County of Fresno
COUNTY ADMINISTRATIVE OFFICE
JEAN M. ROUSSEAU
COUNTY ADMINISTRATIVE OFFICER

Pursuant to the Fresno County Superior Court's order in the case of Hudson v. County of Fresno, the County releases the County's Department of Social Services Confidential Intra-Agency Investigation report with portions blacked out in compliance with the court's order. The report has been referred to in the press as a "Quality Assurance Report."

It has been unfortunate that over the past few weeks reporters have chosen to publish misleading information concerning the facts of the court proceedings and the nature of the discovery dispute in the Hudson case. The Fresno Bee's reliance on statements by Plaintiff's counsel in this matter shows that the Bee's motivation was to produce headlines rather than report on a matter of important public interest. In its efforts to support the Plaintiffs' version of the discovery dispute, the Bee ignored public statements by the County such as the December 23, 2015 press release put out by the County Administrative Officer explaining the County's position and correcting several of the Bee's factual errors. To date no mention of the County's press release statement has appeared in the Bee or in any other media outlet that we are aware of. The biased reporting and misleading headlines by the Fresno Bee may have made it impossible for the County to receive a fair trial in Fresno County when the matter returns to court in October.

When a public entity such as the County of Fresno is engaged in any litigation that could result in substantial liability that has to be paid with public funds, the public entity is at a disadvantage in the public relations campaign often waged by plaintiff's attorneys. Public officials must be very cautious with any public statement in order to avoid having that statement misused by plaintiff's attorneys against the public entity in the trial. Defense attorneys routinely advise public officials to refrain from any comment on pending litigation, regardless of how high profile the case. It is important, however, that the citizens of Fresno County understand certain facts that have been misreported about the discovery dispute in the Hudson case:

1. The Fifth District Court of Appeal overturned a $5.5 million judgment in favor of the Plaintiff and against the County and ordered a new trial on all issues. It is understandable that Plaintiff's counsel is disappointed with this result. Plaintiff's counsel's attempts to sensationalize the discovery dispute over a single document in the Hudson litigation are clearly designed to deflect attention away from the appellate court's reversal of the judgment and to coerce the County into making an unfavorable settlement.

2. The County of Fresno Department of Social Services remains committed to providing children and families in our community with the protection and services they need. Procedures requiring investigations after critical incidents such as the death of a minor are an important part of the efforts of the Department in assuring that its services and procedures are effective and provide that necessary protection. The Quality Assurance report at issue in the Hudson case does not represent an effort by the County to hide any information, but was part of the Department's continuing commitment to analyzing and improving its policies, practices and services.

3 There are no facts concerning the death of the minor Seth Ireland that are listed in the Quality Assurance report, which were not known to both parties at the time of the first trial. The trial lasted several weeks after years of discovery had taken place. Plaintiff's counsel chose to move forward with the first trial while knowing that the Quality Assurance report existed and that the discovery dispute over the report was the subject of an appeal. It is only now that Plaintiff's multi-million dollar verdict in the first trial has been overturned by the Fifth District Court of Appeal that Plaintiff's counsel is concerned with the public's right to know what is in the Quality Assurance report.

4 Statements in the press that the County has "violated" a court order with respect to the discovery dispute over the Quality Assurance report are false. These misstatements apparently stem from a lack of understanding of basic legal matters of civil discovery and law and motion practice, and from an overreliance on the argumentative statements of Plaintiff's counsel. While it is true that the court awarded $4500 in attorney's fees to Plaintiff's counsel on the motion to compel production of the report, an attorney's fee award is not unusual under the California Code of Civil Procedure in discovery matters involving motions to compel.

NEWS RELEASE

FOR IMMEDIATE RELEASE

DATE: DECEMBER 23, 2015

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COUNTY RESPONDS TO THE HUDSON v. COUNTY OF FRESNO LITIGATION

In recent weeks, there have been several inaccurate statements made in the press about the (plaintiff) Hudson v. County of Fresno litigation which involves the tragic death of a minor, Seth Ireland, who was murdered by his mother's boyfriend in 2009:

- The plaintiff's counsel asserts that the court ordered the County to disclose the quality assurance report prepared by the County of Fresno Child Protective Services staff to the public.
- The plaintiff's counsel asserts that the protection of the quality assurance report has withheld relevant facts concerning the minor's death from the public or a jury.

No court has ever ordered the County to disclose the quality assurance report to the public. Additionally, all of the relevant facts concerning the Hudson case have been the subject of extensive discovery and a full trial.

Background

Plaintiffs in the case alleged that the County's Department of Social Services, Child Protective Services unit should have done more to intervene in the case prior to the death. In February 2013, a jury found Fresno County was partially responsible for the death and awarded a multi-million dollar verdict. On September 15, 2015, the California Fifth District Court of Appeals overturned the jury verdict against the County of Fresno and ordered a new trial.

During the first trial in 2012, plaintiff's counsel brought a motion to compel production of the quality assurance report. While the trial court ordered the County to turn over the report to plaintiff's counsel, the order contemplated certain portions of the report be redacted. The trial court also noted that any production of the report should be covered by a protective order preventing plaintiff's counsel from making the report public, at least until trial of the case. At the 2012 hearing, plaintiff's counsel opposed the imposition of a protective order but acknowledged that a protective order would be appropriate under the circumstances stating: "The court said 'Disclose it,' and again, I'd be willing to abide by, you know, a protective order and not disclose it to the media." Defense counsel for the County appealed the order by filing a petition for a writ with the Fifth District Court of Appeal challenging the trial court's order to turn over the report. This writ petition was combined with the appeal in the case that resulted in the reversal of the verdict in favor of the plaintiffs.

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Following reversal of the plaintiffs' trial verdict, plaintiffs' counsel apparently hopes that disclosure of the quality assurance report may improve his chances for a successful verdict in the new trial. Consequently, plaintiffs' counsel and articles and editorials in the Fresno Bee have focused on a portion of the appellate court's decision dealing with the release of the quality assurance report. California statutory and case law provides that quality assurance reports of the type at issue in this case are confidential. The public policy basis for this confidentiality is the public interest in encouraging public entities, hospitals or other possible litigation defendants to thoroughly investigate critical incidents without concern that any findings or recommendations for improvements in policies or procedures will be used against the entity in subsequent litigation.

Last month during the second trial, the County offered to enter into an agreement with the plaintiffs regarding the quality assurance report which would have allowed for the provision of the report to plaintiffs' counsel. This action was consistent with the court direction in the first trial. However, this time the plaintiffs' counsel refused the offer. The issue of what portions of the report are to be disclosed to plaintiffs' counsel and what possible protective order may govern the disclosure will be decided by the current trial court on January 14, 2016.

The County remains committed to the well-being of families and the safety of minors that come to the attention of the County's child protective services unit. As part of the County's Department of Social Services ongoing efforts to improve services to the community, the department analyzes incidents like the tragedy involved in the Hudson case and regularly reviews its policies and procedures to ensure that struggling families and at-risk children are properly identified and provided with necessary services and protection.

The purpose of this press release is to put the record straight for the community while the County defends its organizational and fiscal integrity. Ultimately, the County and its defense counsel will comply fully with any lawful order of the trial court.

