CPS investigation: Despite changes, abused kids still die in Sacramento County system

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Body

Jun. 22--They had names and faces once. Now they have coroner's numbers.

Social workers call them their "worst outcomes."

Adrian Conway was 3 when he became Sacramento's Worst Outcome No. 96-00441, a little boy who was beaten, burned, bruised, bound, tortured and starved to death by his angry, drug-abusing mom.

Others have followed: Christopher Cejas, 12, No. 02-03984. Alexia and Akira Noel, 3-month-old twins, Nos. 04-03525 and 03526. Keith Carl "K.C." Balbuena, 3, No. 05-05953.

What these dead children have in common -- besides the ultimate betrayal by a parent or caregiver -- is their link to Sacramento County's Child Protective Services. Each was once an open CPS case, permanently closed by the coroner.

Twelve years after the death of Adrian Conway, whose murder exposed a risky CPS policy and forced massive reform within the agency, Sacramento's most vulnerable children still are being failed at the most basic level, a five-month Bee investigation found.

The agency's budget has nearly quadrupled since Adrian's death; staffing has doubled. But the results for kids -- on several key fronts -- remain grim:

--A growing number of children who died of abuse or neglect in Sacramento County, or their families, were involved with CPS before their deaths. From Adrian's murder through 2006, 82 more children died -- 35 of their families already known to CPS.

--Among California's 20 counties with the most children, Sacramento had the highest rate of kids being abused or neglected again within a year of an earlier CPS intervention.

--Kids are cycling in and out of the child welfare system at a record pace. Among the largest counties, Sacramento has the highest percentage of kids who land back in foster care within two years of CPS returning them to their families.

This was not the plan.

The legacy of Adrian Conway's 1996 death was envisioned as a revamped system to make kids safer, and some gains have been made. Timely social worker responses to the Child Abuse Hotline are up. Supervisor-tosocial worker ratios have tightened.

But internal problems persist.

The paper trail of statistics and public documents -- especially where children died or were injured -- reveals an agency in 2008 still struggling to ensure adequate supervision and training, appropriate evaluation of children's risk, quality investigations and accountability for mistakes.

Examining 18 local cases in which children died or were hurt on CPS' watch, The Bee found that the tipping point for kids' safety often comes down to seemingly small things: a social worker with poor English skills, an unanswered knock at the door, a miscue between agencies, a lack of follow-through, an incomplete background check, a supervisor on vacation, a poor candidate for parenting classes.

"I just see such blatant examples of a lack of judgment by CPS," said Deputy District Attorney Robin Shakely, who specializes in child homicides and has served on both the county and state child death review teams. "They're not even close calls."

Shakely said she believes the agency has abandoned its promises of the Adrian era -- to pull children out of troubled homes first and ask questions later -- in favor of more leniency toward the caregivers. Shakely was assigned to the Conway case and has prosecuted a progression of child homicides since.

When a child dies with government workers involved in the case, no one inside the agency is held publicly accountable because of juvenile, employee and patient confidentiality. But if caregivers are arrested, details of how CPS intersected with the families often emerge.

Agency officials and social workers say they make the best decisions they can at the time. But hindsight sometimes affords a different view.

The agency was so concerned about Bradley Price's temper that it sent him to anger management classes in 2005. He attended one the night before he fractured his son's skull. Travis Smith, a 2-year-old who loved squirrels and the "Popeye" movie, was thrown into his playpen and died two days later.

From a phone inside Napa State Hospital, Feliciana Reyes said she was allowed by CPS to keep her 1-year-old daughter even after she stabbed her husband in the back in February 2000 -- as long as she attended counseling and parenting classes. The following year, her 4-month-old baby girl died abruptly and was declared a sudden infant death syndrome case. In June 2004, the corpse of another of her babies, 10-month-old Felicia, was found in the back seat of Reyes' car as she drove through Los Angeles.

