Child Abuse Prevention Task Force Report and Community Recommendations

Acknowledgements

The Task Force would like to thank Mayor R.J. Berry and CAO Rob Perry for putting into action a process to address serious concerns regarding how child abuse cases are handled in Albuquerque. The Child Abuse Prevention Task Force members and community members are confident that citizens of Albuquerque, Community Leaders, and the Business Community will continue to make the safety and wellbeing of all children in our community the priority.

Expert Panel Members: April Community Meeting

Dr. Renee Ornelas, Para Los Ninos, Dr. Leslie Strickland, Krisztina Ford, All Faiths, Sgt. Amy Dudewicz, Special Victim's Unit, BCSD, Sgt. Rich Evans, Crimes Against Children Unit, Lisa Madrid, CYFD, Deb Grey, CYFD Regional Attorney, Lisa Tabaudo, District Attorney's Office

Expert Panel Members: May Community Meeting

Dr. Susan Miller, UNM, Angela Baca, Guardians of the Children, Rev. Darnell Smith, President Ministers Fellowship of Albuquerque Metropolitan Area, Macedonia Baptist Church, Kellie Ann Peterson, Every Day Wisdom For Families, Debbie Sant, NM Citizens Review Board, Grace Spulak, Pegasus, Beverly Nomberg, La Familia Inc., Beth Ann Gillia, Director, Corinne Wolfe Children's Law Center, UNM School of Law

The Task Force is thankful for the many individuals and organizations that helped make the meetings a success, certain individuals/organizations went above and beyond:

The Task Force thanks Chief Gorden Eden for allowing openness, accountability, and access to the Albuquerque Police Department.

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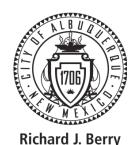
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Child Abuse Force



Mayor

Prevention Task

Project Closure

Report

Project Name: Child Abuse Prevention Task Force

Department Reviewed: Albuquerque Police Department

Focus Area: Improvement of Child Abuse investigations through community collaboration

facilitated by the Child Abuse Prevention Task Force

Product/Process: Community recommendations for process improvement: training, investigations, coordination of resources, best practices, & technological solutions

Date of Project: 2/11/2014 to 8/30/2014

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Project Closure Report Version Control

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TABLE OF CONTENTS

1 PROJECT CLOSURE REPORT......5

2	PRC	JECT CLOSURE GOALS	. 5
3	PRC	JECT CLOSURE REPORT SUMMARY	.5
	3.1	Project Background Overview	.5
	3.2 F	Project Highlights and Best Practices1	10
	3.3	Project Closure Synopsis	11
4	PRC	JECT METRICS PERFORMANCE	11
5	PRC	JECT CLOSURE TASKS1	12
	5.1	Resource Management	12
	5.2	Issue Management	12
	5.3	Customer Expectation Management	13
	5.4	Lessons Learned	13
	5.5	Post Project Tasks	14
	5.6	Task Force Recommendations	14
6	CON	ICLUSION2	21
7	PRC	JECT CLOSURE REPORT APPROVALS2	22
8	REF	ERENCES2	23
a	ΛDD	ENDICES	2/

1 PROJECT CLOSURE REPORT

Project Closure Report Purpose

The Child Abuse Prevention Task Force Report contains final recommendations for practical solutions regarding improving the effectiveness of services, private and public as they relate to the welfare and safety of children. Although the Task Force recommendations are specific to the Albuquerque Police Department and its collaborative partners, some findings are broader in scope and involve other agencies outside of the jurisdiction of the City of Albuquerque. The success of this project was accomplished through multi-agency partnerships and community participation; this being the key strategy for City of Albuquerque government leaders.

2 PROJECT CLOSURE GOALS

Project Closure Report Goals

Through a series of community meetings, the Task Force was able to engage *subject matter experts* within the child welfare system who sat as *Expert Panel Members* at community meetings; expert panel members responded to questions and commentary from citizens. The majority expressed concerns around the safety and welfare of children. Other areas such as funding and legislation were explored. As a result of high community participation, the Task Force was able to 1) identify focus areas and opportunities to improve collaboration, 2) consider technological solutions, 3) enhance training and 4) bring about public awareness regarding a comprehensive strategy for ensuring the safety and welfare of children.

This Project Closure Report is created to accomplish the following goals:

- Review and validate the milestones and success of the project.
- Verify the most pressing issues.
- Confirm outstanding issues and make recommendations.
- Outline tasks and activities required to close the project.
- Identify project highlights and best practices for future projects.

3 PROJECT CLOSURE REPORT SUMMARY

3.1 Project Background Overview

The Child Abuse Prevention Task Force was commissioned by Mayor R.J. Berry, City of Albuquerque, on February 11, 2014. The purpose of this Task Force was to review systems, identify any weaknesses in the processes and to make recommendations to improve the way that child abuse cases are managed in the City of Albuquerque; or perhaps most importantly, at the Albuquerque Police Department (APD).

The Task Force implementation came as result of the case involving the death of nine year old Omaree Varela. After learning details of APD's involvement preceding the death of Omaree Varela on December 27, 2013, Mayor Berry responded with appointing a Child Abuse

Prevention Task Force.