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Department of Children and Family Services
Catherine A. Huerta, M.S.W., Director

Protecting and healing children from abuse and neglect is everyone's responsibility

Confidential Intra-Agency Investigation

Confidential under California Government Code 6254(a)

Date: January 7, 2009

Briefing on Child Death
Prepared For:
CAO
Administration
Foster Care Standards and Oversight Committee

Subject:	10 Year old Male
Date of Incident:	December 29, 2008
Summary of Incident:	Ten year old male who resides with his mother and mother's boyfriend was taken to Community Regional Medical Center (CRMC) with severe head trauma and bruising in various stages throughout his body. He had a severe brain injury. The minor also had bruises on the top of his head, the chest, to the left side of his hip and face, a red circular mark on the inner part of the knee and that he had bruising in different stages of healing, and an old scab on his buttocks approximately one inch in diameter. Minor was placed on life support and on-going medical procedures were completed in an attempt to stabilize him. The minor died on January 6, 2009 at 1:30 a.m. Mother and boyfriend were arrested and are currently incarcerated at Fresno County Jail.

Relevant History:

There have been four previous referrals reported to the Department regarding this

family. There are three younger children ages seven, five and 2 months old that were also in the home at the time of the current referral.

DCFS Referrals:

Date	Allegation	Disposition	Description
08/27/08	General Neglect/ Physical Abuse	Inconclusive	The reporting party states that mother reported minor has been spanked on several occasions by the father, which caused bruising. The Sheriff's Department was involved in the investigation. The minor changed his story about who the perpetrator was more than once, alternating between identifying either his mother or father during separate interviews.
09/19/08	General Neglect	Evaluate Out	Father is concerned because the mother is not allowing visitation with his son. Father was advised to go back to family court, if mother is not abiding by the court orders.
10/12/08	Emotional, Physical and General Neglect	Under Investigation	The referral states that the reporting party can hear the mother and her boyfriend fighting. Reporting party states she can hear the boyfriend yelling at the children. The reporting party is concerned they are being abused. She said that she called the police, however they did nothing. Investigation was on-going.
11/13/08	General Neglect	Under Investigation	Reporting party is very concerned for the welfare of the children as they have been out of school since 10/30/08. The mother's boyfriend claimed he was moving them to another school so he could get medication for them. Investigation was on-going
12/29/08	Physical Abuse	Under Investigation	Reporting party is calling regarding the minor (10) who resides with his mother and her boy friend. Minor brought in by ambulance with major head injury and stage bruising through out the body.

Case History: No prior DCFS case history

Medical Health/Care: The minor was transported to CRMC via ambulance. He had a severe brain injury. The minor also had bruises on the top of his head, the chest, to the left side of his hip

and face, a red circular mark on the inner part of the knee and that he had bruising in different stages of healing, and an old scab on his buttocks approximately one inch in diameter. Minor was placed on life support and on-going medical procedures were completed in an attempt to stabilize him. Medical records have been requested.

DCFS Contact: The Department made contact with the minor on September 3, 2008 and October 21, 2008. The Department also made attempts to make contact with the minor on November 20, 2008, December 5, 2008 and December 29, 2008.

Cause of Death: Medical records have been requested. Preliminary information indicates that the minor died as a result of his injuries.

Summary of DCFS Investigation Results:

The Department has generated a referral and there is an on-going investigation. A hold was placed by police department on the minor's half-siblings. The Department is in the process of completing the investigation regarding this referral.

Department of Children and Family Services
Catherine A. Huerta, M.S.W., Director

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Initial Investigation Document/Timeline

Date: February 24, 2009

Case Name: Antoinettee Rena Ireland # B07492

Minor's Name:	Date of Birth	Age	Sex
Seth Ireland	10/30/1998	10	M
Jevron Ireland	[redacted]	7	M
LeBaron Vaughn, Jr.	04/11/2003	5	M
LeBaron Vaughn, 1st	10/18/2008	4 months	M

Parents:

Antionettee Rena Ireland, Mother
Joseph Hudson, Father (Seth)
Alex Williams (Jevron)
LeBaron Vaughn, Sr. (LeBaron, Jr. and LeBaron, 1st)

Current Social Worker: [redacted], SS23

Synopsis of Incident:

On December 30, 2008 QA received a CIR on behalf of the minor Seth Ireland. Seth who resided with his mother and mom's boyfriend was taken to Community Regional Medical Center with severe head trauma and bruising in various stages throughout his body. According to the mother and her boyfriend the minor was beating his head against the floor and then they put him to bed. Later he was found not breathing. The minor was transported to CRMC via ambulance. He had a severe brain injury. He underwent surgery to have a bolt placed in his head to relieve the pressure on his brain. His prognosis was not good, the minor passed away on January 6, 2009 at 1:30 a.m.

Investigation Procedure:

- Review of referral narratives on CWS/CMS.
- Review of records requested from Fresno Police Department, Fresno County Mental Health, Good Samaritan Hospital, Community Medical Center-Fresno, Fresno Unified School District and Fresno Sheriffs Department.

Social Worker Caseload during timeframe:

Month	Assigned During the Month	Type of Referral	Carry Overs from Prior Month	Total Open
Sept	12	(all 10 day)	5	17
Oct	12	(11 10 day, 1 crisis)	13	25
Nov	13	(13 10 day)	17	30
Dec	17	(16 10 day, 1 crisis (Seth))	23	39

Data from 12/27/08 indicates that 20/38 referrals had been open longer than 30 days. Some referrals on the caseload had been closed after 80-100 days. Upon review of the other 4 workers in the Selma ER unit, their monthly assignment was similar. No indication of a sharp increase in assignments, however the referrals carried over from month to month were steadily increasing. It does seem that SW [redacted] referrals are not closed out as timely as her co-workers.

History:

05/23/08 Fresno Police Department #08-AT864-R/p is Joseph Hudson, upset and will continue to call every 30 minutes until there is a response. Will standby at location has child Seth Ireland and custody paperwork.

05/27/08 Fresno Police Department #08-AU3420-R/p is Rena Ireland, Possible custody order violation-R/p states Joseph Hudson moved out of the City of Fresno and threaten to come into R/p home and take out of county without r/p consent.

08/15/08 Fresno Police Department #08-069951-Mother filed a false police report as she stated that the father Joseph Hudson beat the child Seth Ireland. Seth waivered back and forth on the source of his injuries. Mother admitted to hitting the child. Mother took the child to police headquarters. Mother arrested and cited. On 08/28/08-Detecitve Sam Hernandez, confirmed we had an open investigation. Det. Hernandez issued a Certificate of release form 829.

08/18/08 Seth and Jevron no show at Columbia Elementary.

08/22/08 Seth and Jevron enrolled at Columbia Elementary.

08/27/08 Seth excused absence. Jevron unexcused absence.

08/27/08 Child Custody and Visitation Order

Joint legal, temporary sole physical to mother, and father to have supervised visits.

08/27/08 Referral for General Neglect/Physical Abuse
Reporting Party: Family Court Mediator
Disposition: Inconclusive

Screener narrative: Reporting parting states that the parents are in court mediation. The father reports that on 08/15/08 Seth was visiting him. He noticed a bruise on Seth's inner thigh. Seth wouldn't say how the bruise happened. On 08/16/08, Father asked Seth again and Seth admitted that his mother hit him, but did not say anything further. Father admitted that he did not contact law enforcement or CPS at that time.

Reporting party stated that mother reported that she observed minor Seth to have bruising located on his bottom. On 08/17/08, mother states that she observed bruising located on Seth's bottom. The mother stated that father spanked Seth 20x within a 20 minute time frame. Mother took Seth to the Sheriff's office to file a report. Mother reported that Seth however disclosed to the Deputy that it was his mother who hit him. Mother states that she was cited, arrested for physical abuse, released and returned home with Seth that night.

Reporting party stated that Father said that on 08/18/08 he received a phone call from Detective Aguilar regarding a child abuse investigation. Father stated that he told the detective about the bruises that he saw and Seth's disclosure that it was the mother. He stated that he called CPS on the evening of 08/18/08.