Last fall, Tamaihya Moore's family members said they begged CPS workers to seek medical help when they saw the 17-month-old girl deteriorating in foster care. The coroner ruled the death a homicide, likely due to smothering, and the foster mom has been charged with murder. The family is suing CPS.

"It is absolutely horrible. How could this happen?" asked the girl's grieving grandmother, Debra Oliver.

Asked that question, CPS officials describe complex and time-consuming caseloads and the ravages of drug abuse, poverty and domestic violence. They deny any significant internal problems and characterize their worst outcomes as extreme, isolated incidents -- sometimes the result of human error.

"Because we are an imperfect system made up of human beings trying to carry out the work, there are going to be times when there is an error in judgment," said CPS Director Laura Coulthard, who headed up emergency response for the agency when Adrian died.

Each child death is scrutinized, Coulthard said. When a mistake clearly has been made, the agency takes action against the employee that may range from a formal reprimand to firing.

"Accountability is essential," she wrote in an e-mail to The Bee, though she declined to discuss specific cases, citing county personnel policy.

However, The Bee found evidence in court files that some social workers continued in their jobs after failing to follow department policy in cases that ended with injuries or deaths.

One former social worker admitted under oath she had received no negative job evaluations after her decision in August 2001 ended with an 11-year-old girl being stabbed in the chest, barely surviving. (Read an online-only story about this case.)

Martha McGowan had been on the job about two months, and her supervisor was on vacation, when she returned the girl to her father. McGowan later admitted that she had failed to check the family's CPS file, which would have revealed the man's 30-plus criminal convictions, according to the girl's lawsuit against the county.

McGowan did learn at the last minute that the father had been taking PCP -- a drug that can cause violent, psychotic episodes -- but released his daughter to him anyway. Four days later, the girl and two neighbors, including a 15-year-old boy, were stabbed repeatedly during another of the man's drug-induced rampages.

In a 2006 deposition for the lawsuit, McGowan said that she had "expected some sort of repercussions or something," but instead she and her supervisor talked mostly about her feelings. She couldn't recall ever being debriefed about her decision-making process, or what she might have done differently.

The social worker said she worked for CPS another two years, handling 200 more cases, before resigning to become a stay-at-home mom in Las Vegas.

"There's no way in the world she should have had this case unsupervised," said the girl's attorney, ***Ed Dudensing***, a former prosecutor who has asked the state Supreme Court to review the case. The lower courts rejected the suit, saying state law makes government workers immune from liability for "discretionary acts."

Coulthard said this sort of internal breakdown should not have happened -- and would not happen today.

VICTIMS HAD BEEN ON CPS RADAR

Deputy District Attorney Shakely and others are alarmed by the rising number of children known to CPS before their deaths.

From 2001 to 2003, the county recorded 14 child abuse and neglect homicides, in which five of the families had been involved with CPS, according to data from the county's Child Death Review Team. Over the next three years, child abuse and neglect homicides rose to 20, with 13 families having CPS histories.

In a special report last September to the Board of Supervisors, the team revealed that child maltreatment deaths -- which include abuse- or neglect-related deaths such as drownings or overdoses -- had more than doubled in Sacramento from 11 in 2004 to 24 in 2006. Of the 24 who died in 2006, 11 had histories with Sacramento CPS; nine had been involved with the agency within six months of their deaths.

"As a team, we want to see that the pattern of CPS involvement is changing," said Dr. Angela Rosas, a child abuse expert and former chairwoman of the county's Child Death Review Team.

It was CPS' involvement with Adrian Conway's drug-abusing mother that ignited the furor in 1996. Outrage was rekindled a year later when 2-year-old Rebecca Meza of Rancho Cordova was killed at home despite 10 prior reports to the agency.

At the time, the agency lamented its lack of resources, and the Board of Supervisors responded. Since Adrian's death, the CPS budget has risen from $33.9 million to nearly $125.9 million -- a 271 percent increase in federal, state and local money, most spent on salaries, benefits and employee overhead.