News of Omaree's case triggered an emotionally charged response from the community, activists and leaders; public reaction to Omaree's death was fueled by reports that suggested that Omaree's death was due to a systemic failure by governmental agencies.

There have been a number of violent child abuse cases resulting in death in recent years, but none that drew nearly the attention that Omaree's case did, and at the center of issue was the question that gleaned in everyone's mind; how could this have happened?

Omaree's mother and step father were subsequently charged with his death. Synthia Varela Casaus is believed to be solely responsible for Omaree's death, while his step father, Steven Casaus, is accused of not intervening or seeking medical attention for Omaree, according to charges filed by the Bernalillo County District Attorney's Office.

Case Summary

On December 27, 2013, Albuquerque Police were called to the home of Synthia Varela Casaus (4900 block of Comanche Road, NE) where they found nine year old Omaree Varela dead. His mother told police that Omaree died after falling off of a toy horse and hitting his head. Her story was not consistent with the evidence at the scene according to police accounts given to the public.

On December 28, 2013, police charged Omaree's mother, Synthia Varela Casaus with child abuse resulting in death. While in custody, as she was being led by police in handcuffs, and on camera, Synthia claimed "it was an accident" and said that she was "disciplining him and kicked him the wrong way."

As the case evolved, the public learned that several governmental agencies with jurisdiction over the welfare of children had been in contact with Omaree regarding numerous abuse complaints prior to his death. What was learned about Omaree's family after his death became a realization that there were many missed opportunities for intervention. The death of Omaree signaled a failure in the reporting of this case and quite possibly others.

News reports on the Varela family exposed multi-generational abuse and a long history of involvement with Child Protective Services. According to several news outlets, Omaree was born while his mother was in prison; it appears that Omaree may have had a sad beginning, but according to reports from other family members given during a media interview (KOAT), Omaree experienced some periods in his life where he was cared for and loved while in the placement of extended family members.

This incident begged the question, how did this family fall under the radar for so long and how could this have happened so many times? The Task Force would attempt to answer that question and to make recommendations intended to divert future occurrences.

Lessons learned are many, and this case serves as a stark reminder that succinct communication and coordination are vital to ensuring that appropriate services and

interventions are available to families in crisis.

Much that was learned indicates that perhaps our legislative bodies should fund more programs for prevention on the front end, rather than the more costly alternative-children dying at the hands of their caretakers because of lack of services or other interventions.

Task Force Scope of Work

As the Task Force proceeded through this comprehensive review of practices, policies and procedures, a list of recommendations was developed for the benefit of the City of Albuquerque and for other communities in New Mexico. The City of Albuquerque has the opportunity to advance the way child abuse cases are managed in the future by continuing community engagement and developing lasting interagency partnerships between private and public sector entities. Perhaps the work completed by this Task Force can be used as the foundation from which future projects can grow from; or it can serve as a model for other communities.

The Task Force embarked on a fact finding mission, to research, identify and define best practices or evidence based practices which could be modeled. Additionally, the Task Force set out to locate child abuse practitioners and interested community members to identify process improvement areas, and ultimately to make tangible recommendations for the City of Albuquerque.

The Task Force partnered with All Faiths, Para Los Ninos, University of New Mexico Hospital (UNMH), Children Youth and Family Department (CYFD), the Bernalillo County District Attorney's Office and several nonprofit organizations. The multi-agency, multi-disciplinary review, concluded with a working group meeting held on June 30th, 2014, where recommendations were summarized and prioritized. The recommendations made by community members and subject matter experts were driven by the use of evidence-based practices. Ultimately, these practical solutions can used to improve the wellbeing of every child in every county in New Mexico.

Review of Child Abuse Investigation

In the review of how child abuse investigations are conducted, the Task Force found some consistencies in CYFD investigations and criminal investigations; the primary goal of both being to ensure the safety and protection of children. As in any criminal investigation, police must determine if a crime has been committed, protect evidence- if so, and arrest offender(s) when necessary. Although police cases are submitted for the purpose of prosecution, police are also involved in taking children out of dangerous environments and depend on CYFD for placement into temporary foster care until other determinations can be made regarding the best interest of the child.

Police and Government entities are responsible for maintaining a level of professionalism. In child abuse cases, Government Agencies are responsible for:

- Providing basic and advanced training to practitioners/officers/detectives
- Identifying and implementing policies, procedures and best practices to foster

successful outcomes

- Curtailing future incidents, in particular, those incidents based on errors in decisionmaking
- Ensuring inadequate or outdated processes are addressed; this includes the flow of information, use of technology and advocating for crime legislation that serves to improve the wellbeing of children

CYFD on the other hand, has a broad range of responsibilities. According to CYFD's 2009-2014 Report, Child and Family Plan, some of CYFD's goals are listed as:

...enhancing collaboration among public health agencies, the child protection system and private community-based programs to provide child abuse and neglect prevention and treatment services and to address health needs, including mental health needs of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports. (CYFD 2009-2014 Family Plan)