No case or referral history located on CMS. Allegation was determined to be a 10-day referral: Social worker consulted with PM Morris. A response to mother's home regarding minor Seth and sibling Jevron due to concerns of possible physical abuse. Screener narrative was completed by [redacted]

On 08/18/08 DCFS received a phone call from the father Mr. Joseph Hudon at 12:17 p.m. The call was taken by the Exchange and delivered to reception. It is unclear what happened to this call once it was referred to DCFS reception. The Care Line does not have any record of receiving a call on this date. In addition DCFS reception does not maintain of log of all the calls to the Department.

On 9/3/08 [redacted] attempted contact at the home; however, there was no answer.

On 9/3/08 SW [redacted] responded to Columbia Elementary School and interviewed Seth and Jevron. Seth reported that he feels safe in his home. He stated that his father is the only one that he is fearful of and that he did not want to go back to his house. Seth reported that his mother would send him to his room as a form of discipline and his father is the one that spanked him during this incident. He stated that he told them it was his mother because he was scared of what his father would do but stated that his father is the one that spanks him a lot with a belt. He reported that he often spanks him on the butt and legs with his pants down. Seth reported that his father left marks on his legs that lasted two weeks. Seth also reported that his father and his father's wife smoke crack.

Jevron reported that he feels safe in the home and there was no one that he was scared of in the home. Jevron also reported regarding discipline methods that he gets spanked with a belt. He also reported he could not remember the last time he was disciplined with a belt and could not remember if marks were left.

On 09/09/08, SW [redacted] questioned Ms. Ireland and addressed the referral allegations. Ms. Ireland described that she was going through a very rough custody battle with Seth's father. She reported that she and her boyfriend had seen the marks on Seth. She indicated that she had asked him who did it but he would not tell them anything, finally he admitted that his father had left the marks on him. She then took Seth to the police station. She stated that at first Seth told the police that his dad hit him. When the police contacted Seth's father he reported that the allegation was as a result of a custody dispute. Ms. Ireland reported that she was very confused by the police. She stated that she admitted hitting Seth because she thought they were talking about ever hitting him, not just this particular incident. SW [redacted] asked what was being done and Ms. Ireland reported that she had filled for full custody of Seth. She had dad's visits reduced to supervised and an agency was supervising the visits.

Ms. Ireland reported that for discipline mainly she would send the children to their room occasionally she would spank them but would only use her hand. SW [redacted] discussed parental responsibilities, appropriate discipline and consequences for future referrals. SW also provided her with a list of community resources.

On 09/09/08 DCFS reception logs reflect that Ms. Ireland came into the office and saw SW [redacted] It is unclear why she saw [redacted], however, the logs note that Ms. Ireland was a walk-in.

The referral was closed as inconclusive on 10/15/2008. In her closing assessment SW [redacted] determined the risk level to be low. SW [redacted] determined the allegation to be inconclusive due to the fact that there was conflicting stories during

the investigation and she could not adequately determine who the perpetrator was in the case. She indicated that although Ms. Ireland admitted to the police that she had hit her son it was only because she was scared and confused. In addition SW [redacted] indicated that the minor changed his story more than once.

- SDM hotline tool was completed appropriately and the decision tree indicated a response time within 10-days.
- In compliance with response timeframe as initial response was completed within 10 day timeframe.
- SDM Safety Assessment tool was completed appropriately and determined that no safety threats were identified.
- SDM Risk Assessment tool was completed appropriately and indicated a low risk level.

09/02/08 Seth and Jevron were tardy to school.

09/08/08 Seth had an excused absence. Jevron was tardy.

09/15/08 Seth and Jevron were dropped from Columbia Elementary.

09/16/08 Seth and Jevron were enrolled at Kirk Elementary.

09/19/08 Referral for General Neglect
Reporting Party: Joseph Hudson
Disposition: Evaluate Out

Screener narrative: Father reports that he is concerned for his son because the mother has not allowed him to visit with him and she won't let him talk to him when he calls. He went to Seth's school to see him and Seth wasn't there. School records indicate that the minor has already missed three days of school and/or he comes in late. Father stated that he also talked with the neighbor who reported that mom's boyfriend gets into his son's face and verbally threatens him.

Father was advised to go back to family court, if mother is not abiding by the court orders and is not allowing him to have visits with his son.

Referral was opened for documentation purposes only and evaluated out. It should be noted that the screener narrative also indicates that an open 10 day referral was pending to SW [redacted]. The screener narrative was completed by social worker [redacted]. The referral indicates an end date of **11/04/2008.**

- SDM hotline tool for the 9/19/2008 referral was not completed appropriately as the referral indicates that the neighbor advised the father that mom's boyfriend was getting into his son's face and was verbally threatening him.

Threats of physical abuse should have been marked in the screening tool. This referral should have resulted in an in-person response.

09/21/08 Fresno Police Department 08-BL0973-Welfare check of Juvenile-R/p (A. Star-Maternal Grandparents) states they were just at the residence on Tupman and needs an ambulance as he was assaulted and parents did not want to call. PD responded, house was dark, no response-called r/p back and asked for a phone number; r/p did not have one and stated that she advised the parents that they would be contacting law enforcement and they probably took the child to the hospital. **DCFS not informed by law enforcement.**

10/07/08 Fresno Police Department 08-BN-3296-D/V disturbance, neighbor is located north of location. The R/p reports hearing things hit the wall and a male yelling "that's how a real ass whopping feels". The R/p hears music and still talking to the female, identified as LaBaron Vaughn and mother-Rena Ireland. The male was yelling at female, r/p hearing more banging noises. Male saying "I ought to beat your ass right now, and you wanna hit me". R/p states this happens all the time and can hear female crying. Fresno PD arrived and will be speaking to the subjects now. Checked out ok. Verbal only, there were no signs of anything physical. **DCFS not informed by law enforcement.**

10/12/08 Referral for Emotional, Physical, and General Neglect
Reporting Party: Unknown (appears to be a neighbor)
Disposition: Currently Under Investigation

Screener narrative: Reporting party states she can hear the mother and her boyfriend fighting. She hears banging on the walls when they are fighting and believes it becomes physical. Reporting party states she can hear the boyfriend yelling at the children. The children are often heard screaming "stop" and the reporting party is concerned they are being abused. She called the police two days ago however, they did nothing. She suspects the children are afraid to talk when their mother and boyfriend are present.

Non-crisis response will be made to assess the safety of the minors. The screener narrative was completed by [redacted]. Referral was assigned to SW [redacted]

On 10/21/08, SW [redacted] responded to the address listed on the referral (435 S Thorne Ave #413). SW knocked several times. No answer. SW left card on the door.

That same day SW [redacted] and SW [redacted] made contact with Seth and Jervon at school. Seth remembered SW [redacted] from the last time she had been out. Seth appeared healthy and dressed appropriately. SW [redacted] did not observe

any marks or bruises. Seth was asked who lived in the home and he indicated his brother, his mother and he lived in the home. SW asked Seth about food and clothing supplies. Seth reported there was always plenty of food to eat in the home and he always has clean clothes to wear. Seth was asked about how his parents and significant others get along. Seth reported that everyone gets along well. SW [redacted] asked him about fighting between Mr. Vaughn and their mother. Seth stated that they never fight. He was asked if Mr. Vaughn ever yells at them. He indicated no that Mr. Vaughn never yells. SW asked about safety in the home. Seth indicated he feels safe in the home. SW asked about visiting with his father. Seth indicated that supervised visits were to start next month, but he didn't know if he wanted to see his dad yet. Seth indicated that he still had to think about it. SW asked about discipline methods in the home and Seth reported that they just get sent to their room and their mom and Lebaron talk to them. SW specifically asked about spanking. Seth denied any physical abuse. He indicated that he could not remember the last time he had been spanked. He was asked if Lebaron lived in the home. Seth replied that he did not and that he was just there all the time. Seth denied that anyone in the house used drugs or alcohol.

