DCF's records hold tragic legacy

Christopher Berry pleaded guilty in December in the death of his infant son, William, who had been under Department of Children and Families scrutiny. Credit: Josh Reynolds

By Jenifer B. McKim
New England Center For Investigative Reporting
September 19, 2015

Christopher Berry's troubles started long before he killed his infant son in 2013. After surviving a suicide bombing and returning from Afghanistan with post-traumatic stress in 2011, Berry racked uparrests for allegedly shoving his teenage girlfriend, deliberately running over pigeons, and stealing from his employer.

Yet, when state social workers got a report that the Lowell couple was neglecting month-old William James Berry in the spring of 2013, records show that they assigned the family to the "lower risk" category of state protection, for children considered not to be in immediate danger. These families are targeted for increased social services rather than a full investigation for potential abuse.

A month later, Berry lost his temper over the baby's crying, and shook him for 30 seconds until his body went limp.

“I was holding him, and I was like, ‘Oh, my God, Oh, my God, what did I just do?’ ” Berry told police in a recorded confession.

William is one of at least 110 children 17 and younger whose deaths were linked to abuse and neglect from 2009 through 2013 in Massachusetts, a third of whom had at some point been under the watch of the state Department of Children and Families. Many others were likely known to the state but never subject to DCF supervision. The rest died without ever having a chance at state protection.

Records obtained by the New England Center for Investigative Reporting show that the vast majority of the dead were under the age of 3, and had been beaten, drowned, smothered, or otherwise abused or neglected by caretakers. And their numbers have steadily increased, records show, from 14 reported abuse or neglect deaths in 2009 to 38 in 2013 — and state officials say the number will likely remain elevated when last year’s death toll is made public.

Most of these children’s stories have gone untold, either because their plight wasn’t known to the state until they died, or because the state’s missteps and failures to protect them were long concealed by confidentiality laws and secrecy. An examination of these latter cases shows that mistakes occur at all levels of the child welfare process — from at-risk youths the system failed to catch, to children with open social services cases who fell through the cracks, to infants like William who were funneled into a program meant for lower-risk situations that proved insufficient to save them.

DCF already has faced harsh criticism for failing to protect children under its watch, including Jeremiah Oliver, a Fitchburg toddler who disappeared and was later found dead by a highway last year, and 7-year-old Jack Loiselle of Hardwick, who fell into a coma in July after his father allegedly starved and beat him. Earlier this month, Governor Charlie Baker held a press conference to say that DCF “has many systemic problems and we are going to fix them . . . No one is standing here and saying everything is fine.”

However, many child specialists worry the state swings from one tragedy to the next without learning from past mistakes or implementing lasting reforms. The state’s basic child fatality data is faulty, review teams set up to analyze the causes of fatalities don’t often meet, and DCF social workers say they often are kept from learning anything about what went wrong when a child dies, the New England Center’s review found.

“It’s a very dysfunctional system. Not only is DCF failing, but the other eye of the state, the child fatality review teams, are largely nonfunctional,” said Dr. Robert Sege, a vice president at the Boston-based nonprofit Health Resources in Action who sits on a review team for Suffolk County that has not met for over a year. “How do you make improvements if you don’t open your eyes and look at what is going on?”

The New England Center and the Boston Globe obtained information about child abuse and neglect deaths caused by parents and caretakers through a public records request. Center staff also spent months reviewing court and police records, and interviewing families and child experts for this story, and found that:

■ Thirty-eight children who died from 2009 through 2013 had received services from state social workers, and 26 of those were under state supervision at the time of their deaths. It is thought that others had some contact with DCF, either to receive voluntary services or because their family was the subject of a complaint that social workers dismissed. But DCF declined to release information about complaints that had been rejected.

■A six-year-old DCF intake system for handling maltreatment complaints — opposed by the union that represents social workers — divides children into high-risk and lower-risk categories, and assigns the less

risky cases to workers with lower training requirements. From 2009 to 2013, 10 children on the lower-risk track died, including seven in 2013, records show, raising questions about whether the system has enough safeguards to protect children.

■ The DCF screening system does not require social workers to do criminal background checks on a child's caretakers when analyzing neglect and abuse complaints — a policy that some child advocates say leaves a huge gap in assessing risk.

■ The state keeps shoddy data on child deaths, and its child fatality review system is crippled by a lack of funds and resources. The New England Center found 10 children who were not included in state data even though their deaths were ruled to be homicides, and, in most cases, parents or other caretakers were implicated.

DCF Commissioner Linda Spears, named by Baker to run the agency in January, would not discuss individual cases that predate her tenure, but said that, much as a hospital emergency room has to determine the patients in the most urgent need of care, DCF has to better identify and protect the most vulnerable children.