Although the roles of CYFD investigators and police investigators differ, they are mutually dependent on each other. This cooperative relationship is most important in the child abuse case cycle. States, including New Mexico have taken extraordinary steps to cultivate these relationships and to coordinate those entities in the constellation of child abuse investigations and protective services. In Albuquerque, investigation protocols are found in a Memorandum of Understanding (MOU) "Child Abuse Investigation Protocol" which establishes the Multi-disciplinary Team (MDT): APD, Bernalillo Sheriff's Office, Office of the District Attorney, Children's Safehouse of Albuquerque, CYFD, and UNMH Department of Pediatrics. (APPENDIX A)

The Task Force performed a comprehensive review of the training modules, policies and procedures, supervisory process, and the use of technology at the APD. In regards to technology, the Task Force identified probabilities that could have allowed reports to get lost in the system; it also found that case tracking needed to be addressed. The Task Force explored how information and systems can be improved for better results in the future. These will each be detailed in sections below.

Accountability in Omaree Investigation

The Albuquerque Police Department conducted a thorough administrative investigation into the circumstances of how, where and which officers had been in contact with Omaree Varela prior to his death. The investigation found that the officers involved violated standard operating procedures and have since been disciplined.

• A law enforcement agency receiving a report of a child abuse or neglect shall immediately forward facts of the report by telephone and transmit the same information in writing within forty-eight hours to CYFD. NMSA 1978, Section 32A-4-3(B).

The Task Force concluded that a lack of information sharing between agencies, namely APD,

CYFD, Albuquerque Public School (APS) and the District Attorney's office most likely caused the breakdown of communication and coordination of the numerous cases involving Omaree. The failure to link the cases most likely resulted in the failure to intervene on his behalf. It appears that each agency received information separately and at different times, with the exception of the District Attorney's office -which claimed it received no information at all on Omaree.

Each agency has its own information system, and none of these agencies had access to each other's data. While it may appear that there is a simple technological fix, in reality, each agency falls under differing regulatory oversight, some information being restricted by statute, such as the New Mexico Child's Code-NMSA 1978, Section 32A.

The Task Force identified shortfalls in the use of technology:

- Information technology: each Agency uses a different Records Management System (RMS), CYFD uses State Central Intake (SCI), APD uses Tiburon and Copperfire, and the District Attorney's office uses yet another system. APD also has records on microfiche, and automated programs, i.e. ACOPS and New World, making searches cumbersome for officers. Each time APD upgraded its RMS, data from previous systems were not integrated over into the new automated systems.
- Information collected at each agency has uses which are controlled by internal policies, statutes or federal regulations.
- Systems do not interface between agencies, and probably should not due to quality control issues and confidentiality issues.
- Extracting information may be useful to one agency but may be of no value to the next agency.
- APD began upgrading the agency's RMS in 2008, officers now use a software program, Copperfire to write reports on their Mobile Data Terminal (on board vehicle computer), these reports are then sent to Tiburon, APD's new Records/Computer Aided Dispatch (CADS) integrated RMS. Prior to the upgrade, *records technicians* were responsible for the distribution of all police reports. Distribution of reports can include, reports to the District Attorney's Office, other Law Enforcement Agencies, CYFD, etc.
- After the upgrade, the distribution of reports was shifted to the officer. Tracking the distribution of reports is nearly impossible given the number of reports written daily by officers, in six different areas commands, not to mention specialty units. Unless supervisors ensure that proper distribution is made, there is no other way to track cases that get distributed. Even when officers say they sent reports, there is no way to prove that reports were sent. The DA Liaison Unit which was disbanded was responsible for tracking all cases to the District Attorney's Office.

Currently, the distribution of reports is made by facsimile, SHAREPOINT and in some cases emailed. In the past, APD and CYFD were co-located at CYFD's 1031 Lamberton Pl NE office. Having CYFD and APD co-located would greatly improve coordination between CYFD investigators and police. APD's Crimes Against Children Unit (CACU) detectives are currently located at the Family Advocacy Center (FAC).

In August, 2014, seven CYFD employees and a supervisor moved into the FAC and now

CYFD and APD have the ability to share information, they share office space in the same building. The Task Force believes that the other benefit to co-locating is the face to face contact between detectives and CYFD investigators; this will serve to build relationships.

The role of All Faiths is also an important component of the MDT; the focus is on child-focused services for families in many areas, education, prevention, and outpatient treatment. All Faiths manages the Children's Safehouse where specialists conduct child-sensitive interviews and provide interagency coordination for effective investigation of child abuse. The Safehouse assures that children and families get the services they need while simultaneously caring for the legal aspects of the case. "All Faiths advocates work in the community and in homes to make sure the family's needs are being met and children are safe. These services create an essential link for families by providing life skills coaching, parent training, connection with community resources, transportation, and even emergency funds when necessary." (www.allfaiths.org)

