



# **Sacramento County GRAND JURY**



**Donald W. Prange, Sr.**

April 15, 2009

**Georgia Bastion**

To all the citizens of Sacramento County:

**Michael Broderick**

The Grand Jury has reported on the shortcomings of CPS since 1996. Findings and recommendations have fallen on deaf ears. *“Nothing Ever Changes...Ever.”* When are the citizens going to demand that something be done with CPS? We heard promises that CPS is studying and working on problems. How many years does it take to do “something...or anything?”

**Russ Campbell**

**Robert Cervantes**

**Irene Cervantes**

The current Grand Jury was soon met with numerous complaints and letters from citizens along with past and present social workers concerning CPS. Media reports and articles from the local paper echoed the same sentiments.

**Richard Cochran**

**Robert Devoe**

The Grand Jury heard testimony from the Health and Human Services Director. It was the same old story: they were aware of problems and were working on changes.

**Ann Early**

**David Feldstein**

The Grand Jury discovered that nothing really changed. Systemic problems were found throughout the organization. CPS does not have the capability to record hot line calls, devices that would help the social worker in the field did not work, cases are not properly followed up, evaluations are rarely done, social workers and supervisors are not given the support they need, manuals that could help direct the employees are totally confusing and outdated.

**Patricia Gayman**

**Susan Husa**

**Jerry Jagers**

Social Workers have a very complex job. There are many people who care about the work they do at CPS. Apparently, some top CPS management does not share the same view. Management made misrepresentations to the Grand Jury. We need the help of the community to put pressure on our county administrators to act quickly and take responsibility to see that changes are made.

**Rosemary Kelley**

**Ramona Lavelle**

**Paul McAmis**

**James Monteton**

**Robert Segal**

**Robin Whiting**

DONALD PRANGE SR., Foreman  
2008-2009 Sacramento County Grand Jury

**Report Issued by the  
2008-2009 Sacramento County Grand Jury  
April 2009**

**CHILD PROTECTIVE SERVICES  
“Nothing Ever Changes – Ever”**

**Sacramento County  
Department of Health and Human Services  
Children’s Protective Services**

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## **Introduction**

The Grand Jury's decision to examine Sacramento County's Child Protective Services (CPS) Program came on the heels of the death of 4-year old Jahmaurae Allen in July of 2008. His death brought renewed media attention and questions concerning CPS' ability to carry out its responsibility to protect children from abuse and neglect.

CPS faces the dilemma of whether to leave a child at home and work with the family so that it can be successful or remove the child to be raised in a different environment. These competing philosophies are called "preserve the family" and "protect the child".

The Grand Jury has pointed out areas where improvements are needed and long overlooked. The Grand Jury recognizes that CPS has many dedicated and competent staff. A ride-along gives one a taste of the world in which social workers find themselves on a daily basis. It is a world consisting of abusive parents, drug and alcohol dependence, poverty, unemployment, homelessness, domestic violence, and lack of basic parenting skills. Social workers do not get the attention and credit they deserve for the countless children that are safe due to their personal intervention.

This report documents the facts and findings of the 2008-2009 Grand Jury's investigation.

The Grand Jury findings and recommendations are designed to help CPS improve services to its clients and to weave a tighter safety net to reduce or eliminate needless injuries and deaths to our most vulnerable population group, our children.

### **Issue**

How can Child Protective Services improve the safety and well being of children?

### **Reason for Investigation**

CPS is a significant part of the Department of Health and Human Services (HHS). It has persistent, recurring and systemic problems resulting in child abuse related deaths. The responsible authorities have failed to take corrective actions recommended in previous reports.

The deaths of children under the supervision of the CPS and the related news media reports became a major concern to the Grand Jury. The Grand Jury received complaints about CPS from citizens and social workers following the death of Jahmaurae Allen. The appearance of the HHS Director on TV stating, "We could have done more to prevent the death" caused great concern regarding CPS.

## **Method of Investigation**

The Grand Jury investigation did not encompass all of CPS, but limited itself to specific issues which form the body of this report.

