was in a caretaker role)



Bringing agencies together...





ICAN

- Inter-Agency Council on Child Abuse and Neglect
- 4024 N. Durfee Ave
- El Monte, CA 91732
- (626) 455-4585
- Website: ICAN4KIDS.org

Los Angeles County



Child Abuse and Neglect Protocol



INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT
(ICAN)

4024 North Durfee Avenue, El Monte, CA 91732

Phone: (626) 455-4585; Fax: (626) 444-4851

Keeping Children Safe...

www.ican-ncfr.org

Last Updated 2004

FOREWORD

In 1998, the Office of the Governor, pursuant to the mandate set forth by the California Children's Justice Act, directed each county throughout the State of California to develop an interagency protocol for the investigation of child abuse and neglect. In response, the Los Angeles County Board of Supervisors authorized the formation of the Los Angeles County Child Abuse and Neglect Protocol Task Force. The formation of the task force was implemented by the Inter-Agency Council on Child Abuse and Neglect (ICAN) with leadership provided by the District Attorney's Office. The first meeting of the task force was held in April, 1998.

From the beginning, all participants recognized that the task of creating a practical and meaningful protocol for all affected parties across the expanse of Los Angeles County was monumental. Moreover, there was a consensus that our work product should be a living, breathing document; that is, one subject to periodic review to reflect the changing realities affecting the various agencies and professions involved while remaining true to the important broader goals of enhanced communication, coordination, and cooperation among the participants. Countless hours of research, discussion, drafting, and revision went into creating the protocol. All participants quickly recognized that the process of drafting the document would be as important as the product. The synergy from the exchange of perspectives, ideas, and information during the direct dialogue among participants was very valuable and mutually beneficial to all who were involved.

At long last, the protocol is ready for implementation throughout the County of Los Angeles. It carries with it the hope and expectation that it will make things better for children who have been victims of child abuse and neglect. Of course, the task of helping vulnerable children does not end with the promulgation of this protocol. The protocol requires continuing education and training for those on the front lines dealing with child abuse and neglect as well as periodic revision to conform to changes in the law.

The members of the Los Angeles County Child Abuse and Neglect Task Force dedicate this protocol to the children whom we seek to protect and serve. We commend this protocol to all who care about the safety and well-being of children. For those who desire more information about the protocol, please contact the Inter-Agency Council on Child Abuse and Neglect by telephone at (626) 455-4585; by fax at (626) 444-4851; or at its office located at 4024 N. Durfee Avenue, El Monte, California 91721.

William Hodgman, Chairperson
Los Angeles County Child Abuse And Neglect Protocol Task Force

November, 2004

GUIDELINES FOR EFFECTIVE RESPONSE TO DOMESTIC ABUSE (GERDA)

MISSION STATEMENT

Children exposed to violence in their homes must repeatedly deal with the emotional trauma of witnessing one parent beat, threaten, coerce, and control the other. Many children in these homes also face immediate risks from neglect or of being physically or sexually abused. They are also more likely to suffer long-term psychological and behavioral problems. Studies show that early intervention with families experiencing domestic abuse can mitigate many of these negative effects. Successful early intervention requires a strong community commitment to collaboration among law enforcement, child protective services and support agencies.

Guidelines for Effective Response to Domestic Abuse (GERDA) outlines the best practices for those professionals in Los Angeles County who respond to and work with families where there is domestic violence. Implementation of this protocol will insure that the immediate and long-term safety and emotional needs of the children and victim will be met. It will act to improve the overall public safety and well being by reducing violence throughout the county.

INTRODUCTION AND GOALS

Any protocol is only as good as the overall supervision and enforcement of its tenets. The best practice principles delineated in this document can only be achieved and maintained with earnest and consistent training and consciousness-raising for all stakeholders who hold a position within Los Angeles County departments and private agencies.

GERDA is intended to be a dynamic training and reference manual that supplement the policy and practices of the each particular agency. The audience is primarily those first responders and domestic violence counselors and advocates, though it may also be of interest to others in the Los Angeles community.

It is anticipated that a multi-disciplinary committee provide oversight of GERDA to update any changes in law or practice and to act as ombudsman for any complaints or disputes among any of the agencies.

CORE VALUES

GERDA was also based on nine core values, intended to serve as the foundation of the recommended best practices. Maintaining a commitment to these values is critical for the on-going success of the protocol.

One document in particular helped shape the development of the GERDA protocol, “The Guidelines for Public Child Welfare Agencies Serving Children and Families Experiencing Domestic Violence,” developed by the American Public Human Services Association, National Association of Public Child Welfare Administrators (2001). From this article and other literature reviewed from other states and California counties, best practice principles were identified underlie the nine core values.

Collaboration/Partnering

The ability to work together formally or informally through on-going communication and demonstrated mutual respect is the cornerstone of effective response to any collaborative response. It is only through collaboration that agencies establish consistency in their response to families.

Collaboration must include an emergency trouble-shooting process (preferably with 24 hour coverage). That is, when attempting to follow the County protocol and barriers are encountered, there needs to be a back up process; e.g., each agency shall designate a specific person or office that has the authority to make emergency decisions to address the problem immediately.

Training/Cross-Training

Each participating agency must commit to participating in training within their agency and cross-training opportunities. Mandated ongoing training that incorporates a feedback mechanism to determine its effectiveness through evaluation and review. Key points include:

- Policy/culture shift
- Methodology for basic domestic violence training
- A plan to deal with staff turnover and subsequent training for newly hired staff
- Establishment of a curriculum committee to look at best practices
- Plan to train all stakeholders

Prior to implementation of GERDA, all agency and County Department staff shall successfully complete DV protocol training. The training will be initiated with a set of trainings to “Train the

Trainers.” These trainers will then train their other agency/department staff or volunteers. Also, ideally, the “Train the Trainers” sessions will include a specific curriculum on videotape to ensure that Protocol training is consistent across agencies and County Departments.

Each agency shall develop their domestic violence protocol training in conjunction with a DV advocate (who has successfully completed the “Train the Trainers”) or have a domestic violence advocate conduct the training.

Develop trainings for general awareness about domestic violence dynamics and the roles of various agencies/parties. Also, develop more advanced trainings that reflect a strong understanding of the dynamics and safety concerns of domestic violence and that focuses on the specific strategies to be used with clients.

- All responders are specifically trained in the elements of safety planning.
- The more advanced trainings should include interactive approaches that address interviewing techniques, non-blaming language used in writing of reports or other documentation, appropriate resource referrals, etc.
- If possible, the advanced training should help trainees learn how to distinguish the difference between “high conflict relationships that may have some form of physical expression” and “the abusive relationships where the power & control differential perpetrated by a batterer threatens the well-being of the victim parent and children.”

Investigation/Initial Assessment

Each agency should Institute a step-by-step procedural guide that braids together collaborative protocols, which is consistent with domestic violence philosophy and principles. Each agency’s response procedures must ensure that:

- At every decision point in DV cases, there is reference to the DV Response Protocol criteria.
- Core safety guidelines are clearly delineated for all parties.
- Fail-safe check and balances are in place.
- A checklist is included to ensure thorough investigations.
- An overview of DV dynamics is included.

Whenever possible, include, or consult with a domestic violence advocate to ensure case continuity and a continuum of service to provide consistent information, support and resources for treatment and intervention to the adult victim.

Accountability of Abuser/Support versus Blame of Adult Victim & Children

Each agency should also ensure that their response procedures reflect the goals of holding the abuser accountable and at the same time support the adult victim and children. It is not uncommon for responders focus more on how the adult victim might have caused the abuse or “failed” to leave the relationship than on how the batterer’s physical and emotional intimidation limited the victim’s options. The burden mandates is placed primarily on the abuser.

There is an over-arching philosophy that holds the abuser accountable and views the adult victim and children as a unit that must be given utmost safety consideration through the entire response, investigation and intervention process. Securing the safety of the child is best achieved by securing the safety of the adult victim.

The over-arching philosophy shall prohibit threatening the victims that, unless they cooperate with the prosecutor, the investigating detective, the first responding patrol officer or the CPS worker, their children will be taken away.

Forms used in each agency should be developed using language that embraces the domestic violence philosophy. This should also be true for any written reports. The responder responsible for the report should use language that conveys that the abuser is accountable and reflects accurately the imbalance of power or coercive control elements found in the family experiencing the violence.

Beyond investigation of physical violence towards his or her partner, the batterer also must be assessed thoroughly as a parent, based on his past behavior and the immediate risks to the physical and emotional safety of the adult victim and children.

Cultural Competency & Recognition of Special Populations

While respecting and being sensitive to cultural differences, the protocol should not minimize the seriousness of, nor condone, the use of violence. There needs to be an awareness of cultural nuances. Each agency must construct a clear direction on how to find an impartial consultant for a particular culture, religion or special needs population for any given incident.

Responders must also have an understanding of how culture/religion impacts the adult victim’s choices, her decisions and can create possible barriers to her accessing services.

Service providers also must be aware of their own cultural/religious biases so they do not interfere in their ability to follow the protocol.

Similarly, all agencies must have guidelines to assist in the appropriate response to families where one or more of the members have a special needs and or disability. Finally, the protocol must underscore an acceptance of alternate family structures.

Children's/Victim's Rights

Too often in families where there is domestic violence, children are not seen as victims unless there are obvious injuries. Occasionally they are not identified as, or treated as, witnesses. The risk is that they become invisible and the risks to their emotional and physical well being are minimized.

Children should be seen as individuals with their own set of needs and treated with respect and dignity. Children have a right to protection. Children have the right to remain safe in the home with the non-abusive parent. No one should disenfranchise the children and non-abusive parent. Their rights come before the rights of the batterer. The batterer should leave the home.

All responders should recognize that children have the right to remain children and not be expected to take on adult roles and responsibilities. Unless there is life-threatening danger, all efforts are to be made not to place the children in an adult role: e.g., children should not translate, be given information intended for the adult victim or have primary responsibility for the safety of the family.

The victim parent and children have the right to receive immediate medical trauma services.

Children subjected to violent acts have the right to domestic violence supportive services immediately through expert domestic violence counselors assessment and any other assessment avenues. Moreover, despite legal limitations, the children's right to seek and be given appropriate domestic violence support services (including psychological counseling) should supersede the parameters of custody and a parent's refusal to authorize consent for treatment. Children who may be required to, or wish to, testify should receive maximum services to see them through this process.

When interviewing children: The best interviewers of children are child advocates and/or DV advocates. It is not necessary for interviewers of children to be licensed professionals. All parties should consider that their professional contact with the child could automatically be construed as having an agenda, but interviewing children is not to be done with any agenda. Children shall not be coerced, and their interests shall be placed above those of any other party. Also, it is important to remember:

- Children have the right to be listened to and given the opportunity to express their opinion about visitation, testifying, placement, etc.
- Despite the forensic needs, the focus should remain the best interest of the child (from the child's point of view) with the child's interests placed above those of any other party.
- In the case of a criminal prosecution, when a child is a witness and scheduled to testify, all necessary precautions must be taken to avoid exposing the child to coercion and threats.