3.2 Project Highlights and Best Practices

Project Highlights and Best Practices

- CYFD is now co-located with APD: Cases are being coordinated, as co-location allows for access of resources, and information sharing is improved by data sharing. The majority of MDT members are now working in the same building at the Family Advocacy Center.
- CACU moved to a new model: CACU hired a social worker, and a second is in the hiring process, to assist in many areas: tracking, prioritizing, conducting backgrounds, and ensuring cases are received in the District Attorney's office.
- APD created a new resource in Field Services Bureau (uniform patrol): FSB Officers are receiving advanced training to become specialists in the investigation of child abuse/neglect, each area command will have specialty trained officers; the goal is to have forty specialty officers.
- These officers are being trained by Advanced Training Staff at the Roger Hoisington Training Academy as well as by Dr. Ornelas, who is providing specialty training in the investigations of child sexual abuse cases.
- Michelle Aldana, Director of the Forensic interview program at All Faiths is now providing training to law enforcement officers so they better understand the role of the forensic interview and the investigation process as a whole; this training is aligned with the cross training strategy of Multi-disciplinary approach.
- APD has best practices, although no standardized "best practices" list could be located for law enforcement officers regarding child abuse investigations, the Task Force was able to compile a list of practices/protocols that seem to be present within comparative data collected on like states.

Best Practices: a compilation of evidence based practices include:

- Multi-Disciplinary Teams (MDT's): although comparable states all have unique constellations for MDT's, the majority include health care professionals, prosecuting attorneys, law enforcement and child protective services.
- Inter-Agency collaboration: comparable states all have Executive Orders or government directives to improve collaboration and follow through of services, training and community

Project Closure Report Page 10 of

- education/awareness programs.
- Mandatory Reporting Statutes: comparable states differ in their definition of mandatory reporters, but all states encourage every citizen to report. New Mexico requires all citizens to report; however there still exists some confusion with the interpretation of the New Mexico statute: NMSA 1978, 32A-4-3 Duty to report child abuse and neglect: responsibility to investigate child abuse or neglect; penalty. The CACU Supervisor was not aware of any prosecutions of this statue, and "failure to report" cases could not be located; it is unknown how many cases, if any have been prosecuted in New Mexico using this statute. California and Arizona list out mandatory reporters within the language of the statutes, New Mexico lists some. (APPENDIX B1,2,3,4)
- Automated reporting systems: mandatory reporters such as police, healthcare providers, teachers, coaches, clergy and those specifically involved in the delivery of professional services to children can file online reports for child abuse cases to child protective services; automated reporting for professionals is a best practice, data is essential for understanding practices that work, and those practices that do not effect a positive change.
- State websites: On some state websites, community resources and services can be easily located and accessed, examples can be found at myflorida.com, CALworks, etc.

1 Project Closure Synopsis

Project Closure Synopsis

The scope of work to be completed by the Task Force has been accomplished.

- Reviews are completed: policies and procedure, training, technology, and comparisons are completed. Opportunities for collaboration have been identified.
- The Task Force hosted three community meetings and the final and forth meeting is a Task Force closure meeting to present findings to the public.
- The final community meeting tentatively set for September 16th, 4:30 p.m. to 6:30 p.m. and will commence with opening remarks from the Honorable R.J. Berry, followed by guest speaker, Michelle Donaldson who will share her personal story of success. This meeting will also include a presentation by the Child Abuse Prevention Task Force. The meeting location to be announced at a later date.

2 PROJECT METRICS PERFORMANCE.

Goals and Objectives -Performance Measures

- Feedback from Community meetings was positive, media coverage of Task Force work was positive.
- Policies and procedures have been updated, training is enhanced, information is being shared and cases are being tracked.
- The community is engaged; additionally, work that was being done before the implementation of the Task Force is being highlighted because of the Child Abuse Prevention Task Force publicity: Early Childhood Accountability Partnership (ECAP),

Project Closure Report Page 11 of

Mission Graduate, J. Paul Taylor Task Force, Decade of the Child, Gubernatorial Proclamation (August 3, 2010), New Mexico Citizens Review Board, UNM's Family Development Program and many more.

- Resources available and services by non-profits have been identified.
- There have been no other reported cases where officers have failed to report child abuse/neglect cases to CYFD within the 48 hour period mandated by statute.
- There is more awareness around the work of the MDT, prior to the work of the Task Force, the MDT was relatively unknown.

The MOU regarding the MDT is continuing, Governor Martinez issued two Executive Order on April 3rd, 2014: According to the State's press release the two executive orders issued are to "take a more proactive and coherent approach to working with families who have faced multiple Children, Youth and Families Department (CYFD) investigations, and to improve communication between child welfare caseworkers and law enforcement officers."

Among many things, according to a news release, "any family who has been investigated twice by the CYFD will have any subsequent investigation reviewed by a supervising team. CYFD caseworkers will seek and review police reports and other law enforcement materials related to the cases on which they work. And law enforcement entities will have to comply within a timely fashion with any CYFD request for those materials."