The Grand Jury conducted interviews and took sworn testimony with: the HHS Director, Executive Managers of CPS, supervisors, social workers, human resource personnel, a union representative and child advocate organizations. Lengthy reports with findings and recommendations from at least five previous grand juries revealed that CPS did not comply with the standards one would expect from a child protective agency.

The Grand Jury examined emergency protocols and procedure manuals, reviewed supervisory practices and visited CPS In-take sites to observe how calls were handled. Over 40 subpoenas were issued.

The Grand Jury reviewed its investigations of the County's Department of Health and Human Services over the past 15 years. Seventeen investigations have been conducted, of these seven involved CPS programs, and five involved other aspects of childcare. In both 1996 and 1998 the investigations focused on child abuse and neglect. The 2006-2007 Grand Jury looked at "In-take Services," also a major concern of this Grand Jury.

The Grand Jury takes note of, and has reviewed, other investigations and reports including:

- The Critical Case Investigation Committee (CCIC), a publicly appointed citizens group. A comprehensive report was published in 1996.
- Annual reports from the Sacramento County Children’s Coalition and the Child Protective Systems Oversight Committee that were submitted to the Sacramento County Board of Supervisors.
- The annual Sacramento County Child Death Review Team reviews of all child deaths, regardless of cause.
- CPS Self-Assessment Report for 2006-2009.
- Various media reports.

### **Management and Leadership**

The Grand Jury questions the management skills of HHS and CPS. Senior management within HHS and CPS lack a positive vision and have a persistent unwillingness to accept responsibility for the outcome of their actions. CPS management acknowledged that they failed to follow and enforce their own policies, procedures and rules. Their disturbingly repetitive response was “we’re working on this.”

The March 2009 release of the CPS Self-Assessment Report lists these ongoing deficiencies, but failed to provide solutions.

The Grand Jury also holds the Sacramento County Board of Supervisors and the County Executive ultimately accountable for CPS' management and budget. In its 2008 Annual Report released to the Board of Supervisors, the Oversight Committee concludes in bold type:

**Approximately 75% of the recommendations from the 2006 and 2007 deaths relate to issues that have been occurring since 1996. There continues to be persistent and recurring patterns and recurring concerns regarding CPS' involvement in child-abuse related cases.**

It indicated that the majority of concerns and needed system improvements fall under three primary areas (1) Supervision and Training, (2) Interagency Coordination and Case Management, and (3) Risk Assessment Procedures and/or Practices.

### **Personnel Evaluations**

Personnel evaluation is a mechanism for monitoring employee performance for all levels of employees. Evaluations, when taken seriously and completed on schedule, provide both management and the employee with valuable information.

The union contract and county regulations require evaluations be conducted annually. They are an important part of the supervisory process. Failure to

complete evaluations lowers morale, makes disciplinary actions harder to enforce, hampers effective communication, decreases productivity, and compromises management's credibility.

### **Discipline Procedures**

The disciplinary process helps employees achieve and maintain standards of behavior and performance. According to testimony and documentation, it takes an average of one year to dismiss or suspend an employee.

As of December 12, 2008 there were seven employees on **paid** administrative leave from CPS. This lowers morale of employees who must add to their heavy workload. It is a waste of taxpayer money to pay these employees to sit at home while the investigation is taking place.

A year ago the HR department was reorganized in an attempt to be more efficient. Sworn testimony raised questions as to whether the reorganization achieved its goal.

The County Discipline Manual states:

It is critical that every supervisor document significant events and maintain working files that include precise, factual documentation regarding the employees she/he supervises . . . this documentation should include an ongoing record of the employee's performance and other work-related information. The information in the files may provide

the basis for completing performance appraisals or supporting formal disciplinary action should it become necessary.

Progressive disciplinary practices rely on solid and documented instances of non-performance to support the hierarchy of possible disciplinary options at management's disposal. An important element of this documentation consists of material contained in employee evaluations and the supervisor's "desk file". These can document ongoing problems and attempts to address such issues through training, mentoring and attempted remedial action. The absence of up-to-date documentation, including annual performance evaluations, undermines management's efforts to support their case.