SW [redacted] made contact with Jervon he also remembered her from the last time she had been out to investigate. SW [redacted] explained domestic violence to Jervon and asked him if anyone in his home fought with each other. He denied anyone fighting. He was asked about his safety in the home. He indicated he feels safe in his home. SW asked him how he and Mr. Vaughn got along. He indicated that they got along good. He inquired about discipline methods in the home. He indicated that he would have to go to his room and denied any physical abuse. He was asked about being spanked with a belt. He could not remember the last time he was spanked with a belt. Jervon did not know what drugs or alcohol were. He knew what smoking was and denied that anyone in his home smoked.

On **10/24/2008** SW [redacted] made contact with Ms. Ireland and Mrs. Vaughn at the Thorne address. The home was sparsely furnished but met minimal standards of cleanliness. Mr. Vaughn identified himself as the current care provider for the children. He was also the father of Ms. Ireland's unborn baby. Mr. Vaughn indicated that he was not Ms. Ireland's boyfriend and he did not reside in the home.

SW [redacted] noted that Ms. Ireland appeared somewhat slow in processing information and Mr. Vaughn helped her to remember facts and added to the conversation at times. Ms. Ireland denied all of the allegations. She indicated that the police had never been to her house due to domestic violence issues. Ms. Ireland indicated that since the last referral she had not spanked any of the children. She believed the allegations were coming from her neighbor who is related to the father for Jervon. Mr. Vaughn indicated that the neighbor had been giving them constant stress, left harassing notes on their door and talks to the children without their permission. Mr. Vaughn indicated that this matter along with the situation regarding visits with Seth's father had caused Seth great stress and he had begun to act out. Seth had begun to wet the bed and was generally depressed. Mr. Vaughn

indicated they had been in an out of mental health seeking treatment for Seth and he was seeing a counselor thru Catholic Charities. SW inquired if they needed help with anything. Both indicated that they were taking care of everything.

SW observed plenty of food in the cupboards and refrigerator. SW discussed parental responsibilities, appropriate discipline methods, and consequences of future DCFS referrals. SW explained physical abuse was against the law and if the Department were to fine marks or bruises on the children, CPS intervention would be necessary. SW also explained the same for domestic violence and emotional abuse.

On **10/29/08** Ms. Ireland brought Seth into the L Street office to have him explain to the social worker how he received a bump on his head. SW [redacted] was not in present in the office as a result Ms. Ireland was connected by DCFS reception with SW [redacted] via phone. DCFS reception records reflect that Ms. Ireland was present in the office to speak with SW [redacted]. Ms. Ireland stated she did this because the neighbor had been talking to Seth at the bus stop that morning about the bump, and she was worried the neighbor would call DCFS. Seth explained to the social worker that he had been real sleepy in the shower that morning and had fallen and bumped his head.

In her closing assessment SW [redacted] indicated that based on the information provided during the course of the investigation the allegations appeared to be unfounded. The children denied any abuse or neglect. They also did not report being fearful of anyone. Mom was advised of the consequences of future DCFS referrals. The referral was closed as unfounded on **January 9, 2009.**

- SDM Hotline tool was not completed appropriately. Based on the screener information the response priority should have been within 24 hours due to the current domestic violence issues and the fact that the allegations were against the mother and her boyfriend who had physical custody of the children. There was no protective adult in the home. In addition mother was the alleged perpetrator in the previous referral.
- In compliance with response timeframe as initial response was completed within 10 day timeframe since it was determined to be a 10-day response.
- SDM Safety Assessment was completed appropriately and no safety threats were identified.
- SDM Risk Assessment was completed appropriately and the risk level was determined to be moderate.

10/12/08 Fresno Police Department 08-BN9786-Disturbance inside apt-R/p believes male is beating two children (LaBaron Vaughn-male and mother Rena Ireland). R/p is hysterical and does not have a visual but can hear this going on. R/p advised she called CPS this morning between 8-9am as she could hear the children being hit and could hear the male tell the children they were going to die soon.

Fresno PD makes contact with mother, boyfriend and children. Children contacted away from parents, both denied being hurt in anyway and were being yelled out as they were bad. Children stated that the parents did not hit them, had no visible injuries. Checked the residence, everything was okay. Mother stated everything was fine and was not injured and does not need help. She stated that the neighbor that called police does not like her and wants her to get back with her ex-boyfriend, who is the neighbor's family. **DCFS was not informed by law enforcement.**

10/13/08 Seth brought into CCAIR by his mother and placed on a 5150 hold. Notes: Diagnosed with Major Depressive Disorder severe with psychosis and physical abuse of a child. Seth was prescribed medication.

10/14/08 To 10/18/08 Seth admitted to Good Samaritan Hospital Southwest in Bakersfield on an involuntary basis. Child complained of hearing voices, but denied any visions or paranoid ideas. Patient feels depressed, but is doing well in school. Nursing progress notes note that Seth had an old scrape on his left elbow. Seth reported that he fell after he was playing. He also had four bruises on his right shoulder and arm. He was unable to report how the bruises were sustained. Seth remained there until the 18th. Upon discharge Seth was alert he was oriented to time, place, and person. He was reported to be in a good mood and his affect was appropriate. He denied any delusions, hallucinations, suicidal, or homicidal ideations. He was discharged to his mother with two weeks of medication and an appointment with a psychiatrist in Fresno. **DCFS was not informed by Hospital re: admission or unexplained bruises.**

10/14/08 Seth excused absence. Jevron unexcused absence.

10/15/08 Seth excused absence.

10/16/08 Seth excused absence. Jevron was reported tardy.

10/17/08 Seth excused absence.

10/24/08 Seth is brought into CCAIR by his mother and her boyfriend for a voluntary assessment. Notes: Custody dispute. Mother had not filled medication prescription from 10/14/08. New medication prescription was given. Mother is mildly mentally retarded. Seth did not meet any criteria for a 5150 hold and it was decided that he should go home for the night. Seth already had a tentative appointment with Children's Mental Health. **Child Welfare was not informed by Mental Health.**

*Note SW had been in the home and interviewed the mother and boyfriend earlier in the day and no mention of medication issue or recent hospitalization.

10/25/08 Seth is taken by his mother and her boyfriend to Community Medical Center. Chief complaint: per parents Seth was discharged from Bakersfield Hospital for psychiatric care. Father (boyfriend) wants psychological evaluation. Father (boyfriend) stated Seth has been acting differently for 6 months, has disciplinary problems at school and is hearing voices. Seth acted strangely today, not eating, fatigue, acting different. Hospital notes refer to mother and boyfriend as the parents. Seth described as having a flat affect with old scabs on elbows. Seth denied abuse at home or by anyone. Seth knows parents are concerned but doesn't know why. Various blood tests were conducted. Results were negative. **DCFS not informed by Hospital.**

10/31/08 Seth and Jevron unexcused absence.

11/03/08 Seth and Jevron unexcused absence.

11/04/08 Seth and Jevron unexcused absence.

11/05/08 Seth and Jevron unexcused absence.

11/06/08 Seth and Jevron unexcused absence.

11/07/08 Seth and Jevron dropped from Kirk Elementary.