Also according to the release, "Governor Martinez also announced the creation of a pilot program in Bernalillo County, establishing a new class of child welfare caseworker known as "family support workers." To start, a team of roughly 10 family support workers will be hired to regularly interface with families in Bernalillo County who have been the subject of three or more child welfare investigations in the past 10 years, connecting those families to services, visiting their homes, and monitoring the use and effectiveness of interventions. If the program is successful at helping these families avoid further interaction with CYFD and law enforcement, the family support worker model could be extended to other areas of the state."

• Resources were identified and a comprehensive list is attached to this report as an appendix, currently there is no single website that compiles resources for easy access for victims, families, services, nor is there a single location to distribute a hard copy. (APPENDIX C)

3 PROJECT CLOSURE TASKS

1 Resource Management

The Task Force used community buildings to host meetings.

- Audio visual equipment was supplied by the City of Albuquerque and Miranda Investigative Resources.
- Refreshments for meetings were provided by Miranda Investigative Resources.
- Supplies and other incidentals were provided by Miranda Investigative Resources.

Project Closure Report Page 12 of

3.2 Issue Management

Outstanding issue(s):

- Data Extraction at APD -Information is not readily available to analyze information regarding the investigation of child abuse/neglect cases, both Records and Dispatch have data extraction issues.
- Neither State, nor City websites list resources that can be easily accessed.
- APD Leadership must implement the change at Communications (Dispatch) to define "child abuse codes" so reports can be extracted; for reports, once a "CRYSTAL" report is created in records, all child abuse cases can be extracted by crime code. This has not been completed.
- At the completion of the Task Force work, who will continue to report on each issue's progress? APD's Crimes Against Children's Unit and the Crime Analysis Unit should continue to monitor the data extraction issue, without the data, APD will not be able to ensure that police reports are being written on every reported child abuse case. Comparing dispatched calls to reports written will give the best information regarding reports.
- New Mexico State's website is difficult to maneuver, information is difficult to locate; the City
 of Albuquerque website does not have a comprehensive list of resources that can be easily
 accessed.

3.3 Customer Expectation Management

It is the belief of this Task Force that the City of Albuquerque is pleased with the work completed, the findings and recommendations based on feedback received. Community engagement is the best indicator for deeming the work of the Task Force successful, feedback from member participation has all been positive, some community members expressed a desire to continue the work of the Child Abuse Prevention Task Force.

3.4 Lessons Learned

Task Force members were encouraged by the number of dedicated individuals that gave up their own valuable time to participate in this project. Many groups such as healthcare professionals, nonprofits, parents, teachers, law enforcement officers and concerned citizens all participated and attended evening meetings, outside of their regularly scheduled work hours.

- Which activities and processes worked well?
 - 1. Community meetings, allowing a platform where citizens could express their thoughts and concerns; this was important because they were given a voice, many of the same citizens came back and attended all meetings.
 - 2. Collaboration for final recommendations was seamless, working groups were able to focus and prioritize recommendations quickly.
 - 3. Practitioners all came together and new relationships were inspired through the expert panel process.

Project Closure Report Page 13 of

- 4. There is a better understanding of the hindrances' and magnitude of what it takes to prevent child abuse as a community; no single entity can accomplish this.
- Which could have been improved, and how?
 - 1. Some of the most important entities in the equation were notably absent; citizens and other professionals all expressed a desire for the Albuquerque Public School System to be more involved in collaboration, participation and reporting of cases occurring on school grounds. More outreach to individual school principals may have resulted in better participation.
 - 2. Engaging legislators and other elected officials such as judges, without the support of legislators, programs will not be funded; without involvement with judges, cases cannot be coordinated through the judicial system.
 - 3. Collecting Feedback sheets from community meetings was not done consistently, many feedback sheets were left blank; using a feedback tool such as "survey monkey" may have been a better way to obtain feedback.

3.5 Post Project Tasks

Post Project Tasks

The final Community Meeting is tentatively scheduled for September 16, 2014 from 4:30 pm to 6:30 pm., location to be announced.

- Master of Ceremonies: TJ Wilham, Real Time Crime Center
- Opening Remarks: The Honorable Mayor RJ Berry
- Guest Speaker: To be Announced
- Project presentation: Marie Sisi Miranda.
- Closing remarks: Dr. Renee Ornelas, Krisztina Ford.

3.6 Task Force Recommendations

Project Closure Recommendations

Scope of Project Charter

- I. Are APD training modules both basic and continuing education adequate or in need of improvement in the area of child abuse prevention?
 - a. Field Services
 - b. Crimes Against Children's Unit
 - c. Supervisor accountability training
 - d. Interaction with other agencies, service providers, prosecution and judicial entities

Task Force Findings:

II. In early 2014, the Albuquerque Police Academy implemented scenario based training for basic and advanced training. Officers will "role play" scenarios developed by training staff,

Project Closure Report Page 14 of

this will put into action lesson objectives. Demonstrations on how to conduct a cursory physical examination of the body of a child to look for signs of abuse are now being implemented into current training modules. The Crimes Against Children Unit (CACU) provides advanced training for cadets and officers as part of the Biennium training required for all officers by the New Mexico Law Enforcement Academy (NMLEA). This is tracked and coordinated by Academy staff under APD's Maintenance of Effort (MOE) training.