### **Recruitment and Retention**

Resource limitations were frequently voiced as a major impediment to effective program administration. This was continually expressed as a factor leading to large caseloads and employee burnout. Figures supplied by CPS for the period covering July 2007 through June 2008 disclosed the loss of 94 out of a total workforce of 427 social workers. This equates to an annual turnover rate of 22 percent, nearly a quarter of their professional staff.

Filling vacant social worker positions is time consuming and costly. To do so on the scale associated with the above annual turnover rate becomes a major impediment to program effectiveness and efficiency. This is especially

noteworthy in light of the learning curve required of new social workers to become effective professionals able to operate on their own.

CPS supervisors and managers acknowledged the burden associated with employee turnover, but no one testified to any detailed knowledge of the root causes. CPS faces an increased demand for its services, while budgetary cutbacks would aggravate the problem.

### **Training**

The CPS Policy Manual states that each social worker, supervisor and program manager is required to complete 30 hours of Continuing Education annually. Training is provided at no cost to the employee and is available during normal work hours.

The list of courses is extensive and includes, but is not limited to: Structured Decision Making (SDM), Child Welfare Services/Case management System (CWS/CMS). Critical Incidents, Shaken Baby Syndrome, Failure to Thrive, Body Check, Risk Assessment, Medical Neglect and Animal Removal Training. CPS provided the Grand Jury with names of employees, their position, and the title of training each person received for 2006, 2007 and 2008. This information included the date the employee was hired and the date the class was taken.

## **Caseload and Case Issues**

The Grand Jury repeatedly heard testimony that caseloads were too large and that staff was overworked. For example, the referral rate in Sacramento County was nearly 20 percent greater than the state average. This was echoed in the CPS self-assessment report prepared at the request of, and submitted to, the Board of Supervisors in 2009. Neither witnesses nor county manuals define case or caseloads. They do not make a direct statement as to caseload size, beyond suggesting reasonableness. The union contract also makes no mention of specific caseload size.

Testimony indicated that social workers may be performing activities that could more efficiently be done by support staff.

## **Information Technology**

CPS has an excellent set of software to facilitate their operations. These software packages include State provided software, third party software and special software developed by the CPS IT programmers. Other technologies are also used.

The software programs used are as follows:

- IRIS – Immediate Response Interactive System
- CWS/CMS – Child Welfare Services/Case Management System

- SDM – Structured Decision Making
- SafeMeasures – Performance evaluation tool

<b>CPS SOFTWARE ACCESS</b>				
<b>CPS Personnel</b>	<b>IRIS</b>	<b>CWS/CMS</b>	<b>SDM</b>	<b>SafeMeasures</b>
Intake social worker	Input	Input	Input	View
Intake supervisor	Input	Input	Input	View
Field social worker	View	Input	Input	View
Field supervisor	View	Input	Input	View
Program Manager	View	Input	Input	View
CPS upper-managers	View	Input	Input	View
Non-CPS County personnel	No view	Partial view	No view	No view
Other counties personnel	No view	Partial view	No view	No view

**IRIS**

IRIS is an electronic database designed to ensure communication between Emergency Response (ER) intake supervisors and field supervisors, as well as upper managers for immediate response cases only. Input is limited to immediate response (24 hour) social workers and their supervisors

**CWS/CMS**

CWS/CMS was developed by the Children’s Research Center (CRC), a private nonprofit corporation, and adopted in 1997. CWS/CMS is the primary tool used by CPS to track cases. It is an automated database that allows county and state CPS workers and management to record needs and services to families and children served by the CWS program. CWS/CMS also meets statutory and

regulatory mandates and is used by all 58 California counties. All CPS personnel receive two to five days of training with periodic updates.

All Sacramento CPS employees may make entries to this system. Non-CPS personnel and persons in other counties, as listed in Section 827 of the Welfare and Institutions Code, with certain restrictions, may also access and read these records.