11/07/08 Seth was seen by Dr. Hayat at Heritage. Notes: Diagnosed with Psychosis NOS, Major Depression, single episode, Physical Abuse of Child, PTSD. Seth was prescribed Prozac, Risperdal, Ativan and Therapy. Goals for Seth – positive, stable mood; sleep better; improve school performance; and decrease flashbacks. **Child Welfare was not informed by Mental Health.**

11/12/08 Seth enrolled in Bethune Elementary. Jevron enrolled in Columbia Elementary.

11/13/08 Referral for General Neglect
Reporting Party: Kirk Elementary School Staff
Disposition: Currently Under Investigation

Screener narrative: Reporting party is very concerned for the welfare of the boys. The boys have been out of school since 10/30/08 when their mother's boyfriend claimed he was moving them to another school so he could get medication for them.

Reporting party stated that the boyfriend had Seth 5150'd and was saying the boys need to be on drugs because of their anger and behavior issues. Reporting party stated that the boyfriend has had Seth in different hospitals for these reasons, even though the child does not exhibit any problems at school and has no known health problems. The boyfriend has attempted to have IEP's done on the children, but was informed that the biological parent would have to make the request of the school. Reporting party notes that both of the children have been coming to school with bruises, bumps, and once a black eye and when asked what happened the children always gave an excuse such as ran into something, fell, and/or tripped.

The school had scheduled a meeting with the mother, boyfriend, and the children to be held on 10/31/08 to discuss what the family saw as the problems. Reporting party stated that the boyfriend showed up the day before with a list of things he said he was able to get put together with another school. A copy of the list shows medications like Risperdal and other medications that appear narcotic. Reporting party stated that the boyfriend stated that the children would be attending another school. Reporting party stated that was that last time the family had been seen. No requests for transfer were made. The family did make contact with DeBouis Academy for home schooling, but did not enroll. Reporting party spoke with the grandmother that the family had been living with at 2526 S Lotus, but she didn't know were they had gone either.

Referral determined to be a 10-day response: Mom's boyfriend is actively seeking medication treatment for one if not both boys regardless that the school officials see no health or behavioral concerns with the children. Mother is not taking an active role in her children's care and has made no appearance to confirm or deny the above. Screener narrative was completed by [redacted].

On 11/20/08, 12/05/08 and 12/29/08, SW [redacted] attempted contact at the home. SW knocked on the door, however no one answered. SW left a card on the screen door with the mother's name on it and a note to call.

In her closing assessment SW [redacted] noted that she attempted several times to locate the family and was unable to do so. Since there had been another referral the allegation of general neglect was determined to be inconclusive.

- SDM Hotline tool was not completed appropriately. Based on the screener information the response priority should have been within 24 hours. The screener narrative indicates that that the boyfriend was claiming that the boys, especially Seth, needed mental and behavioral health services. Per the decision tree the response should have been within 24 hours. In addition the reporting party reported that the children were coming to school with bruises, bumps, and once a black eye. The children were always giving an excuse. Physical Abuse Decision Tree was not utilized.
- In compliance with response timeframe as initial response was completed within 10 day timeframe.

- SDM Safety Assessment was completed appropriately.
- SDM Risk Assessment was not completed.

11/18/08 Jevron excused absence.

11/20/08 Jevron excused absence. Seth dropped from Bethune Elementary.

11/21/08 Seth enrolled in Columbia Elementary.

12/08/08 Seth is taken by his mother and her boyfriend to Community Medical Center. Chief complaint: per parents is a bizarre change in behavior. Child was observed to be solemn and quiet and would not talk about reason for being at hospital. Hospital notes refer to mother and boyfriend as the parents. Seth was medically cleared as he denied suicidal ideations and homicidal ideations, was eating and drinking well. Follow up the next day regarding medication refill. Return precautions given. **DCFS not informed by hospital.**

12/13/08 Seth was taken by his mother and her boyfriend to Community Medical Center. Chief complaint: per parents seen 12/10 and given psych referral and Rx (Risperdal, Prozac) which haven't been obtained. Behavior problems in school, not sleeping, making suicidal ideation statements, flat affect, no eye contact, non-verbal. Hospital notes refer to boyfriend as the step-father. He got upset, refused to wait, got family up to leave, staff call security. Family left before security arrived. Fresno PD called. **DCFS not informed by hospital.**

12/13/08 Fresno Police Department 08-BW2987-Children Seth and Jervon Ireland taken to CRMC for a suicide psych hold, before being evaluated, mother and boyfriend left with the children. CRMC contacted Fresno PD to check the residence for the children. PD responded to the residence one time and no one was home. Call closed. **DCFS not informed by law enforcement.**

12/26/08 Referral for General Neglect
Reporting Party: Fresno Sheriff Deputy Nulick
Disposition: **Evaluate Out**

On 12/26/08 SW [redacted] while working Care Line Swing, received a call from Fresno County Sheriff Deputy Nulick, Badge #625, regarding the minors, Seth Ireland (10/30/98) and Jervon Ireland (10/26/01). The Deputy reported that he would be writing up an incident report regarding the minors, but wanted to check to see if CPS had any prior history on the family. Deputy reports that the minors reside with their mother, Rena Ireland, at the following address, 435 S. Thorne Ave., Unit 413, Fresno, CA 93706, (559) 776-1363. Deputy reported that mother and her boyfriend were attempting to get meds for the boys due to their diagnosis of

schizophrenia/bi-polar. Deputy reports parents feel children are out of control and are trying to drop the children off at the FCJ. Parents want children taken to a location where they will be given meds, as currently there is some issue with the medical insurance. Deputy reports he is not placing a 300 hold on the children at this time and will place children back with mother. SW [redacted] checked referral history and found four referrals from 2008. SW [redacted] reported to the Deputy that currently there are two open referrals on the family that are under investigation for General Neglect and Physical Abuse. SW [redacted] read portion of the screener narrative in order for deputy to get an understanding as to why the referrals were under investigation. Deputy thanked SW [redacted] for information and was aware that there are two open referrals on the family. Deputy identified mother's boyfriend as LeBaron Vaugh (DOB: 08/09/1976). Deputy reports he will run mother and boyfriends information prior to placing the children back with mother. Deputy informed SW [redacted] that the incident report number is 08-36570. Deputy reported that the incident report will be written up and sent over later.

At 7:38 p.m., SW [redacted] sent an e-mail message to SW [redacted] advising her of the call and information provided by FSO Deputy Nulick. SW [redacted] evaluated out the referral, as the deputy was not placing a 300 hold and due to the fact that there were two open referrals already pending to SW [redacted].

- SDM Hotline tool was not completed appropriately. Based on the screener information the response priority should resulted in an in-person response. Screener noted that there were two pending referrals that were in the process of being investigated. Narratives for those referrals indicated that the social worker had made attempts; however, the social worker had not established any contact with the family. This referral contained new information that would be important for investigating social worker to assess.

12/28/08 Seth and Jevron seen at CCAIR.

Notes: Mom and boyfriend brought children in because they need medication. However, there was a problem with the insurance. The staff recommended mother return the next day to Outpatient and request a "Tar". Seth is reported to have an appointment with Dr. Hyatt in two days. Children were interviewed alone by LVN. Children only stated that they were hungry. Staff gave them cookies and crackers.

Current Investigation:

12/29/08 Referral for Physical Abuse
Reporting Party: Community Regional Medical Center Staff
Disposition: Currently Under Investigation

Screener narrative: Reporting party is calling regarding the minor, Seth Ireland (10) who resides with his mother and her boyfriend. The minor was brought in by ambulance with major head injury and stage bruising throughout the body. Minor is posturing and it is unknown if he will need surgery. Reporting party is requesting CPS worker to respond. Police have been contacted and an officer is en-route. Referral determined to be a crisis.