A great deal of research suggests that kinetic learning yields a higher retention factor when accompanied by traditional modalities of teaching such as lecturing or rogue reading. (*Udomon, et al.*)

The Task Force recommends that this specialized training be incorporated into basic Training and it continues as part of all future MOE training schedules, even when not required by the NMLEA.

- Field Services: a specialty group of uniformed officers are being trained to investigate child abuse cases in every Area Command. These officers will receive specialty pay for the advanced specialized training and response. The officers will remain in the field and will be available for other calls for service but will be utilized when needed with child abuse calls. This model allows for calls for services to be prioritized while simultaneously providing support to officers who encounter difficult child abuse cases.
- The Crimes against Children Unit is understaffed; data available for calls for services (dispatched calls) and reports written on child abuse/neglect cases should be analyzed to determine appropriate staffing levels, this may provide for a more manageable case load, this is not the only criteria that should be used since cases fluctuate. Having a smaller case load could improve the quality and turnaround time for felony cases submitted for prosecution.
- This information is currently not available through APD's RMS and the data currently available from dispatched calls is limited.

There is no uniform recommended staffing level as cases can range from serious misdemeanors to 1st degree felonies in these types of specialty units. The best data available for comparison with APD comes from a 2007 study conducted by Charlotte Sheriff's Office which concluded that detectives in Charlotte spent about 18 hours investigating each child abuse case, this included child pornography cases. "The focus of this study is to identify the needs of the investigative units by showing supportive data for recommending standards for increases within the various investigative units in Charlotte County, Florida." (William Prummell Abstract)

CACU Detectives routinely carry a case load that exceeds 25; for these difficult cases, this case load may be hindering a detective's ability to manage and complete cases in a timely manner.

It should be noted that data is not being collected regarding the successful prosecution of these cases; complicating further analysis of this data is the fact that the Federal Bureau of Investigations (FBI's) Uniform Crime Report (UCR) does not capture child abuse cases.

Project Closure Report Page 15 of

Supervisor accountability training: all formal training is facilitated through the Police Academy; roll call training is disseminated by the Real Time Crime Center (RTCC) via Power DMS, Daily 49, and SHAREPOINT usage is for dissemination of SOP's, Special Orders, and Administrative Orders.

- Case tracking to the District Attorney's office is being accomplished through the newly hired social workers at CACU. The DA's office has direct access to police reports through SHAREPOINT which is managed by CACU.
- Review of the role of judges showed that some Judges appear to be making decisions regarding custody and visitations through family court cases even when abuse has been substantiated by both the police department and CYFD. Until Family Court Judges consult, collaborate and consider other processes, this will continue.

The Task Force recommends on-going supervisory and leadership training to include subjects such as risk management and civil liability.

- III. Are APD policies and procedures compliant with the Children's code, and do they model "Best Practices" from other jurisdictions, follow State/ Federal guidelines?
 - a. Field Services
 - b. Crimes Against Children's Unit
 - c. Training

Task Force Findings:

APD's policies and procedures are compliant with the New Mexico Children's Code; Standard Operating Procedures have recently been updated to mirror the language in the statute. (APPENDIX H) Comparing department to department procedures was difficult because each state has differing ordinances and statutes. Instead, the Task Force looked at common procedures and protocols that states use as a whole in the processing of child abuse cases. Comparable States all use MDT's and each state, including New Mexico has in place Gubernatorial Executive Orders for the purpose of improving systems involved in the welfare of children.

In 2002, The U.S. Department of Health conducted a review of all 50 states child welfare programs and found that none were in absolute compliance. The federal review provided a snapshot of states' performance in child welfare. New Mexico has improved reporting and data reviewed from the CYFD 2014, 4th Quarter Report lists issues that indicate that New Mexico has work to do to improve the efficacy of the state's child welfare system.

As Reported by CYFD:

• A small percentage of providers in rural and frontier areas of the state have three-through five-TQRIS Star level licenses, compared to some of the metro areas. This is most likely due to a lack of access to resources, community poverty levels (impacting child care centers' and homes' income) and, in some cases, isolation.

Project Closure Report Page 16 of

- Per the 2013 market rate survey, reimbursement rates for most child care providers serving families receiving child care assistance were below the federally recommended level—the 75th percentile of current market rate.
- Early Childhood Services (ECS) is managing a waiting list for all new applicants for child care assistance with an income between 125% -200% of the Federal Poverty Level (excluding TANF participants, teen mothers and special needs children). (CYFD 2014 4th Quarter Report)

Significant to Bernalillo County is the volume of cases, number of families in the system and density of poverty level; it does not appear that these statistics will change anytime in the near future unless funding, educational opportunities and access to resources improves overall.

The number of unsubstantiated cases made to CYFD annually is staggering; CYFD or perhaps even legislators should address this. Other states have statutes regarding knowingly and intentionally making a false report to child protective services. The majority of reports called into the SCI are anonymous; and there are no consequences for abusing the system or using the system to harass, because each and every case is investigated, no matter how frivolous it may appear to be.