### **SDM**

SDM provides workers with simple, objective, and reliable tools to make the best possible decisions for individual cases. It also provides upper management with information for improved planning, evaluation, and resource allocation. SDM was developed by the CRC and has been in use in Sacramento for about six years. The CRC does periodic reviews of this software comparing decisions to actual cases. The State mandates that all counties have a similar tool; however, not all counties in California use SDM. Other counties use the Fresno Risk Assessment tool.

### **SafeMeasures**

SafeMeasures was developed by the CRC and is a sophisticated quality assurance reporting service which captures data from CWS/CMS monthly and links these data elements to key performance standards. It is view-only.

SafeMeasures allows supervisors, Quality Assurance (QA) personnel and upper management a quantitative measure of the performance of case workers.

## **Structured Decision Making (SDM) and Risk Assessment Tools**

All counties in California are required to use a screening tool to determine proper response to reports of abuse and neglect. Since 1996 Sacramento County has been using SDM as a risk assessment tool to determine children's safety.

Emergency Response social workers responding to incoming calls are to follow this scripted tool. The Grand Jury observed an Intake Unit to determine (1) how the SDM and the Risk Assessment tools were being utilized and (2) to learn how the calls were being handled.

The Child Protection System Oversight Committee's 2006 Annual Report expressed concern over the "misuse" of SDM. This report investigated "child abuse-related deaths" from 1996-1997, 2002-2004, and 2005-2006. In their recommendations they cite concern with Risk Assessment. In particular, they base their concern on the ". . . proper use of the SDM tool." They discovered that this tool is ". . . not being used with fidelity and some of the completed SDM tool reflected inadequate information."

The California Family Risk Assessment Tool is used in conjunction with the SDM in ascertaining the level of risk to a child. There are various family conditions which are listed and rated numerically.

## **Child Protective Services Procedures Manual**

A policy and procedure manual is essential for the consistent and efficient operation of a large and complex organization such as CPS. It represents an

important reference tool to assist employees in carrying out program activities and following management policies.

The Grand Jury examined numerous social worker standards, Program Information Notices (PINS), and associated publications, for clarity and ease of use.

### **Legislative Needs**

The Grand Jury believes that two legislative changes are necessary. The first legislative change pertains to whether a child can be detained pending investigation of abuse.

The California Penal Code is silent with respect to the authorized detainment of children pending investigation of suspected abuse. This is a statutory void that can be potentially harmful to children whom physicians suspect may be the subject of possible abuse or neglect. This is particularly troubling when the child is five or under and is not subject to outside independent observation by teachers or others.

In the Jahmaurae Allen case, the doctor who found the fist-sized bruise on the child's chest complied with mandated reporting obligations. In the absence of any imminent danger to the child, coupled with a denial on the part of the mother, Jahmaurae was allowed to return home with her. A delayed response by CPS or law enforcement in such situations allows for the injured child to be abused by the so-called "responsible" adult.

Providing physicians the statutory authority to detain children, especially those five and under, pending the immediate involvement of a social worker and/or law enforcement official is a simple step which serves as an invaluable safety net to ensure the safety and health of possibly endangered children.

The second legislative change pertains to the definition of “persons” who have unrestricted access to see case records. Section 827 lists over twenty classes of person who can access these case records without benefit of the petition process. The Grand Jury is not on the list of “persons” entitled to see the record.

Within six months of Jahmaurae Allen’s death, over 100 persons from all over the State had accessed the case record through the CWS/CMS system. In reviewing this list the Grand Jury concluded that many of the “viewings” were out of curiosity and did not serve any legitimate purpose. Further, CPS has no clear internal guidelines as to the persons who should be able to review the case record.

## Findings and Recommendations

### Management and Leadership

**Finding 1:** There is a longstanding absence on the part of HHS and CPS management to accept responsibility and accountability for the role of CPS in meeting its community responsibilities. This is a recurring criticism found for over a decade of many published reports.

**Recommendation 1.1:** The Board of Supervisors conduct a thorough assessment of the performance of HHS and CPS management. These administrators must demonstrate more than subject matter expertise. They must demonstrate an ability to ignite the enthusiasm of CPS supervisory and rank and file professionals and exhibit the creative energy and management skill necessary to lead CPS in the challenges ahead.