The screener narrative was completed by SW [redacted]

- SDM Hotline tool was completed appropriately.
- In compliance with response timeframe as immediate response was completed.
- SDM Safety Assessment was completed appropriately.
- SDM Risk Assessment was completed appropriately.

Investigation narratives:

Swing shift SW [redacted] responded to Community Regional Medical Center on 12/29/08 at 9:24 p.m. SW [redacted] made contact with FPD officers who advised that that Seth was in the trauma room. They reported that Seth was in a coma and he had trauma to the left side of his face and body. The mother and her boyfriend were being interviewed by other officers in separate rooms.

On 12/30/08 SW [redacted] and SW [redacted], responded to the Fresno County Jail to make face to face contact with Seth Ireland's mother, Antoinette Rene Ireland and her boyfriend, Labaron Vaughn. SW [redacted] and SW [redacted] were informed that Labaron Vaughn was being charged with cruelty to a child, PC 273 (a) (a), inflicting injury upon a child, PC 273 (d) (a), assault with a deadly weapon, PC 245 and child endangerment, PC 273 (a) (d).

SW [redacted] and SW [redacted] were allowed to speak with Mr. Vaughn first. SW [redacted] and SW [redacted] identified themselves and informed Mr. Vaughn that they were from DCFS and were there to speak to him about Seth Ireland and the incident that led to the child sustaining severe injuries. SW [redacted] asked Mr. Vaughn to explain what happened to Seth. Mr. Vaughn stated that Seth had a history of being suicidal and that he had been acting up and that they had taken him to the CCAIR unit a couple of days prior as he was hurting himself. He stated that Seth was not admitted at CCAIR and that Dr. Hyatt prescribed Risperdal and Prozac for Seth but that they had not been able to fill the prescription as they did not have his medi-cal. He stated that he was just protecting his family and kids from Seth as he kept fighting with the other children. He stated that he was trying to discipline Seth and trying to keep him from "hitting my kids". He stated that he punched Seth two times in his chest lightly. Mr. Vaughn stated Seth was hitting his kids and he was right behind him and heard his son crying. Mr. Vaughn stated that when he turned to run to get his child he ran over Seth and knocked him to the floor. Mr. Vaughn stated that he could not stop and accidently hit him with his shoe on the head. He stated that Seth had a habit of holding his breath, making his body stiff and falling to the floor. He stated that he is always doing this and faking as a result they thought he was faking. He stated that when he picked up Seth he started making a gurgling sound and that's when they called the ambulance.

SW [redacted] and SW [redacted] then met with Ms. Ireland. SW asked Ms. Ireland to explain what happened. Ms. Ireland was very slow to respond and kept saying that Seth was bad, that he was acting up, that he wouldn't "mind" her and did not want to talk to her. SW asked what she meant by Seth being bad. She stated that he was always running around, falling, beating up his brothers. She stated that she called Seth out to talk with him about being good and to eat dinner.

At this point she became upset again. She stated that she was scared and that she did not want to get anyone in trouble. She kept asking if Mr. Vaughn was in the room next to her. She also indicated that she already told the police what happened. SW reiterated to Ms. Ireland how important it was for her to tell the absolute truth. Ms. Ireland responded by asking, "the whole truth?" SW at this time asked Ms. Ireland exactly what she told the police.

Ms. Ireland stated that they (Mr. Vaughn, Ms. Ireland, and the kids) were in the kitchen and she was cooking dinner. She stated that she was checking the meat and putting corn on and talking to the kids about being good. She stated the she doesn't know how, because her back was turned, but somehow Seth made Lebaron mad, and Lebaron was "roughing him up". SW asked what she meant by roughing him up. Ms. Ireland stated that Lebaron was punching him in the chest. SW asked if it was with a closed fist and how hard it was. Ms. Ireland stated she did not know. She stated then that Lebaron picked Seth up and threw him on the floor. She stated that she told Mr. Lebaron to stop. She stated that they picked up Seth and that he was not bleeding, but had a busted lip. She stated he was not responsive at this time, but that they thought he was faking. She stated Seth was breathing at this time. She stated that they put him in bed and put a blanket over him. She stated that they went back to dinner and she finished making everyone's plates and that she went back to check on Seth. She stated he was making a moaning sound and she "kind" of thought he was still faking it. They went back, ate dinner and after dinner checked on Seth again. It was at this time that Ms. Ireland and Mr. Vaughn called the ambulance.

Seth passed away on January 6, 2009 at 1:30 a.m. On January 7, 2009, LeBaron Vaughn was formally charged with murder, Seth's mother was charged with child abuse.

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Ireland Concerns and Recommendations

Date: May 11, 2009

Policy Concerns:

8. Collateral adults were not interviewed (i.e. the boyfriend of the mother, reporting parties, neighbors, school officials, etc.). In addition there was no check to see if the police had been out to the home or if a cross report had been completed by the police.
9. It takes a long time to obtain information such as police reports and service call history because currently the protocol is to request the information thru records. Often times the social worker needs to submit a written request via fax and then it is processed by the records department.
10. Referrals were evaluated out due to pending investigations that were already assigned to a social worker.
11. Narratives were not entered into Child Welfare Services/Case Management System (CWS/CMS)in a timely manner in addition they were modified after initial entry. Updating and modify the original entry creates a liability issue.
12. The referral call from FSO Nulick was not on-lined until several days later. The Quality Assurance investigation determined that it had been hand written and placed in a basked to be entered into CWS/CMS. Per PPG 3-3-1 Section IV (A) the referral should have been entered into CWS/CMS within 20 minutes from the time of the call.

Policy Recommendations:

- (C-8) Policy and Procedure Guide 3-3-8 be updated to include adding that collateral adults will be interviewed. In addition that it will be required to run a service call history on the home through law enforcement prior to responding. In addition PPG 3-3-8 to include that the parent who is not present also needs to be interviewed and verification of current custody order. ER division to receive training regarding updated PPG 3-3-8 Assessment in Investigation of Abuse/Neglect Reports. ER division also to adhere to the Manual of Policies and Procedures of the Child Welfare Services Division 31-105 (Emergency Response Protocol) and DCFS KRA's.
- (C-9) DCFS Administration to discuss process of obtaining police reports and service call history in a timely and efficient manner at the next multi-agency meeting.

- (C-10) ER division developed new policy regarding "Evaluating Out" referrals when there are open referrals. New policy includes referring new referral to the social worker and the social worker supervisor. Social worker and social worker to have a discussion regarding whether new referral is to be investigated and/or evaluated out. Policy to include how discussion is to be documented.

- (C-11) ER division to develop new PPG regarding documentation of screener narratives and documentation requirements of investigation narratives into the CWS/CMS. PPG also needs to address updating entries after you have saved to database. In regards to ongoing cases, PPG 3-1-1 also to be updated to address updating entries after you have saved to database.

- (C-11) DCFS management to provide training to line staff regarding legality of narratives, court room testimony and liability issues when narratives appear to be altered.

- (C-12) ER policy was changed and the current protocol is that all referrals are on-lined on CWS/CMS immediately. DCFS policy no longer includes hand writing referral to be on-lined by DCFS clerical staff.

Law Enforcement Concerns:

13. The mother was arrested for child abuse on 8/17/08 the cross report from law enforcement did not come in until 8/28/08.
14. Subsequent to the investigation DCFS learned that Fresno PD had responded to the home on several occasions, however there was no cross report submitted to DCFS.