- The number of times the child is interviewed should be reduced, and agencies should attempt to work together and at multidisciplinary centers whenever possible.
- If a child makes decisions that place her/him at emotional and/or physical risk, advocates may assist the child in understanding safety plans.

In terms of placement, California law currently requires that if a child needs to be placed outside the home of a parent, relatives are given first consideration. However, parties need to recognize that placement in the home of the batterer's family may put the children at risk of the relative's emotional undermining of the victim parent and continued denial of the batterer's accountability. Also, in cases of homicide and murder-suicide, placement with the murderer's family should be considered as inappropriate, especially if relatives of the victim are interested even if not quickly geographically available.

In terms of abduction or threat of abduction, when a parent conceals a child from the primary non-offending caregiver, the non-offending caregiver from whom the child was removed has the right to have the child returned. Such an act should be considered child abuse and a child abuse report needs to be made and local law enforcement needs to respond to reports of such abductions in an immediate fashion and not obfuscate the process. This use of children is an abuse of the child's rights. The existing Los Angeles County multidisciplinary abduction protocol needs to be followed.

Confidentiality

It is expected that the safe location of the adult victim (and children) is to remain absolutely confidential in all documentation between agencies and within the various court systems. This confidentiality also includes any location where the adult victim and children are getting support services. This policy is to protect the family as well as those providing the family with services. If an adult victim is staying in a domestic violence shelter, the name of that shelter shall not be recorded on court documents, provided to the opposing party or that party's attorney or the child's attorney; the name of that shelter shall not be verbalized in court or placed into a court record. Domestic violence counselors from that shelter who accompany the party to court shall not be identified by name in open court or in court records. Advocates shall not be forced to state their affiliation for the court record.

In terms of communication about the family among agencies, confidentiality limitations need to be recognized. The victim must approve of any communication that takes place. Victims need to be informed how best to communicate with other agencies and how to waive confidentiality if they so choose. The guiding principle should be the safety of the victim and the children. That is, if one of the stakeholders/agencies learns of information that impacts the safety and well being of the victim and children, they should be required to share that information with the victim, inform the victim of any legal mandate to cross-report, and provide her with referrals to appropriate advocacy agencies.

It is important to note that the strong confidentiality requirements of shelters are not designed to impede the ongoing work of other agencies such as law enforcement and child protective services but to promote safety. Victims have an absolute legal right to their confidentiality and safety. This cannot be eroded through pressure from the criminal, civil or juvenile court systems.

Promote Safety

Visitation with parents who are batterers should be monitored at all times. Visitation centers should be used whenever possible. Use of visitation centers maximizes the safety of the children and non-offending parents and serves as a parenting training resource for batterers.

It is important to remember that minor and/or egregious violations of any court orders are the batterer's way to continue victimizing his partner and to make the children pawns in this victimization.

All investigative parties have an obligation to become knowledgeable about all existing court orders such as Restraining Orders, Stay Away Orders, Arrest Warrants, Visitation Orders, etc. It is important that the orders of all courts be consistent with one another and ensure the highest level of safety for the victim and children.

It is imperative that violations of existing court orders be taken seriously and addressed in the strongest manner possible.

Cross-reporting needs to be based on concern for the victim and children and its purpose is to provide support in order to empower the victim to make appropriate decisions. Safety of the family unit (the victim and children) should be the focus of all work, and investigations should not re-victimize the victim.

On-going DV Representation in Decision-Making Entities

The experience and knowledge of a DV advocate and preference of the adult victim must guide collaboration among agencies. Taking this guidance into account results in strengthening each agency and, ultimately, helps everyone do a better job and keep the victim/children safer. Also, this will help prevent multiple investigations of the same incident.

Many protocols throughout the U.S. have established that DV advocates and specially trained DV experts within other agencies need to be consulted at decision-making points every step of the way in the investigation or service provision to ensure maintenance of appropriate safety of the victim and children.

WISH LIST

Improving the response to domestic violence victims and their children in Los Angeles County will require a commitment to pursue new programs and practices beyond this current protocol. A partial wish list includes:

- There should be an aggressive pursuit of legislation by Los Angeles County that will facilitate the implementation of these “best practice” principles. For example:
 - As WIC 308 allows foster placement information to remain confidential, it should be amended so that all DV shelter information also remain confidential within court records. Further, all information, no matter how seemingly insignificant, should remain confidential in all court and public records.
 - In cases of DV homicides, the children should be placed with, disinterested parties (not relatives or family friends) pending extensive psychosocial evaluation and assessment, immediate enrollment into trauma-specific counseling, and participation in the forensic interviews. Ultimately, any final placement decision must be deemed acceptable in light of current psychosocial & safety assessments—the placement could be with the non-offending parent, suitable relatives or foster care.
- There should be an aggressive pursuit of funding by Los Angeles County at large to facilitate the implementation of the Protocol.
- There should be development of short-term, residential multidisciplinary facilities where the children of DV homicide victims could be temporarily placed (i.e., an intensive 72-hour hold) and where psychosocial and medical assessments could take place, trauma therapy could be started, and forensic interviews and photos could be completed.
- There should be development of visitation centers where visits could take place under the guidance of trained child-development/DV specialists.

LOCAL AGENCY ROLES

Should we list every agency that has ever come to a meeting? To the main agencies? The Statewide LE Protocol Children Exposed to Domestic Violence (CEDV) guidelines developed by the Crime and Violence Prevention Center of the California Attorney General’s Office in June 2007, suggests: “In this section of your protocol, describe the roles of offices and agencies in your jurisdiction that may become involved when children are present at a domestic violence incident. Provide contact information for all of the agencies included in your protocol. Key members of a CEDV Collaborative may include: police and sheriff, DV shelter and service agencies, CPS, Children’s Advocacy Centers (or Multi-disciplinary Interview Centers), Victim/Witness Program, Probation and Parole, Superior Court and Mental Health.”

I am not sure how realistic listing all of these types of agencies would be for LA County. But it should be included.

Child Death Prevention - Safety Checklist
By: Sergeant Dan Scott, LASD/SVB

1. Safe place to sleep.
 - Inspect sleeping area for young children.
 - Ask parents where the children sleep.
 - Discourage infant children sleeping with adults, explain risks.

2. Cycle of abuse (was parent a victim of abuse).
 - Ask parents how they were disciplined.
 - Check Data bases (FCI, ESCARS, Criminal History) for priors (many of today's parents were in our system 10 - 15 years ago).

3. Domestic violence in the home.
 - Are there children in the home.
 - Interview the children to determine if they witnessed the abuse.
 - Determine if child abuse is also present.
 - Inspect all young child for injuries.

4. Mandated reporting not always carried out by professionals.
 - Los Angeles County now has ESCARS (Electronic suspected Child Abuse Reports), a state of the art system of communicating between agencies. ESCARS is the first of it's kind in the nation and establishes real time cross reporting, case tracking and sharing of information to help ensure a safety net for children.
 - It is imperative that all professionals use this system.

5. Multiple referrals to a single household of alleged neglect.
 - Multiple referrals should serve as a "Red Flag".
 - Each referral should be evaluated to determine if there is a pattern and if the abuse is escalating.

6. Lack of non-reporting to Law Enforcement and the District Attorney.
 - ESCARS has eliminated this problem. All reports of suspected abuse are cross reported immediately from the DCFS Hotline to L.E.
 - LASD has placed a priority on these cases and treat each and every SCAR as a "**Call for service**" requiring a deputy sheriff to respond and evaluate each case face to face.
 - The D.A. audits ESCARS looking for cases that might fall through the cracks.

7. Lack of competent medical evaluation. (Requires child abuse medical expertise).
 - Medical centers in Los Angeles county have always been excellent. Now that these centers are approved by Emergency Medical Services, the standards are even better.
8. Social worker or law enforcement investigator should inspect the child for injuries.
 - Every child should be inspected for signs of physical abuse.
 - Interviews of verbal children is imperative to capture information of prior abuse in which the injuries have healed.
9. Lack of parent child bonding.
10. Verifying identify and relationship of care giver to the child (i.e. stepfather, boyfriend).
 - All involved parties should be identified as to their relationship to the child and their role in the home for further investigation.
11. Lack of collateral contact by social workers/investigators with neighbors, school officials, relatives and friends of the caretaker and child.
 - Interview should be conducted with each of the above whenever possible for they may posses a wealth of information about the child and/or the child's behavioral changes.
 - Witnesses may not see the abuse but patterns that may reveal neglect and caretaker absence.
12. Caseworker or investigative official must assess a care giver's competence if the person is related to the abusive parent.
13. F.C.I. (Family and Childrens Index), ensure it is used.
 - This pointer system can and does show patterns of abuse and prior history of abuse from agencies that in the past never had the ability to share this valuable information.
 - An investigation should not be considered complete an a check of FCI has been complete.
 - All agencies involved in the investigations of child should should be using FCI and inputting information.

14. Check of substance abuse and domestic violence. Most child deaths of a child younger than two years old.

- Substance abuse can greatly increase abuse, both domestic and child in the home.
- The sheriff's Special Victims Bureau views physical abuse cases with the victim under 5 years of age as a priority case. These young victims have limited or no access to help placing them at a much higher risk than verbal children who are in school.

OTHER CASE SCENARIOS

A one-year old girl was submerged in a bathtub and suffocated by her father because he did not want to pay child support. When law enforcement arrived and found the little girl lying on a bed, the officer picked up the child and ran to the elevator, waited for the elevator and brought the child outside for paramedics. He did not perform CPR while bringing the child outside and the paramedics determined that the child was already dead.

A two-month old baby was taken to the emergency room because he had trauma to his mouth that was bleeding severely and had been holding his head to the side. The doctor at the hospital indicated that the wound to the mouth had scabbed up and sent the baby home. At home, the baby was fussy and did not eat well. Six hours later, paramedics were called to the home because the baby was not breathing. The baby was diagnosed with multiple subdural hematomas and retinal hemorrhages. The baby also had several rib fractures and was put on life support. He was taken off life support by a court order and died. The father indicated that he had become tired of the baby's fussing and had thrown him on the bed.

Nine-year old Daniel was autistic and non-verbal. His disabilities were too severe for his family to handle and he was placed in a Regional Center placement. He required 24-hour supervision. Daniel's foster mother described Daniel as having sleep issues and being very disruptive at night. He had been fighting with another boy in the home and the foster mother would lock Daniel in his bedroom at night. Daniel also refused to eat. The foster mother had taken it upon herself to change Daniel's diet so that it would be healthier but Daniel was used to eating fast food and would not eat the food that the foster mother gave him. Daniel lost 20-25 pounds within a very short period of time. Daniel died of dehydration and had an empty stomach at death which meant that he had not eaten for 48-72 hours prior to his death.