Many reports made to CYFD involve families embattled in custody cases. These cases are difficult for both police and CYFD investigators, these emotional cases bring a level of volatility that needs to be considered regarding decisions about the children involved. Having statutes that protect the innocent against false allegations of child abuse may be an option, but one has to consider that anything that discourages reporting may not be in the best interest of the child. This should be explored by the New Mexico Citizen's Review Board; this Board is specifically involved with legislation to strengthen child abuse laws and other processes.

The City of Albuquerque, through Mayor Berry, has allocated funding to improve the audio visual recording system at All Faiths; a member agency of the Multidisciplinary Team, which provides forensic interviews in Bernalillo and Valencia Counties; the updated recording system is used to record forensic interviews for victims of abuse. These interviews are critical to ensuring services are customized for each victim, and can make a difference in a child's overall healing. Additionally, the interviews are used for the prosecution of criminal cases.

The Task Force recommends the continual funding of these types of service programs.

- IV. Is first-line supervision adequate?
 - a. Do biased attitudes exist? If so, has this caused errors in decision making?
 - b. What are Supervisors required to do by policy?

Task Force Findings

Information was sought from CACU supervisors and other uniformed officers to understand how cases are processed and to identify any attitudes or biases about these types of investigations. From all indications, it appears that officers do their best to investigate abuse cases. Field cases are handled by officers who do not have the level of training that detectives do, it is likely that officers

Project Closure Report Page 17 of

respond to so many types of calls, that investigations of cases involving children as victims, are few compared to adult cases.

One explanation for the confusion surrounding children as victims is in recent training officers received regarding children as witnesses, which teaches them that during felony cases, children as witnesses' need parents present during police questioning. It is probable that this was confused with children as victims, in these cases, children need not be interviewed in the presence of their parents, and in fact children should be interviewed away from parents where they are more likely to open up. Field interviews are cursory and used to obtain preliminary information, children as victims are interviewed at All Faiths by forensically trained interviewers.

There were no biases identified in decision-making, and errors in decision-making pointed to lack of adequate training. As stated earlier in this report, officers are now undergoing more substantial training in child abuse investigations.

Supervisors review all reports submitted by officers. There is no requirement for supervisors to collect reports upon the completion of each call; this is not practical and could in fact interrupt or cause a delay in calls for services. Instead it is up the supervisor to track cases needing reports by the end of the shift or the following day. There is nothing in the system that currently notifies the supervisor that reports need to be collected.

Newly promoted supervisors are required to attend "First Line Supervision" training; currently there is no mandatory training schedule to ensure Supervisors are trained prior to being promoted.

The Task Force recommends that succession planning is formalized and that promotions are based on time in service, as well as experience, education and scheduled supervisory training. It is recommend that those candidates who are eligible for promotion, follow a designated training track in order to be eligible to take the sergeant's or lieutenant's test. In other words, train officers for supervision before they are allowed to compete for promotions; it is up to the individual officer to prepare him/herself for promotion. Requiring a certain number of supervisory training hours prior to being placed on an eligibility list, will better prepare supervisors before they take assignments.

- V. Is technology being used to its fullest potential in ensuring proper documentation, reporting, case tracking and case management?
 - a. Technology due diligence
 - b. Referral Process

Task Force Findings

APD has a fairly new RMS, policies regarding mandatory report calls already exist. What may help a field sergeant track cases that require reports is to create a "rule" in the automated system that will not allow an officer to complete (clear) a dispatched call, except by writing a report. What this would do, is designate "report calls" as being cleared by the code "42", which is the "ten code" for report. At the end of the shift, the supervisor would have the ability to run a query and to know exactly how many outstanding reports he/she needs to collect for the shift.

Project Closure Report Page 18 of

In regards to referral of reports, this issue is resolved by co-locating CYFD employees with detectives at the FAC. Moreover, CACU has hired two social workers that will help screen, prioritize and track cases. These social workers will also liaison with CYFD investigators to ensure follow up in services for victims and their families.

This model resembles the Florida model although Florida was not used in the comparative state data; the New Mexico model fits into this model rather than the California or Arizona model which instead hires law enforcement officers into their child protective services departments to conduct criminal investigations into cases received.

This model allows more control over prosecution and this gives the agencies more options as far as diversion programs for criminal cases. The New Mexico model depends on the voluntary cooperation of families through the protective services process and participation cannot be mandated except for cases where children are removed from the homes and placed into foster care through a court order.

As far as information sharing, the Real Time Crime Center (RTCC) is the best tool that APD can leverage in getting the best information to officers in the field. APD is working with CYFD to decide the best way to get the RTCC basic information from CYFD. Decisions will need to be made regarding confidentiality, agreement on what constitutes useful information and the type of information to be shared without compromising protected information at CYFD.

APD's information on child abuse cases is not readily available, making it difficult to bench mark successes in the newly implemented strategies as recommended by the Task Force. For instance, it would be important to know that reports are being written for every child abuse dispatched call. The only way to analyze this is to compare calls for services with reports written and submitted to records. This information is not currently available; The Crime Analysis Supervisor is working on this.