Law Enforcement Recommendations:

- (C-13, 14) DCFS administration to have a discussion at the next multi-agency meeting regarding child abuse cross reporting and timelines to report to DCFS. Discussion to include providing DCFS access to service calls and event reports.

Mental Health Concerns:

15. Mental health is not checking collateral information prior to giving a diagnosis (i.e. information provided by the parents and school behavior problems). Per MH records Seth went from a 3.7 in 4th grade to failing in 5th grade; however, Kirk school staff indicated that Seth was doing well. In addition MH records indicate that the mother reported that 30 police contacts regarding Seth were made to the home due to Seth hitting others. FPD records indicate that 30 police contacts are inaccurate.

16. Per the mental health records there were several instances in which MH should have made a referral to the care line. The mother and Seth made allegations of abuse by father to the clinician. On 10/13/08 the therapist notes that Seth had a bruise above his knee. In addition Seth was hospitalized in Bakersfield, and unexplained bruises were noted.

Mental Health Recommendations:

- (C-15, 16) Dr. Willam Latta, PhD in mental health will be providing a training regarding doing better diagnosis to all therapists in mental health. As of June 2009 managed care records will be returning to DCFS mental health. DCFS mental health will begin to review information in records as part of the mental health assessment.
- (C-15, 16) With the assistance of County Counsel joint policy to be developed regarding exchange of information between Child Welfare, Law Enforcement and Mental Health.
- (C-15, 16) Discuss issues at quarterly meetings with Community Regional Medical Center and Good Samaritan.

School Concern:

17. Concerns regarding school not reporting possible child abuse.

School Recommendation:

- (C-17) Discussion between DCFS and Fresno Unified School District regarding child abuse mandated reporter laws and training. Discussion to include the fact that mandated reporters need to report all allegations of suspected abuse. In addition person with first hand knowledge of abuse is the person that makes the report to DCFS. ER program manager to provide DCFS administration with r/p information from a 3- month period, statistical information to include who was the reporting party. Information to include if the reporting party was the person who observed the abuse.

Confidential Intra-Agency Investigation

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Ireland Concerns and Recommendations

Date: June 3, 2009

Practice Concerns:

1. CWS/CMS narratives do not reflect that a sheriff's records check for history was completed regarding the parents and other household members prior to responding to the referral.
2. CWS/CMS does not reflect that the biological father/possible alleged perpetrator was interviewed. In addition Jervon's father was not contacted nor was he interviewed during the investigation.
3. CWS/CMS records do not reflect that interviews were completed with the reporting parties while investigating several of the referrals.
4. CWS/CMS does not reflect that custody orders were confirmed at the time of the investigation.
5. Jervon reported being disciplined with a belt; however, the investigation did not determine by whom.
6. SDM was not completed appropriately as a result two of the referrals were determined to be a non-crisis responses; however, per SDM they should have been generated as a 24 hour response.
7. Disposition of the referrals were not completed prior to 30 days.
8. Follow up efforts to locate the children for the November referral were not comprehensive (i.e. school attempts, subsequent home attempts etc.)

Practice Recommendations:

- (C-1, 2, 3, 4 and 5) ER social workers to Follow Policy and Procedure Guide (PPG) 3-3-8 Assessment in Investigation of Abuse/Neglect Reports, Emergency Response Key Result Areas (KRA's) and Manual of Policies and Procedures of the Child Welfare Services Division 31-105 thru 135 (Emergency Response Protocol). ER Supervisors to review policies and document that staff training has occurred.

- (C-6) Careline Staff and Swing Shift social workers to follow SDM guidelines regarding evaluating referrals. ER Supervisors to review policies and document that staff training has occurred.

- (C-7) ER social workers to follow KRA's regarding disposition of referrals. ER Supervisors to review policies and document that staff training has occurred.

- (C-8) ER social workers to follow PPG 3-3-26 Timelines for subsequent Contacts After Initial Attempts to Contact the Family Have Been Unsuccessful. ER Supervisors to review policies and document that staff training has occurred.

Policy Concerns:

9. Collateral adults were not interviewed (i.e. the boyfriend of the mother, reporting parties, neighbors, school officials, etc.). In addition there was no check to see if the police had been out to the home or if a cross report had been completed by the police.
10. Referrals were evaluated out due to pending investigations that were already assigned to a social worker.
11. Narratives were not entered into CWS/CMS in a timely manner in addition they were modified after initial entry. Updating and modify the original entry creates a liability issue.

Policy Recommendations:

- (C-8) Policy and Procedure Guide 3-3-8 be updated to include adding that collateral adults will be interviewed. In addition that it will be required to run a service call history on the home through law enforcement prior to responding. In addition PPG 3-3-8 to include that the parent who is not present also needs to be interviewed and verification of current custody order. ER division to receive training regarding updated PPG 3-3-8 Assessment in Investigation of Abuse/Neglect Reports. ER division also to adhere to the Manual of Policies and Procedures of the Child Welfare Services Division 31-105 (Emergency Response Protocol) and DCFS KRA's.

- (C-9) ER division to develop new PPG regarding "Evaluating Out" referrals when there are open referrals. PPG to state that careline will open the referral and send to assigned SW and SWS, who will assess the information and determine if investigation or evaluation out is appropriate.

- (C-10) ER division to develop new PPG regarding documentation requirements of investigation narratives into the Child Welfare Services/Case Management System (CWS/CMS). PPG also needs to address updating entries after you have saved to database. In regards to ongoing cases, PPG 3-1-1 also to be updated to address updating entries after you have saved to database.

Law Enforcement Concerns:

12. Mother was arrested for child abuse on 8/17/08 the cross report from law enforcement did not come in until 8/28/08.
13. Subsequent to the investigation DCFS learned that Fresno PD had responded to the home on several occasions, however there was no cross report submitted to DCFS.
14. The referral call from FSO Nulick was not on-lined until several days later. The Quality Assurance investigation determined that it had been hand written and placed in a basked to be entered into CWS/CMS. Per PPG 3-3-1 Section IV (A) the referral should have been entered into CWS/CMS within 20 minutes from the time of the call.

Law Enforcement Recommendations:

- (C-12, 13) Discussion between Fresno Police, other law enforcement agencies and DCFS regarding child abuse cross reporting and timelines to report to DCFS. Discussion to include providing DCFS access to service calls and event reports.

- (C-14) ER program manager to look into the issue of Evaluated Out referrals being entered into CWS. PPG 3-3-1 to be updated to include section regarding expectations for Evaluated out referrals including those on-lined by DCFS clerical staff.

Mental Health Concerns:

15. Mental health is not checking collateral information prior to giving a diagnosis (i.e. information provided by the parents and school behavior problems). Per MH records Seth went from a 3.7 in 4th grade to failing in 5th grade; however, Kirk school staff indicated that Seth was doing well. In addition MH records indicate that the mother reported that 30 police contacts regarding Seth were made to the home due to Seth hitting others. FPD records indicate that 30 police contacts are inaccurate.
16. Per the mental health records there were several instances in which MH should have made a referral to the care line. The mother and Seth made allegations of abuse by father to the clinician. On 10/13/08 the therapist notes that Seth had a bruise above his knee. In addition Seth was hospitalized in Bakersfield, and unexplained bruises were noted.

Mental Health Recommendations:

- (C-15, 16) Discussion between Child Welfare and Mental Health regarding how they verify facts and child abuse reporting expectations. Discussion to include other providers such as Good Samaritan Hospital.

School Concern:

17. Concerns regarding school not reporting possible child abuse prior to 11/13.

School Recommendation:

- (C-17) Discussion between DCFS and Fresno Unified School District regarding child abuse cross reporting.