Four-year old Larry's mother had a history of mental health problems. She had been diagnosed with bipolar disorder and psychosis. She was put on medication and saw a private psychologist. At one point she was hospitalized for taking an overdose of lithium. Mother became more stable and was responsible for Larry's care. Larry's school made a referral to DCFS alleging emotional abuse because Larry's mother was yelling and accusing the school of trying to kill her son. DCFS determined the referral to be inconclusive but did set up a safety plan that required the Maternal Grandmother to be present at all times. Unfortunately, the Maternal Grandmother did not comply with this plan. Mother ultimately lost her medical insurance and was seen by the Department of Mental Health (DMH) one year later for a follow-up. DMH did not have the medical records from mother's prior hospitalization or her private psychologist. The DMH psychologist did a write-up without this history and diagnosed mother with an eating disorder and anxiety. One night mother called law enforcement stating that she needed help or she would kill herself. Law enforcement went searching for her but could not locate where she lived. Mother called her brother and pleaded for help. The brother came over and calmed mother down. He then left. Ultimately, mother stabbed four-year old Larry to death and then killed herself.

CASE VIGNETTE

Jennifer, age 4, started life living with her mother, father and two siblings. She used to hear her parents argue every night and was afraid that something bad might happen. After a long time of fighting, her father disappeared and her mother became heavily involved with drugs. Jennifer and her siblings would be left alone for long periods of time and Jennifer was very scared. Jennifer's father came back into the picture and she and her siblings went to live with him. However, he began drinking a lot and Jennifer and her siblings were placed in foster care. Her father disappeared from her life again. Eventually, her mother, who had disappeared for a while, came back into her life. By this time her mother had a boyfriend and two more children. The mother received services from the Department of Children and Family Services (DCFS).

One of Jennifer's siblings, Sammy, was 8-months old at the time they were placed in foster care. At that time, he was diagnosed with failure to thrive, anemia, a heart murmur and possible fetal alcohol syndrome. All of the children did well in foster care and Sammy gained weight and received needed medical care. When Jennifer was 6 years old and Sammy was 2 ½ years old, they and their sibling Jocelyn, age 4 were returned to the care of their mother. Sammy was no longer viewed as "failure to thrive" and was doing well medically. Jennifer was happy to be home with her mother but she did not like her mother's boyfriend. Jennifer and her siblings would be hit by their mother's boyfriend with belts and shoes. Jennifer also saw her mother's boyfriend punish Sammy by submerging his face in a sink full of water. One time, Jennifer saw the mother's boyfriend punch Sammy in the stomach so hard that it made him vomit. Jennifer was afraid that she and her siblings were going to be hurt badly by the mother's boyfriend and Jennifer told her mother she was scared but this only led to a big fight between her mother and mother's boyfriend.

DCFS was still providing services to the mother and she was supposed to take Sammy to the Martin Luther King (MLK) Hub for monthly weight monitoring and general check-ups. Mother decided to take Sammy to a local clinic instead of the Hub and she did not tell the staff at the clinic about Sammy's prior diagnoses. He was seen by multiple providers at the clinic and was weighed each time. However, no one seemed to pick up on the fact that Sammy was not gaining any weight. One time, Sammy was brought into the clinic for a burn on his flank; his mother reported both to the clinic staff and the DCFS social worker that she had left Sammy in the tub to attend to some burning food and he turned on the hot water. Neither the social worker nor the staff at the medical clinic made a report to the Hotline believing her explanation that the injury was accidental.

Less than a year after being returned to their mother, Sammy was rushed to the hospital by his mother – he was in full cardiac arrest. His mother stated that Sammy had fallen from a bunk bed and hit his head four days earlier. However, physicians at the hospital did not believe the mother's explanation. Both Sammy's mother and her boyfriend denied that they had ever hit any of the children. Sadly, Sammy died as a result of cardiac arrest. His siblings were removed from the home. A DCFS Emergency Response Social Worker found that the siblings were suffering from lice infestation for which they needed medical care, the home was unsanitary, had a bad odor, was infested with roaches and mold was found in the children's bathroom.

At autopsy, Sammy was found to have two healing rib fractures that were several weeks old. He died as a result of a single blow to the abdomen which perforated his small intestine. This perforation led to a resultant infection which ultimately caused his death. The Medical Examiner stated that

Sammy's abdominal injury would have occurred several days prior to his death. The explanation that mother gave that he hit his head four days earlier from a fall off a bunk bed did not explain Sammy's injuries. The Medical Examiner also reported that after returning home to live with his mother, Sammy had not gained any weight but had grown 5 inches.

Law enforcement began to investigate. Both Sammy's mother and her boyfriend were given polygraph tests. The stepfather passed his polygraph but the mother failed. Her explanation for failing the polygraph was that she thought she may have injured Sammy while giving him CPR on the way to the hospital. Law enforcement was initially unaware of the mother's extensive history with DCFS and her substance abuse history and had focused their investigation on the mother's boyfriend. Given the polygraph results, law enforcement began to look more extensively at the mother. However, they have not been able to determine who was with Sammy at the time of his injury and have been unable to submit the case to the District Attorney for the filing of criminal charges. Their investigation remains open. As it is unclear who actually caused the fatal injury, it is likely that neither mother nor her boyfriend will ever be prosecuted for Sammy's death.

Risk Factors

Jennifer, Jocelyn and Sammy's mother and father both had a history with DCFS when they were minors (**cycle of abuse**).

There were numerous referrals on the mother that were "unfounded" when she was a minor (**large number of prior "unfounded" referrals**).

Jennifer, Jocelyn and Sammy's parents were teenagers when their first child was born (**very young parents**).

All three adult caregivers had a history of **substance abuse**.

There was **domestic violence** between the mother and both men with whom she was involved.

This was a **blended family**. Sammy was not biologically related to the mother's boyfriend (**mother's boyfriend, sexual jealousy**).

The focus of the DCFS services for all of the children was on the mother and did not include the mother's boyfriend (**lack of attachment and involvement by the boyfriend**).

Sammy was 8-months old when first removed from his mother and he was 2 ½ -years old when he was returned to her care (**lack of attachment and bonding**).

Sammy was **not potty-trained** and the siblings reported that mother's boyfriend had punched him for peeing on himself.

The clinic did not pick up on his lack of weight gain (**failure to thrive; medical care not provided by professionals trained in child abuse and neglect**).

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March 31, 2011

Report Says New York City Overlooked More Children in Danger

By MOSI SECRET

A city review made after the death of a malnourished 4-year-old in September found at least 10 more instances in which child welfare workers missed signs that children were in imminent danger, a report by the city's Administration for Children's Services and the Office of the Public Advocate said on Thursday.

The report did not detail what happened to those children, though it said the agency followed up on their cases once it discovered that they had been mishandled. In addition to those cases, 52 others had been closed despite evidence that the families still needed supervision, the report said.

The review occurred after Marchella Pierce, a 4-year-old from Bedford-Stuyvesant, Brooklyn, whose family was under the child welfare agency's supervision, died in September weighing 18 pounds. Prosecutors said she had been repeatedly beaten and tied to a bed every night for months to keep her from taking food from the refrigerator.

Her mother has been charged with murder, and last week, the Brooklyn district attorney announced the indictment of a former agency caseworker, Damon Adams, and his former supervisor on charges of criminally negligent homicide, saying that their failures had contributed to Marchella's death.

The death, and the results of the review, suggest that after several rounds of reforms that followed highly publicized deaths of children, the agency is still plagued by serious deficiencies. In addition to the indictments, Charles J. Hynes, the Brooklyn district attorney, announced last week that he would convene a special grand jury to look at "systemic failures at A.C.S."

Marchella's case had been assigned to a nonprofit Brooklyn agency, Child Development Support Corporation, in January 2010 after her mother, Carlotta Brett-Pierce, tested positive for marijuana while giving birth to a boy.

But in June, the city canceled its contract with the nonprofit agency, citing “performance issues,” and canceled contracts with several other independent agencies because of budget cuts. Many cases were closed as a result, but 70 open cases were transferred to employees of the Administration for Children’s Services like Mr. Adams.

After Marchella’s death, the city’s public advocate, Bill de Blasio, and the children’s administration formed a task force to review the handling of the cases that had been closed or transferred. They looked at 70 that had been transferred to administration caseworkers. They also reviewed 223 cases at random from 2,095 that had been closed by the independent agencies.

Out of the 70 cases, the task force found one case where the child was in imminent danger and called the state’s emergency phone line to begin an investigation. Another 17 needed further review because poor documentation raised questions about whether the children were at risk. And of the 223 cases, 9 required immediate calls to the emergency line and another 35 required further review.

The agency did not provide any names or details of the cases, but in its report released on Thursday, it said, “All of these issues were addressed and appropriately followed up.”

The children’s administration does not plan to review the 1,872 closed cases that were not a part of the random sample.

The report proposed a host of reforms, including enhancing its monitoring of nonprofit providers, improving the review of cases when contracts are canceled, strengthening supervision of caseworkers and carrying out new documenting requirements.

“This report is a fair representation from experts outside A.C.S. to show what needed to be done to make this kind of situation less likely in the future,” said John B. Mattingly, commissioner of the agency, referring to Marchella’s death.

Representatives from the Child Development Support Corporation did not immediately respond to calls seeking comment.

Last year, the city proposed cutting \$12 million in financing for nonprofit agencies providing “preventive services” to children and families. Three thousand families would have lost services under the proposed cuts; 7 of 59 providers planned to close.

The City Council, led by Annabel Palma, chairwoman of the General Welfare Committee, restored

financing for 2,900 of the slots that were cut, with a temporary infusion of \$11.7 million, but not before the nonprofit providers had begun laying off workers and reducing service.

When the financing was restored, the children's services agency invited all but two of the providers to return, but some could not ramp up quickly, and continued only some programs. Cases like Marchella's were closed or transferred.

As a result of the task force review, the Bloomberg administration guaranteed financing at this year's level to stabilize contracts with the nonprofit providers.



January 13, 2006

Long Chain of Alarms Preceded Death of Girl, 7

By [ALAN FEUER](#) and [THOMAS J. LUECK](#)

A day after the bruised body of a 7-year-old girl was discovered in a blood-stained Brooklyn apartment, city officials revealed new and harrowing details of her short life yesterday, as well as repeated missed opportunities to save it. Mayor [Michael R. Bloomberg](#) declared, "We, as a city, have failed this child."

The body of the girl, Nixzmary Brown, was found Wednesday at her mother's home in Bedford-Stuyvesant. Investigators said that the girl's stepfather, Cesar Rodriguez, had banged her head against a faucet in the bathtub and that they were trying to determine whether that was what killed her.

Nixzmary was the fourth child in two months to die while in the custody of parents who had had contact with the city's Administration for Children's Services. "It is obvious they did not pursue this case with the intensity that they should have," Mr. Bloomberg said of the agency.

Agency officials said it would immediately begin a review of every open case involving a child who is the subject of an abuse or neglect complaint, roughly 8,000 to 10,000 cases.