**Recommendation 1.2:** The Board of Supervisors direct HHS and CPS management to publicly adopt the Grand Jury's findings and recommendations, prioritize the achievement of suggested improvements, including their own "Areas of Concern", and develop a project planning strategy for meeting these goals.

**Recommendation 1.3:** Request that HHS and CPS invite the 2009-2010 Grand Jury to return in six months to observe what progress has been made toward the improvement of CPS operations.

**Recommendation 1.4:** The County Board of Supervisors require that a public report be made in six months as to progress made.

**Finding 2:** A shield of privacy and secrecy that surrounds much of the operations of CPS is unwarranted. This lack of transparency serves to raise questions and leads to inaccurate conclusions being made regarding what takes place in CPS. The acknowledged need to protect the confidentiality of case information can be accomplished without adopting a “closed door” attitude.

**Recommendation 2:** Greater transparency of CPS operations must be exhibited on the part of CPS management. They should do more to aggressively open the doors of CPS activities to the eyes of the public, the County Board of Supervisors, non-profit organizations, K – 12 schools and universities, the Legislature, the medical community, and the media. Transparency does not prevent possible negative publicity, but does mean that questions can be asked and answered in an atmosphere of openness and honesty.

### **Evaluations**

**Finding 3.1:** CPS personnel have rarely had performance evaluations.

**Finding 3.2:** CPS management acknowledged they have failed in this area despite their agreement that yearly evaluations are critical. They tend to fall back on the excuse of “competing priorities” which were never explained to the satisfaction of the Grand Jury.

**Finding 3.3:** Personnel have been promoted without a current evaluation.

**Recommendation 3:** The completion of yearly evaluations on all employees must be recognized as a critical, high priority activity required of supervisors and managers.

**Finding 4:** The County's Human Resources Department (HR) disseminated annual evaluation reminders to CPS management. However no follow-up action was done to see if such evaluations actually took place.

**Recommendation 4:** HR must accept its responsibility for ensuring the completion of annual performance appraisals as part of their fundamental personnel oversight responsibilities.

**Finding 5:** HR has neglected to train supervisory personnel in the proper method of personnel evaluation.

**Recommendation 5:** CPS supervisory personnel must attend a training course specifically focused on employee performance evaluations

**Finding 6:** Substantial finger pointing exists between CPS and HR personnel regarding quality of service.

**Recommendation 6:** Greater interdepartmental cooperation must exist between CPS and the HR Department. CPS management must do more to demand and improve the delivery of services from the HR Department. Management attention and involvement must be brought to the table to reconcile this festering issue.

## **Discipline Procedures**

**Finding 7:** Disciplinary proceedings are compromised by the absence of evaluations of all employees.

**Recommendation 7.1:** CPS management should work with the Human Resources Department to immediately complete employee evaluations on all CPS personnel.

**Recommendation 7.2:** CPS supervisors and managers should be held accountable for ensuring that employee evaluations are completed in a timely manner.

**Recommendation 7.3:** Formal disciplinary action should be mandated in instances where evaluation timetables are not met.

**Finding 8:** There is an average time of one year from the start of **paid** administrative leave to resolution. This contributes to the caseload of other employees, and decreases staff morale.

**Recommendation 8.1:** Given the number of cases referred for discipline and the lengthy time until resolution, the Grand Jury recommends that more of the current HR staff be reallocated to CPS.

**Recommendation 8.2:** The length of time that employees are on paid administrative leave must be reduced.

**Recommendation 8.3:** Supervisors should be held accountable for keeping an active up-to-date file on employees as mandated in the County Discipline Manual.

**Finding 9:** According to sworn testimony, the recent HR reorganization increased the ratio of CPS disciplinary cases per HR analyst.

**Recommendation 9:** An alternative organizational structure, which would provide more efficient HR disciplinary support to CPS, should be considered.