DCF faces a daunting task in figuring out which situations are so dire that children need to be removed from the family setting, even though it could mean sending them to a foster home that may have its own problems. Responding to more than 92,000 child-abuse complaints last year, social workers substantiated 62,452 maltreatment complaints, a 34 percent increase over 2013, records show.

What needs refinement, Spears said, is how "we make decisions based on risk factors that we know in the case. . . I'm taking a very broad, systemic view."

In contrast to the headlines about Oliver and Loiselle, most abuse and neglect victims die with little public notice. That includes Dejalyse Alcantara of Boston, who was put under state watch at birth in 2011 because of her mother's drug abuse. She died six months later in an overheated car, her motherasleep or unconscious in the front seat. Two-year-old Yarelis Rosario-Pereyra of Boston died allegedly of abuse and neglect in 2013 even though social workers had confirmed that she suffered periods of maltreatment throughout her short life. No one has been charged in her death.

Peter MacKinnon, president of the DCF's chapter of the Service Employees International Union, Local 509, said social workers are devastated when a child dies on their watch, but seldom learn from their managers about what went wrong or how they could improve their work.

"If you are truly looking to get a sense from DCF about what you did well, what you might have missed, you need to see what that analysis is," he said. "If you don't know what you are doing" wrong, he said, "how can you fix it? It goes into this black hole."

Child fatalities — from natural and abuse-related causes — are supposed to be reviewed by a panel of experts, but the system has ground to a halt. The state review team, chaired by the Office of the Chief Medical Examiner, has filed just four reports since its launch 15 years ago, even though state law requires it to file findings and recommendations annually.

State officials say the review teams lack funding to do their work, but regular appeals for more money from the state Office of the Child Advocate have gone nowhere.

Spears called the rise in child maltreatment deaths “tragic but not surprising,” linking it partly to the state’s opioid crisis as well as an increase in reporting of infants who die suddenly due to unsafe sleep practices, such as sleeping with an adult, which state officials consider a form of neglect. Sixteen child deaths in 2013 were sleep-related, according to state reports, including five in families with histories of maltreatment.

And Spears said she expects the figure for last year, not yet finalized, to remain elevated. “I don’t think anything in the caseload and the community would give me any indication that the number will go down,” she said.

William James Berry’s shaking death, some say, points to weaknesses in a system launched in 2009 to help social workers separate cases where children are in imminent danger from those where the family simply needs help.

The grandmother of infant William Berry (right) reacted to a description of the child's death in court. Credit: Josh Reynolds

The shift in policy, which followed a national trend, was quickly embraced in Massachusetts: In 2013, 38 percent of child abuse reports were assigned to the lower-risk group, DCF records show.

The higher-risk cases, which include allegations of sexual or serious physical abuse or neglect, are referred to social workers whose primary purpose is to investigate and “determine the safety of the

reported child," state documents show. For children in the lower-risk group, the policy says, social workers are supposed to "engage and support families."

The state social workers union opposed the two-tier system from the onset, chapter president MacKinnon said, based on concerns that families considered at lower risk may get short shrift. Social workers who handle full investigations are provided more training on how to interview children and ferret out signs of abuse, he said, and staff members with less specialized training are assigned lower-risk cases.

Currently, caseworkers who handle lower-risk cases are less likely to interview the child away from parents, often a key to getting at the truth, explained Taunton DCF social worker Laurie Cyphers. They are also less capable, she said, of pushing parents to cooperate if they refuse state help. She worries that social workers with less experience and less training won't be able to accurately assess safety risks.

"They don't have the training and they don't have the experience to fall back on," said Cyphers, a 14-year DCF veteran who mainly oversees lower-risk cases.

There is no national data tracking deaths of children who had been placed on the lower-risk track. But there have been enough incidents, here and elsewhere, to lead some child welfare advocates to question the idea of a two-tier system. In Minnesota, for example, the murder of a 4-year-old boy who had been placed on the lower-risk track prompted statewide scrutiny and recommendations to narrow, and perhaps do away with, the program.

In Massachusetts, 3-year-old Alyvia Navarro was put on the less-severe track months before the autistic preschooler drowned in a pond behind a Wareham trailer home, in a death that DCF attributed to neglect, state records show. There's also 10-year-old Isaiah Buckner from Athol, who died from abuse and neglect-related injuries in July 2013, according to DCF, a case that remains unsolved. At least four other children on the lower-risk track died of what DCF determined were neglect-related unsafe sleep issues, records show.

Sharon Crawford, Isaiah's maternal grandmother, said she was not aware that her daughter was being visited by social workers. She said the state should have taken special care with her grandson, who was deaf and legally blind. She's angry that social workers never reached out to her because she was very involved in Isaiah's life.