Since Adrian's death, the population of children under 18 in the county grew by about 58,000, or 18 percent.

CPS officials say the agency's budget largely reflects its high social worker caseload, which has been the state's fifth highest since 2002 and exceeds state recommendations. Staff turnover and vacancies remain high, too.

"The caseload is out of control," said Ted Somera, executive director of United Public Employees (UPE) Local 1, which represents about 400 social workers.

Budget cuts decided last week will carve into CPS' new budget, which deeply concerns both union and agency officials.

Yet as far back as 1996, the citizens committee appointed after Adrian's death cautioned that money alone would not improve CPS. The 15-member panel, led by a retired Superior Court judge, concluded that "clearer procedures and protocols that make the best use of staff time should be the highest management priority."

The Bee's analysis of public records, coroner's data and thousands of pages of court documents reveals ongoing problems with some of CPS' procedures and protocols, particularly in how workers evaluate children's risk of being hurt.

15 REFERRALS FOR ONE INFANT

The Sacramento family of one 4-month-old girl, admitted to a hospital last October for suspected shaken baby syndrome, had 15 prior CPS referrals -- 12 in Sacramento County and three in Butte County, according to the state Department of Social Services. The girl nearly died.

"How many times do you have to call CPS before they do anything?" asked Richard Melm of Sacramento, whose stepdaughter, Daelynn Foreman, starved to death in July 2006 while living with his ex-wife -- despite six reports to Sacramento County's CPS of suspected neglect over a four-year period.

Daelynn's death was so shocking that CPS' own spokeswoman said the case "sent shudders down the corridors of all CPS."

When she died, the 12-year-old Orangevale girl with cerebral palsy had withered to 23 pounds, the average for a 1-year-old. The girl's mother, Brandy Foreman, has been charged with murder for allegedly having withheld food; she also faces drug charges.

Daelynn's death after six local referrals is acknowledged within Sacramento CPS as a problem case, one in which the worker "did not understand the situation well enough to be able to identify an appropriate intervention," said Coulthard, who took the agency's top job last year after rising through the ranks since 1985.

The department previously told The Bee that an internal investigation had resulted in "personnel actions," but would not elaborate.

Out of Daelynn's case, the agency developed new programs and assigned workers to specialize in "medically fragile" children and medical neglect referrals. It also created a Medical Neglect Review Team to monitor the more complex cases.

Coulthard and other top CPS managers say their ability to evaluate children's risk and make good decisions also has been vastly improved by a procedure adopted after Adrian's death. Workers in five CPS programs, including emergency response and family maintenance, are required to use what's known as SDM, or Structured Decision Making.

The written, check-off system provides structure to social workers trying to assess a child's safety and risk by making them note present circumstances and history such as prior CPS contact, excessive discipline, drug abuse or domestic violence.

SDM has been widely praised in California for increasing consistency and accuracy, and improving outcomes for kids.

But only if it's used correctly. The CPS oversight committee, in its examination of four child deaths, found that some completed SDM forms "reflected inadequate information." The committee also found that social workers were completing the forms at the end of cases, rather than relying on them for key decision-making along the way.

"They were doing it as part of closing their paperwork," said Alyson Collier, the committee's chairwoman. "So it was getting done, but it wasn't being used appropriately."

The spotlight on child deaths and CPS' inner workings has intensified in the past 10 months, as both its oversight committee and the death review team released critical reports to the Board of Supervisors.

The oversight committee cautioned supervisors in August that problems have persisted over the past decade, and that "a systemic change needs to take place."

The committee cited inadequate supervision and training as problems dating back to the Adrian era. In reviewing four child deaths, it found that social workers "did not receive regularly scheduled supervision." In one case, a worker tried for three days to get help from a supervisor and "found him to be unavailable."

A NEW EMPHASIS TO SAVE CHILDREN

As its top recommendation, the oversight committee advised CPS to make clear to social workers and families that "it must err on the side of child protection as opposed to family reunification."