The other issue that has contributed to not having good data on child abuse cases is that the FBI Uniform Crime Report (UCR) does not track child abuse cases, there is no single place to obtain information on arrests, prosecutions, cases closed or unsubstantiated for the City of Albuquerque.

The Task Force recommends: that APD continue to develop the ability to analyze trends in child abuse cases and that information sharing continues. Accessing information from CYFD on prior cases involving the same family would be important for field officers. This information could be sent through the RTCC, this would help officers in their response and handling of child abuse calls.

In regards to tracking of report calls through the RMS, the Task Force recommends that this is accomplished through the automated system so that supervisors can run queries on the status of report calls. In dispatched cases that involve audio recordings, the dispatcher should attempt to transmit recordings to officers, while the officer may not be able to listen to all recordings, when there is recorded evidence, this should be sent to officers. This evidence needs to be preserved so that this evidence can become part of the case file and can be shared with CYFD.

Project Closure Report Page 19 of

- VI. What is the current interface with Child Protective Service Providers?
 - a. Can agencies improve reciprocal reporting?
 - b. What conditions exist that pose barriers to officers, dispatchers, records personnel in the handling of child abuse cases?

CACU and CYFD are now co-located, efforts are in place to share historical data in their reciprocal reporting. No significant barriers currently exist- that hinder the process in APD, dispatch or CYFD.

- VII. How does APD compare to similarly situated Agencies?
 - a. Does APD have Best Practices?
 - b. Compare and Contrast

Task Force Findings

In the review of best practices, as compared to similarly situated agencies, comparisons were not made agency to agency but instead, state to state comparisons were made. The matrix below gives a visual of what New Mexico has compared to other states. Additionally comparisons by state are included on "state comparative data" sheets for easy access. (APPENDIX B1,B2,B3,B3,B4)

State Comparison

State	MDT	Mandatory Reporting Statutes	Reciprocal Reporting Statutes	Automated Web Reporting	LE at CPS	Social Workers at LEA	Resources Websites
New Mexico	н	н	н			н	
Arizona	ㅂ	н	н	н	ㅂ		н
Colorado		н	н				н
Texas	н	н	н	н			н
California	ы	н		н			н

MDT - Multidisciplinary Team

LE-Law Enforcement

LEA - Law Enforcement Agency

CPS - Child Protective Services

Project Closure Report Page 20 of

VIII. What other collaboration opportunities exist?

Task Force findings:

Through the work of the Task Force, it was learned that there are many entities working to improve the outcomes for children in New Mexico in many areas: early childhood education, health care access, mental health services just to name a few. It is the belief of this Task Force that state entities must take the lead in moving smaller communities out of extreme poverty and assist with better access to services.

Community members also expressed concern over educational opportunities and equal access to health care, which some believe to be a key to improving overall outcomes for all children and families in New Mexico. One concern that was expressed at a community meeting was the lack of services for juvenile sex offenders; this group of offenders showing the most promise for being successful in treatment.

APD has to work closer with APS School Police and other school officials, there seems to be a perception that APS is a closed system and does not collaborate with other agencies involved with child abuse investigations, this was expressed by many community members, and some even believe they should be mandated to enter into the MOU that establishes the MDT.

4 Conclusion

Nonprofits, state agencies, local law enforcement and citizens all came together for this project. Awareness is high and every entity involved in the welfare of children should use this momentum to push funding initiatives, public education and continued resource development.

It takes extraordinary actions to respond to extraordinary circumstances and there is no worse experience in life than the loss of a child. Omaree Varela will forever remind us that we all have a duty to protect children and we should respond to each child's call for help as if they were our own.

The City of Albuquerque was quick to move on the opportunity to improve in areas that it may not have known needed improving until a single case showed all the hallmarks of a failsafe system operating in a vacuum.

Today we see an entire community that was moved into action, and the opportunity to impact the welfare and safety of our children is now and has always been in all of our hands.

Acronym list

APD Albuquerque Police Department

APS Albuquerque Public School System

Project Closure Report

CACU Crimes Against Children Unit **CADS Computer Aided Dispatch System** COA **Chief Administrative Officer** CPS **Child Protective Services** CRB Citizens Review Board **CYFD Children Youth & Family Department** DOM **Doctor of Oriental Medicine ECAP** Early Childhood Accountability Partnership **ESC Early Childhood Services** FAC **Family Advocacy Center** FBI Federal Bureau of Investigations **FSB** Field Services Bureau LE Law Enforcement LEA Law Enforcement Academy

MDT	Multi-disciplinary Team
MOE	Maintenance of Effort
NMLEA	New Mexico Law Enforcement Academy
RMS	Records Management System
RTCC	Real Time Crime Center
SCI	State Central Intake
SOP	Standard Operating Procedures
TANF	Temporary Assistance for Needy Families
TQRIS	The Quality Rating Improvement System
UCR	Uniform Crime Report
UNMH	University of New Mexico Hospital

Project Closure Report Page 22 of 26

5 PROJECT CLOSURE REPORT APPROVALS

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7 APPENDICES