Interviews with school and child welfare officials revealed just how close Nixzmary had been to getting help.

Education and teachers' union officials said that school staff members had noticed that the girl was missing classes, appeared malnourished and suffered an eye injury, and that the staff members had notified state and city child welfare officials repeatedly. In response, the city agency workers talked with Nixzmary and her parents, visited her home and took her to a doctor, who said her injuries were consistent with falling down.

Finally, in the crucial weeks before her death, child welfare workers were unable to get into her home and did not take the necessary steps to get a warrant.

"We considered asking the family court for a warrant to have the police come with us to make sure we gained entry, but at no time did we get the warrant," said John B. Mattingly, the commissioner of children's services. "People made judgments about whether this was an emergency, and those judgments turn out to be wrong."

Mr. Rodriguez was arraigned yesterday with the girl's mother, Nixzaliz Santiago, in Criminal Court in Brooklyn. Mr. Rodriguez was charged with murder and endangering the welfare of a child. The mother was charged with manslaughter, reckless endangerment and endangering the welfare of a child. Neither entered a plea.

In the hearing, a prosecutor described a frightful sequence of abuse, saying that the girl had been "systematically tortured" for several weeks.

The girl was not quite four feet tall and weighed 36 pounds when she died, the officials said.

The girl had been tied up by her stepfather, she was denied food and her head was submerged under water, the prosecutor said. The final, fatal beating apparently came after she took yogurt from the refrigerator, the prosecutor said.

"There was barely a spot on this child that was not marked by her parents," said the prosecutor, Cathy Dagonese, of the Brooklyn district attorney's office. Describing the moments before Nixzmary died, Ms. Dagonese said Nixzmary had been lying on the floor, naked and unconscious, as Ms. Santiago stood by.

Officials of the Administration for Children's Services said they had visited Ms. Santiago at home in May and in December after officials at the girl's school, Public School 256, had complained. In May, they reported that she was missing classes, and in December that she had bruises around her eye.

After their first visit, caseworkers decided that Ms. Santiago was overwhelmed by her six children. They believed they had persuaded her to return Nixzmary to school and closed the case, Mr. Mattingly said.

An official of the United Federation of Teachers said a union staff member at the school faxed a report to the child welfare agency saying that Nixzmary was malnourished. Child welfare officials said they were aware of concerns about the girl's health and had discussed them with her

mother.

On Dec. 1, the child welfare agency received the report of bruises around the girl's eye. At that point, Mr. Mattingly said, a team including two police detectives was sent to the home. A doctor was also called to examine Nixzmary's black eye. Mr. Mattingly said that the family told the team Nixzmary had hurt herself in a fall and that the doctor "confirmed for us that the injuries appeared to have occurred the way the child and her parents had said it had happened."

It was then that the child welfare agency officials began "encountering difficulties" with the family, Mr. Mattingly said. Agency workers made repeated attempts to call and to visit the home in person, but were constantly rebuffed, he said. The agency considered asking a Family Court judge to issue a warrant that would let officials enter the house, but did not.

Nixzmary returned to school on Dec. 6, 8 and 12, education officials said. Dec. 12 was the last day she or any of her siblings were at school.

Nonetheless, school officials continued to try reaching out to the family, officials said. Michele Cahill, a top adviser to the chancellor, said that school attendance teachers visited the family's home on Dec. 15 and Dec. 21, but that nobody answered. School staff members also tried to contact the family by letter and telephone, education officials said, and were in touch with child welfare workers throughout December and January.

Nixzmary and her siblings enrolled at P.S. 256 in January 2004. Since January 2005, three long-term absentee reports were generated for Nixzmary: two during the last school year and one this year. While school officials are obligated to report evidence of "educational neglect" to the state, persistent absenteeism does not necessarily constitute neglect.

At the arraignment, Ms. Santiago's lawyer, Laura Saft, said her client was an overwhelmed mother who had suffered a miscarriage in November and was in no shape to stave off what she said was Mr. Rodriguez's abuse. Judge Robert Allman ordered the two held without bail and issued a restraining order barring them from having contact with Nixzmary's five siblings, who are now in city custody.

One law-enforcement official said investigators searching the apartment found what appeared to be human tissue in a jar, which the mother said had been given to her by hospital staff members after she had a miscarriage, possibly last year.

"There was something there, whether it was a fetus or not, there was something in a jar that came out of her from a miscarriage," the official said. "They kept it."

Mayor Bloomberg, at a news conference, defended the city's policy of trying to keep troubled families together but criticized the child welfare agency for having not moved with "sufficient urgency."

"In retrospect, had they pushed harder, perhaps they could have - although we'll never know - prevented this from happening," Mr. Bloomberg said.

Asked if the city's policy of keeping families together when possible needed to be rethought, the mayor said, "It is best if families stay together," adding that "when you have a dysfunctional family, there are myriad problems." and that if they are kept together, the city can "marshal resources" to help.

At the same time, a grim picture of Nixzmary's life arose in interviews with law-enforcement officials and several of her relatives. Investigators said the girl had become the target of her stepfather's anger and was sometimes bound to a chair in her room and forced to eat cat food. Because she was often held in isolation, she was sometimes made to use a litter box, they said.

They also said that Mr. Rodriguez would sometimes punish Nixzmary and her siblings by dunking their heads in a water-filled sink.

Nixzmary's grandmother, Maria Gonzalez, said Mr. Rodriguez was at times abusive. "I didn't like the way he scolded them," she said. "All children act up, it's no excuse."

Mr. Rodriguez's younger brother, Miguel, said that he had served in the Army, mainly at Ford Hood, Tex., but was discharged four or five years ago. At one point, Miguel Rodriguez said, his brother had taken the city police exam, but had never tried to join the force.

"There was no arguing," Miguel Rodriguez said of his brother's apartment at 571 Greene Avenue. Nonetheless, asked if his brother had a temper, he went on to say: "I'm not going to say no, but it was not into extremes."

The police said Cesar Rodriguez had been arrested before, on March 10, 2003, after getting into a fight with a man in Manhattan. Mr. Rodriguez was arraigned on March 11, 2003. Then, three days later, on March 14, Mr. Rodriguez pleaded guilty to harassment as a violation, the case was conditionally discharged, and he received a sentence of two days of community service.

Mr. Rodriguez met Ms. Santiago about two years ago when he was working as a security guard at her Brooklyn apartment building, said Caridad Ramos, Ms. Santiago's aunt. She had come to the United States from Puerto Rico in 1995, Ms. Ramos said.

Reporting for this article was contributed by Al Baker, Kareem Fahim, Janon Fisher, Elissa Gootman, Leslie Kaufman, William K. Rashbaum, Jim Rutenberg and Matthew Sweeney.

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January 14, 2006

This Time, a Harsh Light on a Child Agency's Chief

By LESLIE KAUFMAN and JIM RUTENBERG

Just three months ago, the city's child welfare commissioner, John B. Mattingly, discussed the circumstances that could most imperil an official's job, saying, "If a bad child death does happen, the agency gets no protection."

This week, his agency was caught in a firestorm over just such a case: the gruesome death of 7-year-old Nixzmary Brown, whose killing has led to investigations into whether welfare caseworkers failed to act on signs of abuse and take the kind of quick, strong action that could have prevented her death.

When he made the remarks in October, Mr. Mattingly was still basking in the glow of his agency's sensitive handling of the case of Valery Belén Saavedra Lozada, a sweet-faced 4-year-old who had been left on the street by her mother's killer. In that case, the agency acted quickly to put the child on television, assuring her swift return to relatives.

Now Mr. Mattingly is facing what he calls "a perfect storm." Everyone wants answers on why welfare officials delayed getting a warrant to enter Nixzmary's house for four weeks as, the police say, she was slowly tortured and beaten to death by her stepfather. At least one newspaper called for Mr. Mattingly's firing.

Yet so far, Mayor Michael R. Bloomberg has been emphatic in support of the commissioner. "I think John Mattingly is an expert," he said on Thursday. "We were lucky to recruit him from the Casey Foundation in Baltimore. I think he certainly has the skills and the knowledge to do this job."

Mr. Bloomberg seemed to be doing what he typically does when agencies come under attack: loyally standing by a commissioner under siege. It is something for which he has been praised and criticized.

For instance, he never wavered in his support of his deputy mayor for economic development and rebuilding, Daniel L. Doctoroff, after his campaign to build a stadium on the Far West Side failed spectacularly - along with his bid to bring the 2012 Olympic games to the city. Nor has he softened his public support for his transportation commissioner, Iris Weinshall, amid continued criticism for what some have called a woeful lack of oversight of the city's ferry service before the 2003 Staten Island ferry crash, in which 11 people died.

Yet city officials said while the mayor is standing by Mr. Mattingly, he would not do so if it were determined that the commissioner was personally responsible for systemic flaws that led to children's deaths. So far, there is no evidence of that.

"Commissioner Mattingly has the mayor's full confidence," said Ed Skyler, the deputy mayor for administration. "You don't dismiss a dedicated, experienced professional in a knee-jerk reaction to appease an editorial board."

It is telling of Mr. Mattingly's reputation as a fixer of child welfare bureaucracies that the mayor has never expressed doubt about the commissioner himself investigating what went wrong in the case, even if it means the inquiry could implicate Mr. Mattingly. In addition, city officials said that the Department of Investigation was considering starting its own inquiry into certain aspects of the case.

"John has approached his job completely without political concerns," said Marcia Lowry, executive director of Children's Rights Inc., who has been critical in the past of the agency's doing its own reviews of child deaths. "I don't think he is capable of being anything but truthful. He is an outstanding public servant."

A short man with a pale goatee, Mr. Mattingly presents an unimposing figure. Yet as the head of the child welfare system in Toledo, Ohio, in the 1980's and later as the director of human service reforms at the Annie E. Casey Foundation, the Baltimore-based child welfare advocacy and research organization, he earned a national reputation for mastering the vast minutiae of child welfare policy and practice and overhauling troubled systems.

His standing is so strong among child welfare advocates that even those who have recently raised questions about the agency's performance under his watch are unequivocal in wanting him to stay on the job.

"Any disruption in the continuity of management of the agency at this point would be a grievous error," said Gail Nayowith, executive director of the Citizens' Committee for Children.

The commissioner also has a high-placed ally in Linda I. Gibbs, the city's new deputy mayor for social services. Ms. Gibbs, who helped lead an overhaul of the New York child welfare agency in 1996, has previously credited Mr. Mattingly, who was then at Casey, with helping her introduce new procedures for caseworkers in the city. She remains his great booster.

And, most important, Mr. Mattingly said he has had nothing but support from the mayor. He said he has remained calm because "pressure comes with the territory and also because I have had a lot of experience with this." He also credits his wife with keeping him sane. "She does everything from watch the media to cook my meals and pat my cheeks," he said.