Acting independently, the Child Death Review Team came to a similar conclusion: CPS must place child safety over keeping families together "in both written policy and active practice."

The Department of Health and Human Services agreed with both committees' findings and, when Coulthard came back before the board in March, supervisors lauded the agency's plans for improvement.

But a disconnect between CPS policy and what happens in the field was cited over and over by members of both citizens groups.

"I think that's where the breakdown is: It's practice vs. policy," said Sgt. Jeff Reinl, a member of the oversight committee and head of the Sacramento County sheriff's child abuse bureau.

CPS Division Manager Melinda Lake candidly said that the agency failed to follow its own policies in the 2005 beating death of Keith Carl "K.C." Balbuena, a 3-year-old with a speech impediment whose mother and roommate were convicted of the crime earlier this year.

The first CPS emergency response worker, who speaks with a heavy accent, admitted in court that he closed the case even though he couldn't really understand the boy. A second social worker visited the apartment nine times but never found the couple, despite agency guidelines listing numerous strategies for locating a family.

The boy died eight days after that worker's last unsuccessful visit.

But Lake, who then supervised emergency response workers, also argues that the community at large bears some responsibility for its worst outcomes.

Christopher Cejas was 12 when he was tortured, starved and beaten to death in August 2002 while visiting his father, a registered sex offender.

A social worker had gone to the Watt Avenue apartment complex in June 2002 to follow up on a neighbor's 1:30 a.m. call to CPS nine days earlier. The anonymous caller claimed to have heard a terrible beating of a boy named Christopher, about 10 years old.

The case was not flagged as an emergency, and, lacking a last name or apartment number -- and getting no help from the apartment manager -- the social worker left. The case was closed as "unable to locate."

"If a child being severely beaten and screaming doesn't deserve an immediate response, who does?" asked Shakely, who prosecuted the case.

The upstairs neighbor overheard the boy being beaten again 11 weeks later but did not call CPS or 911. That vicious beating, which lasted for hours, proved fatal to Christopher Cejas.

Christopher's North Carolina family said the social worker could have found him in time had she gone to the local school and aggressively interviewed residents at the apartment complex. State regulations and CPS' employee handbook clearly lay out requirements for workers to talk with people beyond the immediate family in their investigation, including teachers, neighbors, police and others.

Lake said scant information provided in the anonymous call led the social worker to conclude she was in the wrong place.

"This case just screams out for civic responsibility," said Lake, who thinks many more residents knew of the horrors inside Apartment 13 but did nothing.

The county has staked much of its strategy since Adrian's death on preventing family crises, creating eight Family Resource Centers in high-risk neighborhoods that provide services to help families cope, and care for their children.

Families whose cases are investigated and opened by CPS, but who retain custody, are offered services including counseling, drug treatment, parenting and anger-management classes.

"Most of our families need help and support," Lake said. "Most aren't vicious murderers."

The agency points to success stories -- women like Angela LeBeau of Sacramento. The former meth addict was reunited with her four children as she took 180 classes on topics ranging from alcohol and drug use to parenting to self-esteem. She works for CPS as a meeting scheduler and a parent leader, helping others navigate the system.

Coulthard and her boss, Lynn Frank, director of the county's Department of Health and Human Services, complained that the recent committee reports' focus on child deaths -- the "worst outcomes" -- creates a distorted picture of the large agency and its hardworking staff.

"If that's all they see, it's fairly easy to jump to conclusions that we aren't keeping kids safe," Frank said.

But William Grimm, a senior attorney at the Oakland-based National Center for Youth Law, said it is critical to publicly examine child deaths because they are often "just the tip of the iceberg of a system that's not treating kids well."

SOME STATISTICS SPELL TROUBLE

Grimm said he sees a troubling combination in Sacramento County's child welfare data.

Among the state's 20 largest counties, based on child population, Sacramento County has the highest percentage of kids reunited with their families within a year of being placed in foster care, according to a Bee analysis of the most recent data compiled by UC Berkeley's Center for Social Services Research (*http://cssr.berkeley.edu*). The county's reunification rate more than doubled between 1998 and 2006.