More Information Needed Concerns:

18. DCFS exchange log reflects that Mr. Hudson did call the Department on 08/18; however, he was connected to "L" Street reception.
19. [redacted] reportedly advised family to take kids to jail if they couldn't handle them. He was not working form 9/15/08-11/14/08 (last day). "L" Street reception log shows that Ms. Ireland did come to the office on 09/09/08 as a walk in. Log indicates that [redacted] met with mom. It is unclear what transpired during this meeting or what direction [redacted] provided Ms. Ireland.

More Information Needed Recommendations:

- (C-18) Program to further assess the reason that Mr. Hudson was connected to DCFS reception when it was apparent that he was attempting to call the care line.
- (C-19) Program to look into this issue and see if further clarity can be obtained.

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Concerns: Regarding 08/27/20

08 referral:

1. CWS/CMS narratives do not reflect that a sheriff's records check for history was completed regarding the parents and other household members prior to responding to the referral. Did we know about criminal history for the boyfriend or the biological father prior to responding?
2. Mother was arrested for child abuse on 8/17/08. Cross report from law enforcement did not come until 8/28/08.
3. DCFS exchange log reflect that Mr. Hudson did all the Department on 08/18; however, he was connected to L. St. reception. Why was Mr. Hudson connected to DCFS reception when it was apparent that he was attempting to call the care line?
4. CWS/CMS records do not reflect that SW [redacted] completed an interview with the reporting party, collateral adults i.e. no mention of boyfriend.
5. In regards to the Police Department/Sheriff's Department. What were the preparation efforts prior to responding to the referral?
6. CWS/CMS does not reflect that SW [redacted] interviewed the biological father/possible alleged perpetrator.
7. CWS/CMS does not reflect that SW [redacted] inquired about Jervon's father.
8. CWS/CMS does not reflect that SW [redacted] confirmed the custody orders at the time of the investigation.
9. Jervon reported being disciplined with a belt; however, the narrative investigation does not determine by whom. Was de disciplined by his mother or boyfriend?
10. Narratives were not entered into CWS/CMS in a timely manner and the Disposition of the referral was not completed prior to 30 days.

Concerns: Regarding the 09/19/2008 referral:

11. Screener narrative completed by SW [redacted] indicates that referral was for documentation purposes and would be evaluated out. Referral should not have been evaluated out due to threats. At minimum hotline tools should have included threat of physical abuse. This would have prompted an override screen and a response decision tree if an override was not appropriate.
12. What follow up efforts were completed by SW [redacted] to advise SW [redacted] of this new referral as there was an open referral pending to the same family? Were SW [redacted] and her supervisor made aware of the 09/19/2008 referral by either the screener or the Care Line supervisor?

13. Issues regarding the mom's boyfriend making verbal threats to the children were not addressed in addition the neighbor was not contacted to verify the information she provided to the father due to the referral being evaluated out.
14. The referral remained in assigned to SAO [redacted] from 09/19/2008-10/24/2008 approximately 36-days. Why did this referral remain in SOA's in-box for this amount of time?
15. The referral was then assigned to SWS [redacted] on 10/24/2008 and closed on 11/04/2008. Did SWS [redacted] verify that SW [redacted] was aware of this referral before the referral was closed?

Concerns: Regarding the 10/12/2008 referral:

16. Screener narrative was completed by SW [redacted]. This referral was determined to be a non-crisis response. Did SW [redacted] consult with SW [redacted] as the 08/27/2008 referral had not been closed out when this new referral was received? CWS/CMS indicates the 08/27/08 referral was not closed until October 15, 2008.
17. The referral was determined to be 10 day response and not a crisis; however, per SDM it should have been determined as a 24 hour response.
18. The screener narrative indicates that the reporting party says she called police 2 days ago but they did nothing. During the investigation did SW [redacted] check to see if the police had been out to the home or if a cross report had been completed by the police?
19. Narratives were not entered into CWS/CMS in a timely manner. CWS/CMS indicates they were updated on December 30, 2008. Prior to this the narrative indicated, "more complete narrative to follow."
20. The Disposition of the referral was not completed prior to 30 days.
21. 10/13/08 indicates that the referral reported to Madera County on behalf of Mr. Hudson was determined to be unfounded?
22. 10/13/08 MH records – Mo states that 30 police contacts re: Seth in the home because Seth hitting others – 30 not accurate, however at least 3 responses with no cross reports to DCFS.
23. 10/13/08 MH records – therapist notes that Seth has a bruise above his knee – no referral

Concerns: Regarding the 11/13/2008 referral:

24. Why did we not attempt to locate the minors through Fresno Unified?
25. 10 day response? Why not a crisis? If Hx was considered and physical abuse tree used because r/p didn't seem to believe children's explanation of injuries
26. While completing the investigation of the 11/13/08 referral the attempts by SW [redacted] – which address does she go to? Lotus or Thorne?

Concerns: Regarding the 12/26/2008 referral:

27. There were two open referrals regarding this family assigned to SW [redacted] that had not been completed; yet the 12/26/08 referral was evaluated out and assigned to the current worker.
28. The referral call from FSO Nulick was not on-lined until several days later. The quality Assurance investigation determined that it had been hand written and placed in a basket to be entered into CWS/CMS. Per PPG3-3-1 Section IV (A) the referral should have been entered into CWS/CMS within 20 minutes from the time of the call.

General Concerns:

29. Concerns re: school not reporting abuse prior to 11/13.
30. Per the mental health records, mother and Seth made allegations of abuse by father. However, there was no referral from Mental health to the Care Line.
31. While Seth was hospitalized in Bakersfield, unexplained bruises were noted. There was no referral to the Care Line for investigation.
32. MH not checking collateral information prior to diagnosis (i.e. parents report and school behavior problems)
33. Verify grades. Kirk school staff indicated Seth was doing well. Mom and boy friend report problems in school. Seth does to during MH evaluations. One note says went from 3.7 in 4th grade to failing in 5th. [redacted] obtaining grades.
34. Unclear on timeframes and LeBaron's place of residence.
35. No cross reports from PD on several calls.
36. PD call on 9/19 any verification that child was admitted to the hospital.
37. [redacted] advised family to take kids to jail if they couldn't handle them. He was not working form 9/15/08-11/14/08 (last day). Any record of the parents calling in and [redacted] taking the call on the care line prior to 9/15/08?
38. Who dropped kids from school? Mom, boyfriend, school?
39. PD not following up on 12/13 5150 and 12/26 decision

Recommendations:

C-1: Emergency Response (ER) division to adhere to PPG 3-3-8 Assessment in Investigation of Abuse/Neglect Reports.
C-2: Discussion between Law Enforcement and DCFS regarding cross reporting timelines.

C-3: DCFS to evaluate Exchange and efficiency in routing calls to appropriate departments.
C-4, 5, 6, 7, 8, 9, and 13: Emergency Response (ER) division to adhere to PPG 3-3-8 and the Key Results Areas (KRA's) for the ER division and Division 31 regulations.
C-10: ER division to adhere to KRA's for the ER task area regarding case disposition.
C-11 and 27: ER to develop new PPG – regarding "Evaluate Out" referrals.
C-17: All care line screeners including swing shift to receive refresher training on SDM.
C-19: ER to develop a new PPG regarding updating contacts.
C-21, 22, 30, 31: Discussion between DCFS and Mental Health regarding cross reporting expectations this would also include contracted providers such as Good Samaritan Hospital.
C-28: ER to adhere to and/or update PPG 3-3-1 regarding entering referrals within the 20 minute time frame.
C-29: Discussion between DCFS and Fresno Unified School District regarding child abuse reporting expectations.