**Finding 10:** Poor communication between HR and CPS contributes to lengthy disposition of discipline cases.

**Recommendation 10:** HR should develop effective training seminars for all supervisors and managers of CPS to promote greater understanding of the requirements needed for a rapid adjudication of cases.

### **Recruitment and Retention**

**Finding 11:** A 22 percent annual turnover rate in CPS social workers is a major impediment to program efficiency and effectiveness.

**Recommendation 11:** CPS management should prepare an analysis of this turnover problem and implement a recommendation plan.

**Finding 12:** Skilled social workers who do not want to be supervisors have no way to be promoted.

**Recommendation 12:** Establish a “specialist” classification in CPS available to social workers that are able to take on unique and complex cases.

### **Training**

**Finding 13.1:** Except for the first year of employment, employees are not compliant with the 30-hour training requirement. In a sample review of 60 employee records, 50 were not in compliance.

**Recommendation 13.1:** Program managers and supervisors must ensure that their employees attend classes and satisfy the 30-hour annual requirement.

**Finding 13.2:** Program managers receive employee training records twice a year.

**Recommendation 13.2:** Program managers and supervisors use the training records in conducting annual employee evaluations.

**Recommendation 13.3:** Supervisors should recommend beneficial training and should maintain an attendance log in their Desk File.

**Finding 14:** Training entries for new employees do not show the correct total number of training hours those employees actually took.

**Recommendation 14:** CPS should review the training log for accuracy and corrects erroneous entries.

## **Caseload**

**Finding 15.1:** A caseload is not defined.

**Recommendation 15.1** CPS should define a case and establish caseload and workload criteria.

**Finding 15.2:** Cases are allowed to remain open unnecessarily.

**Recommendation 15.2** Case supervisors should monitor and ensure that cases no longer needing services are closed in a timely manner.

**Finding 16:** Social workers do work that could be done by support staff.

**Recommendation 16:** Tasks not needing the skills of a social worker should be turned over to support staff.

## **Information Technology**

**Finding 17:** Management has not required personnel to take full advantage of their available software. CPS management acknowledges its failures to fully use these systems.

**Recommendation 17.1:** All CPS personnel should be required to pass software proficiency examinations.

**Recommendation 17.2:** Proper software utilization by all personnel should be assessed monthly.

**Finding 18:** The Grand Jury found that supervisory personnel and upper management were not adequately using IRIS. The current design of the software changes each case entry information to a red font when the case exceeds certain limits. This is helpful but does not provide enough information about the urgency of the case.

**Recommendation 18.1:** Division Managers should provide additional IRIS training and demand greater use of the software by program managers and supervisors. Program Information Notice 08-12, which provides detailed instructions of the use of IRIS, should be strictly followed.

**Recommendation 18.2:** The Grand Jury recommends that the cases be shown in a color code (e.g., green for good, yellow for cautionary, red for urgent and flashing red for immediate attention.)

**Recommendation 18.3:** The IRIS program should be modified to automatically send emails to the appropriate program manager, the division manager and the CPS director and when any case is red or flashing red.

**Finding 19:** The CWS/CMS software package is provided and controlled by the State and cannot be modified by CPS IT personnel. These personnel can recommend appropriate change through statewide user-councils to improve the software.

**Recommendation 19.1:** Changes should be made that will not allow deleting, but will require strikeouts and additional comments.

**Recommendation 19.2:** Create an identifying log that records author and date of any changes.

**Finding 20:** There is a lack of management control of SDM usage. It was reported to the Grand Jury that at most 60 percent of the social workers adequately use SDM. The Self Assessment Report states: “. . . its use remains inconsistent and inaccurate.”

**Recommendation 20:** Social workers should be required to use SDM 100 percent of the time.

**Finding 21:** The SafeMeasures program has not been used adequately by many of the supervisors and managers. Usage is reportedly less than 20 percent.

**Recommendation 21.1:** All supervisors and management should receive additional training in the use of SafeMeasures.

**Recommendation 21.2:** SafeMeasures results should be used in staff meetings and as a means of tracking employee performance.