January 19, 2006

Supervisors Are Suspended After Girl's Death

By LESLIE KAUFMAN and JIM RUTENBERG

Six New York City child welfare workers were suspended or reassigned yesterday for their roles in the failed investigations leading up to the death of a 7-year-old girl in Brooklyn. The commissioner of children's services also announced a reorganization of his top aides aimed at improving the oversight of hundreds of frontline abuse investigators.

Commissioner John B. Mattingly, speaking at a news conference after a week of embarrassing disclosures about the city's Administration for Children's Services, said he was taking action against the six workers because they had failed to take "basic and important steps" in the investigation of complaints of abuse and neglect involving the girl, Nixzmary Brown.

Prosecutors say the child was abused by both her parents over many months and was ultimately beaten to death by her stepfather last week, even though concerns about her safety were known to child welfare caseworkers, school personnel and the police.

"The staff made poor investigative decisions and gave inadequate attention to clear warning signs of the danger Nixzmary Brown was facing," Mr. Mattingly said. "While it's true that this work is extremely difficult, these are examples of incomplete and inadequate steps. Everyone at Children's Services must act with urgency and absolute thoroughness when responding to allegations of abuse and neglect. That's what the city expects and that's what I expect."

The three agency workers who were suspended were those most directly involved in the handling of Nixzmary's case. Mr. Mattingly suspended without pay Andrew Bartley, the supervisor who handled the first reports of neglect involving Nixzmary last May, when the case went nowhere, though the child had missed 47 days of school and had suffered a variety of injuries.

He also suspended without pay Joyceline St. Hill and one other supervisor, who both investigated a December report by school officials that Nixzmary might have been physically abused. The child was not seen by a doctor, and no caseworker ever gained access to the child's home or sought a warrant to get inside the family's apartment after the stepfather refused to cooperate. The names of the workers disciplined were not released by the agency, but two of them were confirmed by a person with direct knowledge of the action.

Three other child welfare workers in the Brooklyn office that handled Nixzmary's case were not suspended but were reassigned to a new supervisor.

Mr. Mattingly said he had asked the city's Department of Investigation to conduct its own inquiry into the handling of the case to determine if there was actual wrongdoing - falsifying records, for instance - by any of the caseworkers or their supervisors.

Mr. Mattingly announced no changes in actual policy - involving, say, how investigations are conducted - and reiterated that the city already had implemented nationally respected training programs and other reforms over the last decade. However, several of the changes involving senior agency officials made clear how seriously the fallout from the botched case was being treated.

As a first step, he said that the agency's executive deputy commissioner, Zeinab Chahine, would be working full time on child safety issues throughout the agency and would take direct authority for the Division of Child Protection. Ms. Chahine was in fact director of child protection until Mr. Mattingly promoted her a year ago. He never named a permanent replacement.

Mr. Mattingly also announced the establishment of a new ombudsman's unit at the agency. Now, employees at any city agency, or at the dozens of private nonprofit agencies involved in child welfare work, can call the ombudsman's office for immediate assistance when they have concerns about the progress of a child protective investigation.

City officials said Mayor Michael R. Bloomberg had been "deeply involved" in the drafting of the new managerial plan.

The caseworkers and the supervisors who are being suspended or reassigned are civil servants and cannot be fired immediately, the agency said. Joseph Cardieri, general counsel of the child welfare agency, said the workers would be suspended for 30 days, or until an administrative hearing. Penalties, if they are assessed, could range from a reprimand to termination. In the case of Elisa Izquierdo, a 6-year-old girl killed by her mother in 1995, the agency fired one caseworker and suspended a supervisor.

Charles Ensley, the president of Social Services Employees Union Local 371, which represents the caseworkers, called the commissioner's actions yesterday inappropriate.

"If in fact the commissioner found some failure in casework practice, the most appropriate response would have been additional training," Mr. Ensley said. He warned that "workers will start removing children at the least sign of abuse, and that is not good practice."

Child protective services first heard of Nixzmary last May, when her school guidance counselor reported her prolonged absence from school. Despite additional notes reporting bruising and an interview with her older brother, who said she had been burned, the caseworkers did not determine that she had suffered what is known as "educational neglect."

Mr. Mattingly called such a finding impossible to understand.

In December, the agency received a straightforward complaint of abuse from the Brooklyn elementary school that Nixzmary attended with several of her siblings.

Although agency workers interviewed Nixzmary and her siblings at the school the day the complaint was made, they never took the 7-year-old to a medical professional to have her injury evaluated and never again met with any family members. Neither Nixzmary nor her siblings attended a day of school in the month before she was found naked and dead on the floor of her Brooklyn apartment.

Mr. Bloomberg, who attended the girl's wake on Tuesday, did not attend yesterday's announcement. And the announcement itself was not held in the Blue Room at City Hall, but at child welfare headquarters.

But senior aides said that the location of the announcement was in keeping with the mayor's statements that he has full confidence in Mr. Mattingly to sort out whatever problems the case has brought to light.

Officials said last night, however, that the changes announced yesterday would not necessarily be the last new efforts meant to improve the handling of abuse cases.



January 24, 2006

Mayor Outlines New Procedures for Child Abuse Cases

By [JIM RUTENBERG](#)

Responding to a public outcry over the death of a 7-year-old girl in a home already under city investigation for abuse, Mayor [Michael R. Bloomberg](#) announced today that retired law enforcement workers would be dispatched to work in child welfare offices and that he was creating a mayoral office to ensure that city agencies worked together to prevent abuse.

The changes were part of the largest overhaul of the system that handles child abuse cases since its wholesale restructuring some 10 years ago, when the city, as now, was struggling to come grips with the death of a child already suspected of being abused.

Officials said today's changes were devised to enhance that system, not dismantle it. Still, they were a reflection that while that system has been held up as a national model in recent years, it nonetheless continues to have clear, and potentially deadly, inefficiencies.

Referring to the case of the 7-year-old girl killed last month, Nixzmary Brown, Mr. Bloomberg said that "we are determined to find out exactly where the system broke down and to marshal the resources to fix it."

Many of the changes highlighted today were aimed at creating a new set of so-called "red flags" that would trigger more immediate action by case workers while improving training and interagency cooperation, which seemed to be lacking in the case of Nixzmary Brown.

In addition to the systemic changes announced today, Mr. Bloomberg said the city would devote another \$25 million to the Administration for Children's Services for new managers and case workers, and new training for existing workers.

The mayor also said that the city would place 20 "seasoned law enforcement professionals" in the 14 children's services offices in the city to help train field workers in the latest investigative techniques and to step in and help in specific cases when necessary.

Mr. Bloomberg said those officials would ideally be retired police detectives or retired investigators from district attorney offices, and that they would act independently of the Police Department.

The city will also hire 32 new lawyers to ensure that children's services is efficiently handling family court cases and to be readily available to case workers seeking advice.

The changes reflect the myriad problems officials say they now believe led to the system's failure to save Nixzmary Brown's life despite several clear cases in which it could have.

The New York Times

October 10, 2013

Grand Jury Cites Deaths of Children in Inquiry

By JENNIFER PRESTON

A Brooklyn grand jury found that 19 children in New York City died of abuse and neglect because the city's child protective agency had failed to rigorously investigate cases even after a city report recommended new practices in 2007.

In a 102-page report, the investigative grand jury said that "children will continue unnecessarily to live and die in fear and in pain" unless the city's Administration for Children's Services makes the "necessary changes" to more effectively investigate cases of abuse and neglect and impose measures to better safeguard children at risk.

The panel's report was released on Friday during a court proceeding for two former caseworkers who have been awaiting trial for more than two and a half years on charges of criminally negligent homicide in the death of 4-year-old Marchella Brett-Pierce.

Marchella's mother was convicted of murder in 2012 in the death of the child, who had been drugged and starved to death, weighing only 18.8 pounds when she was found dead in 2010. Prosecutors said the caseworkers, Damon Adams and Chereece Bell, were negligent and contributed to her demise. They have pleaded not guilty, saying they are being blamed for crimes they did not commit.

In addition to the criminal charges brought against Marchella's mother, grandmother and two caseworkers, her death prompted the Brooklyn district attorney, Charles J. Hynes, to impanel a special investigative grand jury to examine the city's child welfare system. The jurors spent more than a year interviewing 40 witnesses and examining more than 110 exhibits.

The grand jury found that Marchella died unnecessarily, along with 8 other children in Brooklyn and 10 others across the city from 2005 to 2010 because of "serious errors and shortcomings" of the agency and the failure to "implement in a professional and effective manner the laws and regulations governing" investigations of child abuse.

The grand jury said that caseworkers at the agency "must be hired in sufficient numbers, they must

be rigorously trained by qualified and experienced instructors, and they must be provided with sufficient resources and skilled supervision so that they can fully and effectively comply with the laws and regulations that prescribe how they are supposed to investigate complaints of child abuse and neglect.”

The city’s Department of Investigations recommended changes in 2007 after another high-profile case in which a child, Nixzmary Brown, 7, died at the hands of her stepfather in 2006.

In a statement on Friday, the Administration of Children’s Services defended its record in protecting children, insisting that recommendations had been implemented to strengthen investigations and preventive services for families.

“We acknowledge the grand jury’s efforts, but are deeply troubled by the report’s sweeping generalizations and conclusions,” the statement said. “Not only did the grand jury review limited cases between 2007 and 2010, it wholly disregards key steps A.C.S. has taken over the past seven years, including the addition of more preventive services for children with special medical needs, hiring additional investigative consultants, and reducing our caseloads to among the lowest in the country.”

Michael Fagan, a spokesman for the agency, said that it was “plain wrong” to say that the agency’s caseworkers did not conduct thorough investigations. “They have caseloads that are among the lowest in the nation, and they indicate cases, finding credible evidence of abuse and neglect, at higher rates than the national average,” he said.

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April 7, 2011

When Blame Isn't Enough

By OLIVIA A. GOLDEN

Washington

THE death of Marchella Pierce, a 4-year-old girl in Brooklyn who was beaten, malnourished and tied to a bed, has again aroused anger over child welfare in New York City. Her mother stands accused of murder, and a caseworker and a supervisor were charged last month with criminally negligent homicide.

Reading about Marchella's death in September brought back painful memories. When I was the director of child welfare in the District of Columbia I often woke up at 3 a.m., fearing all that could go wrong. During my tenure, there were increases in adoptions and speedier investigations, and more children went to live with foster families rather than in institutions. But substandard care and terrible cases also continued.

Because there is so much to fix, improvements and calamities can happen simultaneously in long-troubled child welfare systems. In Washington, where I took over from a court-appointed receiver, the work ranged from reducing caseloads to overhauling information technology, contracting, licensing and personnel systems. On good days, we reminded ourselves that it was all worth it. But when a child was hurt or killed, we often reacted defensively, fearing that a misdirected public outcry could undercut our plans for reform.