"Something is not right here," said Crawford, 53, who lives in Whitinsville. She wonders why he would be placed on the lower-risk track, she said, "if he couldn't hear and couldn't talk?"

Before taking charge of DCF, Spears last year oversaw a report on the agency conducted by the Child Welfare League of America. The report found that DCF's budget cuts, lack of staff support, and growing caseloads compromise the effectiveness of the two-tier system. It also said DCF needs to put a higher priority on a "child's right to basic safety."

Spears, in her new role, affirms that the two-tier program needs to be tightened up. She noted that, when the system works properly, children can be shifted to the higher-risk group as social workers learn more about the families.

"We may walk in and find that something else is going on, at which point the case can then go back over to the investigation response track," Spears said. "The paths are not so distinct."

A new DCF review on Jack Loiselle, the Hardwick boy in a coma, found that social workers had dismissed multiple allegations of abuse and neglect as far back as 2008. When they finally opened a case

on the boy in February in response to two new complaints, the social workers placed him in the lower-risk category, records show.

Elizabeth Bartholet, a Harvard law professor and national critic of the two-track program, said the Loiselle report “screams out” that the social workers were more concerned with keeping the family together than ensuring the boy’s safety.

Especially for children in the lower-risk category, Bartholet said, the “best interest of the child is clearly not the standard.”

William Berry’s case, which did not get the same kind of public scrutiny as Jack Loiselle’s, also raises questions about how closely social workers studied the baby’s home life before concluding he was at low risk of harm.

When a maltreatment call comes in, individual caseworkers must decide which track to place a family on based largely on agency files and phone conversations, according to DCF documents. They can also request a criminal background check — a “Criminal Offense Record Information,” or CORI — though it’s not required.

DCF won’t say whether staffers checked Christopher Berry’s CORI when they received a neglect complaint in 2013. If they did, the review would have shown Berry was facing a series of pending criminal cases, including an allegation that he repeatedly shoved Tabatha Cupan, his 18-year-old girlfriend who was then pregnant with William, during a dispute in their Lowell apartment.

In the end, DCF assigned the family to the lower-risk group a month before Berry killed his son, state records show.

A Boston pediatrician and child-abuse expert, Dr. Eli Newberger, said that he was “appalled” to learn that social workers are not required to request a person’s criminal history as part of a screening, and that the state is ignoring key evidence that puts a child at risk.

Commissioner Spears said DCF hasn’t traditionally believed every neglect case requires that level of scrutiny, but agrees the agency needs to reexamine the role CORI checks can play in evaluating abuse and neglect complaints.

“We need to look at when CORI should be done, and we should make those things routine,” Spears said.

Of course, even a full-scale investigation is no guarantee that children will be safe. Dejalyse Alcantara, for instance, died in March 2012 even though she had been under state supervision since birth because of her mother’s substance abuse, DCF documents show.

D.J. Alcantara , Dejalyse’s father, had separated from her mother before the child’s birth to deal with his own drug problems. But now the Boston resident can’t stop thinking of what he could have done to save his baby, who died of heat exposure in the back seat of a car while her mother was passed out in the front seat. He said he told Boston police two weeks before Dejalyse’s death about his concerns for his daughter’s safety, citing the mother’s drug use. But the police report shows the concern was not relayed to DCF.

Marivette Morales, the mother, declined requests to comment for this story. But Alcantara wonders how social workers could have failed to see that his 6-month-old daughter was in danger. He said the baby didn’t even have a crib, and had slept on the couch for months.

Some argue that until DCF makes a clear commitment to put child safety above all else, including keeping families together, deaths like Dejalyse's will continue to be a troubling problem.

"Strengthening families and keeping children safe are both vital, but child safety must always take precedence," said Gail Garinger, former head of the state Office of the Child Advocate. "In some cases it may not be possible for vulnerable infants, especially those born prematurely or with drugs in their systems, to be safely maintained in their homes."

The New England Center for Investigative Reporting is an independent, nonprofit news outlet based at Boston University and at the studios of WGBH News (NPR/PBS) in Boston. NECIR interns Shan Wang, Bianca Padró Ocasio, Weiwen Zhao, Tessa Roy, Brittany Comak and Jordan Abosch, as well as Todd Wallack of the Globe staff contributed research to this project. Jenifer McKim can be reached at jmckim@bu.edu.

Downloaded on 9/29/15 from: https://www.bostonglobe.com/metro/2015/09/19/department-children-and-families-failing-child-abuse-deaths-rise/0PN3NejwBWx421u6jE53jI/story.html