**Finding 22:** Quality Assurance (QA) personnel are not knowledgeable in the use of all the software and were not using the SafeMeasures software to assess the quality of services provided.

**Recommendation 22:** QA personnel should receive training in the use of all CPS software and be required to use SafeMeasures in their assessment of CPS programs.

**Finding 23:** The CPS in-take phone lines currently do not have recording capability. CPS personnel have investigated this issue and found that other counties have this capability and it did not interfere with reporting.

**Recommendation 23:** High priority should be given to purchasing and installing the voice recorder system as soon as possible.

**Finding 24:** Testimony from CPS management indicates that social workers do not have electronic devices to record information while they are in the field.

**Recommendation 24:** CPS should investigate electronic devices that could improve social worker efficiency. Factors such as worker safety and client confidentiality should be considered.

**Finding 25:** Currently social workers, with password generation devices called “Tokens” (a secure means of handling sensitive data) can access the CWS/CMS computer system from home. CPS has issued about 80 of these “Tokens.”

**Recommendation 25:** This system should continue but annual reassessments should be conducted to evaluate its value, safety and security.

### **Structured Decision Making and Risk Assessment Tools**

**Finding 26:** Flaws in the SDM may result in children being exposed to dangerous and abusive conditions. The Risk Assessment process requires that CPS respond within 24 hours if a child is under age two. If the child is over two, the response time may be extended to ten days.

**Recommendation 26:** The County should expand this age group to five and under. With this change in place any child who is not of school age would require 24-hour response.

**Finding 27:** SDM is not been utilized as envisioned. Testimony indicated that this valuable risk assessment tool was frequently completed after the fact and viewed simply as an administrative “requirement” by social workers.

**Recommendation 27:** Social workers should use the SDM tool as designed to adequately assess risk.

**Finding 28:** SDM allows a response of ten days even when there is a history of “physical abuse, domestic violence, caregiver mental health, or substance abuse concerns” if there is a “responsible” adult on the premises. Experts in domestic violence state that if there is domestic violence in the home there is a 50 percent chance that the children will also be abused. When these circumstances exist, no adult on the premises should be considered “responsible. “

**Recommendation 28:** Whenever there is prior history of physical abuse or domestic violence, the response should be 24 hours or less.

**Finding 29:** The California Family Risk Assessment Tool can fail to adequately determine the level of risk to which a child may be exposed.

**Recommendation 29:** CPS should reexamine this tool and find ways to improve its usage.

### **Policies and Procedures Manual**

**Finding 30.1:** The CPS Policies and Procedures Manual is an exercise in redundancy and fails in its purpose to provide concise and useable direction.

**Finding 30.2:** The CPS manual does not have a usable table of contents, index, or electronic search engine capability.

**Recommendation 30:** The CPS policy manual should be completely rewritten to include an index and expanded table of contents and be in digital form with electronic search capability.

### **Legislative Needs**

**Finding 31:** The law governing reporting does not require that the Mandated Reporter hold or detain a child suspected of being abused. It only requires that he or she report the suspected abuse to the proper authorities.

**Recommendation 31.1:** The County Board of Supervisors should request the State Legislature amend the appropriate sections of the Penal Code to authorize such detention.

**Recommendation 31.2** Sacramento County should be designated as a Pilot Project County to establish and evaluate the efficacy of detaining children at possible risk.

**Finding 32:** The Grand Jury does not have full access to unredacted reports for legitimate investigative purposes.

**Recommendation 32.1:** The County Board of Supervisors should request the State Legislature amend Welfare and Institutions Code 827 to include the Grand Jury in the list of “Persons Authorized to View Juvenile Records without a Petition or Court Order.”

**Recommendation 32.2:** Access to the case records in CWS/CSM of children who died, or were subject to a near-death situation, should be restricted to persons who demonstrate a legitimate need to see the case record.

## **Response Requirements**

**Penal Code sections 933 and 933.5 require that specific responses to both the findings and recommendations contained in this report be submitted to the Presiding Judge of the Sacramento Superior Court by July 14, 2009**

**from:**

- **Sacramento County Board of Supervisors**