After I left that job, I kept looking for solutions. For ideas, I examined institutions like airlines and some hospitals that have reduced deaths and injuries. Through rigorous data analysis, they have developed systemic approaches to safety, focusing on clear communication, minimum-staffing requirements and "fail-safe" strategies to reduce the consequences of inevitable human error. Such strategies — including checklists and passing on information at crucial moments like shift changes — can be applied to protecting children.

Findings from the Institute of Medicine, the Commonwealth Fund and other organizations point to several lessons from safety initiatives in these fields:

- You can't fix a systemwide problem by simply blaming or retraining individuals. When systems are broken, workers respond in counterproductive ways. They try "workarounds," as when a nurse guesses at a doctor's unreadable handwriting on a prescription because she is afraid to ask. Or they withhold information to avoid responsibility, wanting someone else to make a decision even if it is wrong. Blaming individuals can also make it harder to recruit and keep the most qualified employees. (In child welfare, talented caseworkers too often give up on investigating troubled families and gravitate to handling adoptions.)
- You can't learn what's wrong with the system from just one case. Understanding what to fix requires analyzing many cases, including deaths, injuries and "near misses." That is why airline safety analysts collect information about maintenance problems and planes that come too close to each other on the runways or in the air, and why hospitals study medication errors. Looking just at Marchella's death focuses attention on the caseworker, while looking at more cases gets us closer to understanding trends and patterns.
- You can't understand problems and fix them unless you create a culture in which employees share information without fear. The Department of Veterans Affairs increased reporting of potentially dangerous errors by promising hospital staff members they would not be punished unless the mistake was intentional or criminal or involved substance abuse. Pilots who anonymously report an unsafe episode receive a number they can use in an investigation to show that they made a report, shielding them from punishment in most circumstances.

These insights can yield simple fixes. In 2005, for example, the Illinois inspector general found that a failure to identify parents' mental health and substance abuse problems was a common feature in child deaths. Harried caseworkers who had to substantiate a complaint of abuse or neglect didn't have enough time to thoroughly investigate whether drug addiction and mental illness were involved. When state forms required them to choose yes or no in those first hectic days, they chose no — and often no one came back to help the families. So the inspector general urged the state to give workers another option, one that would indicate a need for continuing assessment in these in-between cases.

But we need to aim even higher. The Department of Health and Human Services should create a national commission to review deaths and serious injuries to children from abuse and neglect. Among other things, it should examine practices in sectors with strong safety records; look at deficiencies in access by parents to drug counseling and psychiatric care; and recommend procedures for caseworkers to report mistakes anonymously without getting blamed.

For too long, we have had a stalemate: Child welfare experts, worried that anger over high-profile deaths often leads to the unnecessary removal of children from their homes to an overloaded foster care system, are reluctant to talk about systemic safety improvements. Meanwhile, the number of children who die each year from abuse or neglect in the United States — an estimated 1,770 in 2009, or 2.3 deaths for every 100,000 children — has been rising.

There is a way out. Making sweeping policy changes and scapegoating individuals are not the best way to enhance safety, but rather, clear-headed, evidence-driven examination of the resources, conditions and communication that guide decision-making in the workplace. That way Marchella's death will not become just another example of the cycle of outrage and failure.

Olivia A. Golden, the director of the District of Columbia Child and Family Services Agency from 2001 to 2004, is a fellow at the Urban Institute and the author of "Reforming Child Welfare."



January 31, 2006

Bronx Boy, 4, Is Dead; Family Was Investigated

By LESLIE KAUFMAN and AL BAKER

A 4-year-old Bronx boy whose family was being investigated by child welfare officials died yesterday after suffering a fractured skull and severe lacerations to his liver in the messy, cold two-bedroom apartment he shared with four siblings and two adults, officials said.

The boy's mother, 26, and her companion, 18, were being held last night for questioning in the child's death, the police said. Law enforcement officials said they were also investigating whether the boy's siblings, who were taken into custody by the Administration for Children's Services, had been abused.

The death of the boy, Quachon Browne, was at least the fifth fatality since November of a child whose family was known to the child welfare authorities. The previous cases included the death of Nixzmary Brown, a 7-year-old Brooklyn girl who the police said was killed by her stepfather.

That case, shot through with a litany of missed opportunities to save the girl, put intense public scrutiny on the agency and its efforts to protect children.

"This is just so sad," said Daisy Castro, a neighbor of Quachon's family. "He was a beautiful little kid. We just can't understand how it happened."

Hours after Quachon's death, the child welfare agency released a review of the mistakes it made in the Nixzmary Brown case — including a failure to quickly interview a guidance counselor who had made the original complaint to the child abuse hotline — and the agency's commissioner, John B. Mattingly, weathered intense questioning during a City Council hearing. [Page B1.]

Mr. Mattingly said child welfare workers had made "a timely visit to the home" after a recent allegation that one of Quachon's sisters was not attending school. He could not say how recent the visit had been.

As the story of Quachon's life and death unfolded, it quickly took on many of the familiar dark aspects of deaths of children whose families had come to the agency's attention: warnings by school officials who suspected problems in the family; a visit by the police; suspicions by neighbors; and the recent arrival into a troubled home of a new boyfriend for a struggling mother.

Officers went to Quachon's family's first-floor apartment on Kossuth Avenue in the Norwood section of the Bronx about 3:30 a.m. after the mother, identified as Aleshia Smith, called 911 to report that the child was unconscious. Quachon was taken to North Central Bronx Hospital, where he was pronounced dead on arrival at 4:18 a.m., the police said.

The mother and her boyfriend, identified as Jose Calderon, were immediately taken for questioning to the 52nd Precinct station house, where they spent the day.

A law enforcement official said the mother told the police that Quachon was struck by a falling television on Friday and began vomiting on Sunday night.

The police said that Quachon and four siblings were jammed into a single bedroom in the first-floor apartment, which was unusually cold due to a broken window, and that there was no food in the refrigerator.

Ellen Borakove, a spokeswoman for the city's medical examiner's office, said the cause of death had not been determined. A law enforcement official said, however, that the medical examiner's office had told detectives that the child had had a lacerated liver, old and new bruises, and atrophied leg muscles.

Detectives said that they were told by hospital personnel that Quachon had a fractured skull. They said they believed that the child had been assaulted and that the assault had caused his death, a law enforcement official said. He and other law enforcement officials spoke on condition of anonymity because the investigation is continuing.

Complaints about the family had been made to child welfare authorities three times — twice by school officials and once by the police, officials said. The first report came on May 16, when Public School 280, which two of Quachon's older sisters attended, filed an allegation of educational neglect, meaning that the girls were missing too much school, an education official said.

Officials at that school contacted the State Central Register of Child Abuse and Maltreatment regarding both girls. Then, in June, the police took Quachon and his five siblings — ranging from 1 year old to 10 — from the home when they found them abandoned for the weekend.

"Officers responded to that location; the six children were there by themselves," said Police Commissioner [Raymond W. Kelly](#). "The mother had apparently gone to Atlantic City and had thought that the grandmother was going to go and take care of the children.

"That didn't happen," he continued. "All of the children were removed from the home at the time. A.C.S. conducted an investigation. Ultimately, the children, I think five of the six children, were brought back to the home; that's the contact we had."

It was not clear yesterday how long the children had spent away from the home. The sixth sibling is believed to be staying with relatives in Brooklyn.

On Nov. 15, P.S. 280 filed another allegation of educational neglect for the two sisters. Both had been chronically absent, the education official said.

Rhona Weiss, the guidance counselor at P.S. 280, said last night that she was saddened by the death.

"The school did everything we could," she said in a brief telephone interview. "We filed the necessary paperwork."

School absenteeism is often a red flag for child abuse, child welfare professionals have said. In the case of Nixmary Brown, officials of Children's Services acknowledged the agency erred when it did not determine that the girl was a victim of educational neglect, even though she had missed 46 days of school.

One of Quachon Browne's sisters, education officials said they believed, soon went to live with other relatives. She transferred to P.S. 145 in Brooklyn by mid-December. Her case was closed on Dec. 16. School officials closed the other sister's case on Dec. 15 because she had returned to school, officials said.

Child welfare officials say their caseworkers were still in the process of evaluating allegations regarding the older children when Quachon died.

At the City Council hearing, Mr. Mattingly said, "A preliminary review of this case showed that home visits were made immediately after the report, at which time the household was found to be in order." He declined to elaborate when reporters asked him to do so after the hearing.

The family was also known to the Department of Homeless Services, which had provided Ms. Smith with the apartment as part of a long-term shelter arrangement. Angela Allen, a spokeswoman for the agency, would not discuss details of its involvement with the family.

Neighbors from the large apartment building on Kossuth Avenue said they believed trouble started in Apartment 1A when Mr. Calderon, a nephew of the building's superintendent, moved in about eight weeks ago. He brought his pit bull, named Blue, they said, and had loud arguments with Ms. Smith.

Lisa Cashin Overton, a neighbor and friend, said Ms. Smith was a good mother. "She would get up early in the morning, drop her kids at school and pick them up," she said, "But when Jose moved in she became real isolated."

Several of Ms. Smith's friends said that when the city caseworker visited last month, the caseworker noticed that the house was well kept and the refrigerator was well stocked.

At least three neighbors said, however, that since Mr. Calderon moved in, they had seen or heard things that had made them contact child welfare or the city's 311 complaint line. The child welfare agency would not confirm any complaint other than the one received on Nov. 15 from the children's school.

Guadalupe Garcia, who lives next door to the family, said she had been calling 311 since December to complain about noise and fighting coming from the apartment. Speaking Spanish being translated by neighbors, she said that fighting broke out in the apartment again at 10 o'clock on Monday night and just got louder and louder. "At about 12:40 screaming started," she said.

Reporting for this article was contributed by Kareem Fahim, Elissa Gootman, Kate Hammer, Corey Kilgannon, Colin Moynihan, Nate Schweber and Matthew Sweeney.

February 1, 2006

City Was Told 6 Times of Trouble in Bronx Boy's Home

By AL BAKER and LESLIE KAUFMAN

Correction Appended

Even though the city's child welfare agency had received six complaints about the family of Quachaun Browne since 2004 — and even though caseworkers had been inside his home four times since November — it failed to act before a weekend-long torrent of abuse and neglect that ended with the 4-year-old's death late Sunday, the authorities said yesterday.

In all the encounters, including the most recent visit, on Jan. 12, caseworkers did not detect a dangerous new presence in the family's Kossuth Avenue apartment in the Norwood section of the Bronx: Jose Calderon, the boyfriend of the boy's mother, who was charged yesterday with second-degree murder in his death, officials said.

The police said Mr. Calderon, 18, told detectives that he lost his temper and hit Quachaun, whom he blamed for toppling a television Friday afternoon, and that the boy's mother, Aleshia Smith, 26, did nothing to intervene until it was too late. She was charged with second-degree manslaughter.

The Administration for Children's Services — still reeling from the death last month of 7-year-old Nixzmary Brown in Brooklyn — outlined its encounters with Quachaun's family in a squalid apartment where the police said cold air streamed in through a broken window, most of the children slept in a single room and there was little food in the refrigerator.