What sounds like good news comes with a giant caveat: Sacramento also has the highest percentage of kids re-entering foster care after being reunited with their families, triple the rate of Los Angeles County, and more than double that of San Diego, Fresno and Orange counties.

Kids are coming right back into the system.

"What that says to me is, this is a system that is not operating well," Grimm said.

"It's not protecting children, and it's not helping families, either, because you're putting children back in homes that are not prepared or supported to maintain the children in the homes," he said. "And they're coming back in re-victimized."

In Sacramento County, kids are being re-victimized at an alarming rate, as well.

The data show that, among the largest counties, Sacramento has the highest rate of children being abused or neglected again within a year of CPS confirming a report involving them. One in five kids abused or neglected in 2004 was referred to the agency again within 18 months -- more than 1,000 children.

Even after CPS cases are closed, repeat abuse and neglect in Sacramento is among the highest in the state's urban counties.

CPS officials reject such county-to-county comparisons, saying each operates independently, with different policies and programs. Yet CPS' own improvement plan states that reducing repeat abuse and foster care re-entry are high priorities.

Coulthard said the county has made "slow and steady" progress in cutting back on repeat abuse, mostly through community partnerships to quickly hook troubled families into support services. "We know we're improving, but we're not good enough," she said.

The county hopes to address high re-entry rates with team decision-making, a strategy that pulls together children, social workers, birth families, service providers and others to help make decisions about a child's placement.

Without team decision-making, planning has been inadequate, Coulthard said, making children susceptible to problem placements. But she noted that the vast majority of kids who landed back in foster care last year had not actually been abused or neglected again; instead, their caregivers had violated conditions of the requirements set when they regained their children.

Alyson Collier, chairwoman of the CPS oversight committee, said the team approach eases the burden of a "lone social worker out in the field," making difficult decisions in isolation.

"We have to stop doing business that way," Collier said.

A LONE WORKER IS OVERWHELMED

The consequences of a lone worker shouldering a complex case can be extreme.

In one horrific example, CPS handed off a troubled family to a home visitation worker outside the agency, who knew her limitations but couldn't get the agency to intervene.

Alexia and Akira Noel, 3-month-old twins, were found dead in July 2004 by their father, Ernest Noel, in a sweltering upstairs bedroom.

Before the twins were born, CPS had been monitoring Noel and his girlfriend, Vanessa Hackett, who were both mentally disabled and struggling to raise a daughter, according to court records. When Hackett became pregnant with twins, CPS "became very concerned about the couple's ability to care for three young children," according to a document from Noel's attorney.

CPS enlisted the help of Birth & Beyond, a county program now part of CPS that provides support and guidance to pregnant women and struggling new parents.

After the twins' birth in April 2004, a Birth & Beyond worker visited the apartment at least 16 times over three months, finding the home and children in varying states. In May, she persuaded Hackett to take the babies to the Sacramento Crisis Nursery, but CPS returned the girls to the home six days later, after Noel assured the agency he and Hackett had completed a parenting class.

Birth & Beyond stepped up its visits, bringing in a public health nurse, but the Birth & Beyond worker cautioned CPS in July that the case was "intense" and perhaps beyond her scope, the prosecutor's trial brief shows. Again, CPS decided "no further actions were necessary since Birth & Beyond was involved with the case," according to the brief.

At this point, one of the twins had a diaper rash so severe her bottom was bloody.

The saga abruptly ended on July 14, 2004, when the girls were found dead inside the apartment. The coroner ruled the deaths homicides; both parents went to prison.

Coulthard acknowledged that the twins' deaths were an example of "practice not being aligned with procedure." The agency's response "wasn't appropriate," she said, and the family should have been a formal child welfare case.

Instead, Alexia and Akira Noel became Worst Outcomes 04-03525 and 03526.

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