"After reviewing the history in this case, the obvious evidence of chronic neglect should have prompted a stronger response rather than addressing and resolving each incident separately," said John B. Mattingly, the child welfare agency's commissioner. "However, nothing in the record suggests A.C.S. failed to act in a way that might have prevented this fatality."

The police described a chilling weekend of victimization for the boy that began when the television fell. Based on physical evidence, as well as the statements of Mr. Calderon, Ms. Smith and some of her children, the police said Mr. Calderon beat Quachaun off and on through Saturday, went with the family to a nearby Chuck E. Cheese's restaurant where the boy vomited blood, and then beat him at home again that night.

At times, the police said, Mr. Calderon grabbed the boy's neck, pushed his face into the wall and grabbed him by the ankles, swung him and hurled him into the wall. A law enforcement official said Mr. Calderon had beaten the boy with his fists, a belt and a plastic bat. Quachaun suffered a fractured skull and a lacerated spleen and pancreas.

The police believe he died late Sunday night. His mother woke early Monday morning to find Mr. Calderon trying to revive him, and then argued with him about calling for help. She got hold of his cellphone, about 3:30 a.m., and dialed 911.

Quachaun was declared dead about 45 minutes after the police and paramedics responded to the call and found the boy with a body temperature of 83 degrees, indicating that he had been dead for hours, the official said.

Yesterday, while the city medical examiner's office said it had not yet determined the official cause of death, because of the need for further tissue testing, Quachaun's mother and her companion were led in handcuffs from the Police Department's 52nd Precinct station house to face arraignment.

Mr. Calderon held his chin up, pursed his lips and defiantly scanned a crowd of reporters yelling questions at him as he walked from the old red-brick station house. Ms. Smith, who emerged moments later, kept her head mostly up but her eyes cast down, expressionless, as she walked from the building.

After a 24-hour investigation that included intense questioning of Mr. Calderon and Ms. Smith, the police said that two of Quachaun's five sisters, a 6-year-old and a 9-year-old, indicated that they saw Mr. Calderon deliver the blows to their brother's tiny body that the police believe led to his death.

During a court appearance last night, a prosecutor described some elements of Mr. Calderon's version of events that he told detectives. Mr. Calderon said that he thought Quachaun had damaged his stereo on Friday night, and admitted that he had hit the boy four times with a red belt, according to the prosecutor.

Mr. Calderon said he told Quachaun to go to his room. But, he said, Quachaun refused, cursing at him, which sent Mr. Calderon into a rage; he said he hit the boy seven times with his open hand, according to the prosecutors.

Two nights later, Mr. Calderon said in his statement, Quachaun soiled himself in bed and had blood in his stool. He said he took the boy to the bathroom to rouse him. When Mr. Calderon left the bathroom, Quachaun fell and hit his head on the floor, causing his ears to bleed, Mr. Calderon said.

Mr. Calderon was remanded and ordered to appear March 3.

Ms. Smith's lawyer, Lewis A. Mazzone, said her client wanted to help her son but felt threatened by her boyfriend. Bail was set at \$40,000; it was not clear if she could post it.

A child welfare official said yesterday that complaints were made about how Ms. Smith was raising her children eight times in the last 10 years, including six times since October 2004. Most of the calls, which came from family friends, a school guidance counselor and a doctor, involved neglect.

"They were consistently about inadequate guardianship, poor housekeeping and school absences," said the official, who spoke on the condition of anonymity because the inquiry into Quachaun's death was continuing.

Two of the reports indicted that there might be physical abuse in the house, one reported excessive corporal punishment, and one involved Quachaun being burned, the official said. While the child welfare agency investigated them all, it was unclear how many — if any — of the cases were substantiated.

The most recent complaint was made on Nov. 15 by a counselor at Public School/Middle School 280, which two of Quachaun's older half-sisters were attending. That investigation was continuing when Quachaun died, the official said.

The two girls were said to be "frequently absent, were hungry and didn't have adequate clothing and were not well supervised."

The official added that "nothing in it alleged anything about Quachaun; there were no physical abuse allegations."

The child welfare caseworker made a first visit to the house within 24 hours of the complaint and made five more visits. Two times, the family was not home. On four occasions, the caseworker was admitted to the home, most recently on Jan 12.

"The casework was solid and up-to-date," the official said. Even so, the official acknowledged, the caseworker apparently had no knowledge about Mr. Calderon.

"There is nothing in case file about Jose Calderon," the official said. "He wasn't known to us or to the Department of Homeless Services. He was never present when we were there."

Neighbors have said Mr. Calderon moved in about eight weeks ago with all his belongings and his pit bull. The police said they believed that he had been living there since August and that he discouraged Ms. Smith from seeing her friends, hid her keys and hit her friends' children.

They say they believed that Mr. Calderon may also have hit and neglected the other children but that Quachaun was the main target of his aggression.

When Quachaun was found, he was lying on a mattress in a makeshift bedroom in the apartment's living room, bleeding from the ears and rectum, the police said. The television was lying on the floor.

Mr. Calderon was arrested on Jan. 19, when the police said he was stopped driving a stolen vehicle in the Bronx.

Janon Fisher contributed reporting for this article.

Correction: Feb. 2, 2006

Two articles on Tuesday about a 4-year-old Bronx boy who died after suffering a fractured skull and severe lacerations to his liver misspelled his given name. He was Quachaun Browne, not Quachon.

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July 26, 2011

Children's Services Leader Leaving After 7 Years

By MOSI SECRET

John B. Mattingly, the commissioner of the Administration for Children's Services, is stepping down after seven years on the job, the mayor's office announced on Tuesday.

In Mr. Mattingly's tenure at the agency, he hired hundreds of caseworkers in an effort to reduce the average load per worker, but the agency also faced strong criticism in prominent cases, including the death last fall of Marchella Pierce, a 4-year-old who weighed 18 pounds.

Mr. Mattingly will leave in September to work at a foundation in Baltimore.

"I reached this difficult decision after much careful thought, taking into consideration my desire to continue contributing to the important work of child welfare, while also wanting to spend time with my family," Mr. Mattingly said in an e-mail to his staff.

Several people who have been close to Mr. Mattingly said that his wife might be ill and that he had long hoped to return to Baltimore, his hometown.

He will rejoin the Annie E. Casey Foundation, which is dedicated to child welfare, as a senior fellow.

Mayor Michael R. Bloomberg, who chose Mr. Mattingly as commissioner in July 2004, and leaders in the child welfare community praised Mr. Mattingly's work.

"As I've said countless times over the last seven years, New York City has been extraordinarily lucky to have a nationally renowned expert, John Mattingly, ably and tirelessly leading our Administration for Children's Services," Mr. Bloomberg said in a news release. "Few people have worked harder and more effectively in such difficult circumstances than he has."

Marcia Robinson Lowry, executive director of the watchdog organization Children's Rights, called Mr. Mattingly's departure "a real loss."

“There are far too few child welfare commissioners anywhere in this country that share his courage, strength, integrity and tenacity,” she said. “He aimed high and while he may not have hit every goal he set, his aim was dead on.”

Jennifer March-Joly, executive director of Citizens' Committee for Children, an advocacy group, praised Mr. Mattingly's work, saying that his legacy would be one in which child protection was strengthened and foster care caseloads were kept down.

Mr. Mattingly leaves an agency that came under fire after Marchella's death. The Brooklyn district attorney, Charles J. Hynes, charged a worker on the case, Damon Adams, and his supervisor, Chereece Bell, with criminally negligent homicide. The prosecutor said that Mr. Adams had not made required visits to the family and lied about it, and that Ms. Bell had failed to supervise him.

Mr. Hynes also convened a grand jury to explore what he called “evidence of alleged systemic failures” at the child welfare agency. The grand jury has not yet released its conclusions.

Richard Wexler, executive director of the National Coalition for Child Protection Reform, said Mr. Mattingly let the fatal cases during his tenure define him. “I think he was so personally affected by the horror-story cases that he lost sight of the fact that the majority of the cases are not horror cases,” Mr. Wexler said.

During his tenure, Mr. Mattingly presided over the hiring of 600 additional caseworkers. The agency also began an accountability program, modeled on the Police Department's CompStat program, called ChildStat: agency leaders meet regularly to review statistics and cases. Retired detectives were hired as consultants to train caseworkers on investigative techniques. The turnover rate among caseworkers dropped.

“There is never a good time to leave a child welfare leadership job,” Mr. Mattingly said in the e-mail to his staff on Tuesday. “There are always tragedies behind you and much work yet to be done.”

But he said he felt “blessed” to be leaving the agency “in very capable hands.”

David W. Chen contributed reporting.

INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT

County of Los Angeles



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ICAN SUMMARY INFORMATION

2013



**INTER-AGENCY COUNCIL ON
CHILD ABUSE AND NEGLECT
(ICAN)**

The Inter-Agency Council on Child Abuse and Neglect (ICAN) was established in 1977 by the Los Angeles County Board of Supervisors. ICAN serves as the official County agent to coordinate development of services for the prevention, identification and treatment of child abuse and neglect. It is the largest county-based child abuse and neglect network in the nation.

Thirty-two County, City, State and Federal agency heads are members of the ICAN Policy Committee, along with UCLA, and five private sector members appointed by the Board of Supervisors. ICAN's Policy Committee, Chaired by Sheriff Leroy D. Baca, Los Angeles County Sheriff's Department, is comprised of the heads of each of the member agencies. ICAN's activities are carried out through a variety of committees comprised of both public and private sector professionals with expertise in child abuse. These committees address critical issues affecting the well-being of the most vulnerable children including prenatally substance affected infants, pregnant and parenting adolescent, children exposed to family violence, abducted children, and siblings of children who are victims of fatal abuse. Twelve community based inter-disciplinary child abuse councils interface with ICAN and provide valuable information to ICAN regarding many child abuse related issues. ICAN provides advice and guidance on public policy development and program implementation to improve the community's collective ability to meet the needs of abused and at-risk children with the limited resources available. ICAN Associates is a private non-profit corporation of volunteer business and community members who raise funds and public awareness for programs and issues identified by ICAN.

In 1996, ICAN was designated as the National Center for Child Fatality Review. ICAN has also received national recognition as a model for inter-agency coordination for the protection of children.

All ICAN Policy and Operations Committee meetings are open to the public. All interested professionals and community volunteers are encouraged to attend and participate.

ICAN COMMITTEES

POLICY COMMITTEE

Thirty-two department heads, UCLA, and five Board appointees. Gives direction and forms policy, reviews the work of subcommittees and votes on major issues. (Meets in April & November, no set dates)

OPERATIONS COMMITTEE

Member agency and community council representatives in a working body. Reviews activities of subcommittees, discusses emerging issues and current events, recommends specific follow-up actions. (Meets every 2nd Wed., 1:30 p.m., Hall of Administration, Los Angeles)

MENTORING TASK FORCE

Provides leadership and manages a countywide Task Force designated by the Board of Supervisors to work towards the goal of providing a mentor for every foster child in Los Angeles County by the year 2010. (Meets as needed)

SAFELY SURRENDERED BABY LAW (SSBL)

Responsible for notifying the Board of Supervisors, Chief Administrative Office and others of safe surrenders and abandonments, as well as collecting and analyzing data on these cases and preparing an annual written report to the Board of Supervisors. ICAN maintains a Speakers' Bureau, which provides training upon request to the public and private sectors. ICAN also is responsible for updating and managing the BABYSAFELA.org website as well as responding to requests for information that are generated through that site. ICAN also participates in the County's Public Information campaign.

SAFE SLEEPING FOR INFANTS CAMPAIGN

In February 2009, the National Centers for Disease Control reported a four fold increase in the rate of infant death during the past twenty years due to a rise in the number of babies who share a bed with their parents. Unsafe bedding, pillows, blankets were also cited as risk factors. ICAN, First5LA and the Department of Public Health are working together to distribute over 300,000 Safe Sleeping pamphlets, both in English and Spanish, across Los Angeles County.

DATA/INFORMATION SHARING

Focuses on intra and inter agency systems of information sharing and accountability. Produces annual ICAN Data Analysis Report which highlights data on ICAN agencies' services. (Meets on the 4th Thursday every month, Edelman Children's Court)

LEGAL ISSUES

Analyzes relevant legal issues and legislation. Develops recommendations for ICAN Policy Committee and Los Angeles County regarding positions on pending legislation; identifies issues needing legislative remedy.

CHILD ABUSE COUNCILS

Provides interface of membership of 12 community child abuse councils involving hundreds of organizations and professionals with ICAN. Councils are interdisciplinary with open membership and organized geographically, culturally, and ethnically. Coordinates public awareness campaigns, provides networking and training for professionals, identifies public policy issues and opportunities for public/private, community based projects. (Meets monthly, 3rd Monday of the month)

CHILD ABUSE/DOMESTIC VIOLENCE

Examines the relationship between child abuse and domestic violence; develops interdisciplinary protocols and training for professionals. Is developing a countywide protocol for the response to children and families in homes with domestic violence. Provides training regarding issues of family violence, including mandatory reporting. (As Needed)

FAMILY AND CHILDREN'S INDEX (FCI)

Developed and implemented an interagency database to allow agencies access to information on whether other agencies had relevant previous contact with a child or family in order to form multidisciplinary personnel teams to assure prior history is known and service needs are met or to intervene before a child is seriously or fatally injured. Participating agencies communicate with each other via an online communications log. (Meets every quarter on the 3rd Thursday of the month, MacLaren Children's Center, 1:30 p.m.)

AB 1733/AB 2994 PLANNING

Conducts needs assessment and develops funding guidelines and priorities for child abuse services; participates in RFP process and develops recommendations for funding of agencies. (Meets as needed)

CHILD ABUSE PROTOCOL

Development and implementation of a countywide protocol for inter-agency response to suspected child abuse and neglect. Training provided upon request to ICAN. (Meets as needed)

INTERAGENCY RESPONSE TO PREGNANT AND PARENTING ADOLESCENTS

Focuses on review of ICAN agencies' policies, guidelines and protocols that relate to pregnant and parenting adolescents and the development of strategies which provide for more effective prevention and intervention programs with this high-risk population. Includes focus on child abuse issues related to pregnant teens, prevention of teen pregnancies, placement options for teen mothers and babies, data collection, legal issues and public policy development. (Meets every last Wed. of the month, 12 p.m., Children's Law Center)

CHILD ABUSE MEDICAL EVALUATION

Coordinates efforts to facilitate and coordinate quality forensic medical exams for child abuse victims throughout the County and in particular for children seen at the DCFS HUB system; Is developing a set of best practice principles for expert medical forensic exams for child under 14 in LA County. (As Needed)

LOS ANGELES COUNTY INFANT SAFE SLEEP CAMPAIGN: SAFE SLEEP FOR BABY

ICAN has partnered with First 5 LA for a two-year \$1.5 million Infant Safe Sleeping campaign to address the preventable tragedy of losing an infant due to unsafe sleep practices. Infant Safe Sleeping has been an ongoing effort for ICAN and ICAN Associates, the members of the Los Angeles County Infant Safe Sleeping Task Force and the ICAN staffed Child Death Review Team. These entities realized that at least 70 babies per year were dying due to unsafe sleep practices and identified a clear need for the LA County Infant Safe Sleep Campaign. The goal of the ICAN-First 5 LA partnership is to create a campaign that brings together county agencies, community based organizations, health professionals and others to raise awareness of best practices through compelling messages about the dangers of unsafe sleep practices and offer safe sleep solutions for caregivers of infants up to one-year of age.

INFANTS AT RISK COMMITTEE

Works to improve the system rendering services to drug/alcohol exposed children and their families; collaborates with hospitals and DCFS to facilitate effective identification of infants at risk of abuse/neglect and their families; provides training on evaluating needs of prenatally substance exposed infants and their families; assists in developing and identifying resources to serve drug impacted families; and is developing a computer tracking system to assist in coordination of service systems for neonates reported to DCFS. (Meets as needed but ICAN and DCFS staff are working on a system to capture clean data on neonatal reports by hospital)

GUIDELINES FOR RESPONSE TO SEVERE NON-FATAL INJURIES TO CHILDREN

California Emergency Management Agency helped ICAN develop Guidelines for investigation of Nonfatal Severe Child Abuse and helped create the ICAN California Hospital Network. (See below)

CALIFORNIA HOSPITAL NETWORK

136 California hospitals ranks by number of injured children under age 3 are working to automate case management. Networks have begun with 12 Child Burn hospitals and 25 Pediatric Intensive Care Units, PICU. This program helped create a perinatal hospital network. A small First Five grant addressed certain high risk pregnancies including from sexual abuse and pregnant women in jail. A new project will address fatal and nonfatal severe child abuse as part of another national system.

CHILD SEXUAL EXPLOITATION COMMITTEE

The ICAN Child Sexual Exploitation Committee focuses on Internet Crimes Against Children, Child Prostitution and Human Trafficking of Children through the coordination of local, state, and federal agencies and service providers. The goal is to improve the effectiveness of the prevention, identification, investigation, prosecution of and provision of services for victims of these crimes.

CHILD DEATH REVIEW TEAM

Provides multi-agency review of intentional and preventable child deaths for better case management and for system improvement. Issues annual report.

This is a closed meeting.

CHILD AND ADOLESCENT SUICIDE REVIEW TEAM

A multi-disciplinary sub-group of the ICAN Child Death Review Team. The Team reviews child and adolescent suicides, analyzes trends and makes recommendations aimed at the recognition and prevention of suicide and suicidal behaviors.

This is a closed meeting.

CHILD ABDUCTION/REUNIFICATION

Public/private partnership to respond to needs of children who have experienced abduction. Provides coordinated multi-agency response to recovery and reunification of abducted children, including crisis intervention and mental health services.

This is a closed meeting.

ICAN EVENTS

MACLAREN CHILDREN'S CENTER HOLIDAY PARTY

Each year MacLaren opens its doors to over 600 community children to participate in a day of education, arts and crafts, performances and holiday themed activities.

CHILDREN'S POSTER ART CONTEST

ICAN Associates hosts a Poster Art Contest each year in conjunction with National Child Abuse Prevention Month designated in the month of April. The contest is open to all 4th, 5th and 6th grade children throughout Los Angeles County. Since 1998, ICAN and ICAN Associates has reached approximately 14,000 students on this important issue of child abuse prevention.

NEXUS CONFERENCE

ICAN's annual NEXUS conference; a large multi-disciplinary conference addressing "Violence in the Home and It's Effects on Children." (Meets as needed during planning months) Nexus XVIII Conference will be October 16, 2013, at the Pasadena Convention Center, Pasadena.

GRIEF AND TRAUMATIC LOSS CONFERENCE

A professional peer group which serves as a resource pool of experts in grief and loss therapy to those providing mental health interventions to surviving family members of fatal family violence. The Group is developing specialized training in grief issues in instances of fatal family violence and a resource directory of services. Also develops an annual conference on Grief and Loss. (Meets regularly, no set time) 2013 Grief and Traumatic Loss Conference will be March 20, 2014, at the Pasadena Convention Center.

CHILD SEXUAL EXPLOITATION COMMITTEE'S (CSEC) VICTIM'S SERVICES SYMPOSIUM

This symposium will focus on effective strategies in interviewing and interventions with adolescent victims of commercial sexual exploitation. (Meets monthly)

CHILD SEXUAL EXPLOITATION COMMITTEE'S (CSEC) CYBER CRIMES PREVENTION SYMPOSIUM

This symposium will focus on cyber bullying, cyber safety, cyber risks to teens, child exploitation, smartphone training, Internet piracy, and digital reputation. Presenters will be from the Federal Bureau of Investigation, Los Angeles City Attorney's Office, and local law enforcement. The Symposium is on November 8, 2013 at the California Endowment in Los Angeles.

PERINATAL SOCIAL WORK NETWORK

This group began as part of a First 5 grant for high risk pregnancies. Social workers in birth hospitals met to share problems and resources. This group should begin again with expanded perinatal programs in 2014.

Deanne Tilton Durfee
Executive Director
Inter-Agency Council on Child Abuse and Neglect

1. **DCFS, Law Enforcement and the Department of Public Health should work with ICAN to assure all EDAP hospitals have active Suspected Child Abuse and Neglect Teams and reporting systems.**
2. **Law enforcement personnel responding to domestic violence calls should inquire and physically check for the presence of children in the home. If present, children should be interviewed separately from the adults for signs of physical or emotional injury. A report should be made to DCFS regarding suspected risk to the children's safety and well being.**
3. **Training for all new DCFS staff should include multi-agency participation using the Los Angeles County Child Abuse and Neglect Protocol. This would include law enforcement, medical professionals, mental health, substance abuse counselors, domestic violence counselors, public health, school personnel, and medical examiners/coroner investigators. Staff should be trained to make joint home calls with other appropriate agency staff such as mental health or public health nurses. They should also have names of multi-agency contacts for consultation when responding to and evaluating suspected child abuse or neglect or assessing a parent/caregiver's progress in addressing the abuse/neglect.**
4. **The following protocols should be updated and included in countywide multidisciplinary training:**
 - The Guidelines for the Effective Response to Domestic Abuse**
 - The Los Angeles County Child Abuse and Neglect Protocol**
 - Multi-Agency Identification and Investigation of Severe Nonfatal and Fatal Child Injury**
5. **The Child Death Prevention-Safety Checklist developed by Sergeant Dan Scott should be implemented by all law enforcement agencies and DCFS.**
6. **ICAN should report directly to the Board of Supervisors to equally represent all agencies in the child protection system.**

12/6/13