OFFICE OF THE CHILD ADVOCATE

Monitoring Report: The Department of Human Services Institutional Abuse Investigations Unit

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February 3, 2005

Monitoring Institutional Abuse Investigations in New Jersey

Prepared by

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ACKNOWLEDGEMENTS

The Office of the Child Advocate acknowledges with enormous gratitude the support and collaboration of our colleagues in the development, implementation and publication of this audit of the Institutional Abuse Investigation Unit within the Department of Human Services. First and foremost, we thank the Center for Children and Families at the Rutgers University School of Social Work for their efforts in developing the research methodology, collecting and analyzing data, and preparing a preliminary report of the findings from the six-month IAIU review. We especially appreciate the leadership of Dean Mary Edna Davidson, a member of our Board of Advisors, for her tireless efforts to ensure that this audit at every turn reflected the highest standards of monitoring and research. Professors Paul Glasser and William Waldman of the Rutgers School of Social Work and Donna Van Alst, Associate Director of the Center for Children and Families, dedicated countless hours to the audit over the course of the last several months, and their contributions have been vital. We also appreciate the important efforts of Frederick Lowe, William Tatum, John Klena, Adam Staats and Brenda Francis.

We extend our thanks and appreciation to Sarah Morrison, Center for the Study of Social Policy, Washington, D.C. and Mary Coogan, Association for Children of New Jersey for their assistance in the developmental phase of this project.

We gratefully acknowledge the support and direction of Professor Diane DePanfilis of the University of Maryland School of Social Work, whose first audit of IAIU in the Winter of 2003 served as a model for our work. She was an enthusiastic supporter of this effort and enhanced the quality of our efforts immeasurably. Thanks, too, to Professor Gisele Ferretto, a member of the original DePanfilis research team, who traveled to New Jersey to train our team.

Thanks to Marcia Lowry, Susan Lambiase, Eric Thompson, and their colleagues at Children's Rights, Inc., for putting us in touch with Dr. DePanfilis and supporting our overall monitoring efforts in connection with the IAIU.

Finally, we express our thanks to Department of Human Services Commissioner James M. Davy, Assistant Commissioner Gerald Suozzo and Director of Program Compliance and Public Safety Lisa Taylor for their full cooperation with our data requests, including the timely production of IAIU files in September 2004.

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Section I. Introduction

Office of the Child Advocate

Created by statute in September 2003,[1] the Office of Child Advocate (OCA) is a State child protection agency with the authority to investigate any New Jersey State agency's response to an allegation of child abuse or neglect and to review and make recommendations concerning the procedures established by any such agency that provides child protection or permanency services.

The OCA is statutorily mandated to monitor and evaluate the activities and practice of the Institutional Abuse Investigation Unit (IAIU), which was formerly a part of the New Jersey Division of Youth and Family Services (DYFS), and is now (since July 2003) located in the New Jersey Department of Human Services (DHS), Office of Program Integrity and Accountability. The OCA's monitoring of the IAIU includes the review of the daily referrals and final investigative reports prepared by the IAIU. In addition to these routine monitoring activities, the OCA conducted a statewide audit of randomly selected IAIU investigative files. The goals of the OCA's ongoing monitoring activities are:

- To monitor the screening of institutional abuse allegations;
- To determine if the safety of each child potentially at risk of abuse or neglect has been secured at the termination of the investigation;
- To ascertain if the investigative activities of the IAIU lead to safer out-of-home placements for the children of New Jersey; and
- To identify out-of-home settings where children are potentially at risk.

In October 2004, the OCA contracted with the Center for Children and Families (CCF), an applied social science research training center affiliated with Rutgers, The State University of New Jersey to assist with its monitoring of IAIU investigations of alleged child maltreatment.

To assist the OCA in carrying out its monitoring function the CCF, in conjunction with the OCA, developed a rigorous, research-based case review process in compliance with human subjects guidelines. Tasks included (1) identifying and training child welfare experts to serve as case reviewers; (2) managing the data collection process; (3) analyzing data from the case review process; and (4) preparing a preliminary report of the findings. The final report, prepared by the OCA, delineates and presents the findings of this monitoring study. The report presents an (1) overview of the IAIU; (2) methodological details of the study; (3) findings from the audit, including (a) a description of the characteristics of reports of alleged child abuse and neglect in out-of-home care settings in New Jersey, (b) an assessment of whether the decision-making related to required investigative procedures was formed with reasonable professional judgment, and (c) a description of the investigative response to the reports; and (4) recommendations to strengthen the IAIU investigative practice and operations and to enhance the efficacy of the

[1] *N.J.S.A.* 52:17D-1 to -11.

system, specifically targeted towards improving the safety of out-of-home care settings and framing potential areas of consideration for future monitoring efforts.

Purpose of the Institutional Abuse Investigation Unit

The DYFS Field Operations and Casework Procedures Manual (IIA 1008.3) identifies the IAIU as "a child protective service investigative unit, which responds to allegations of neglect and abuse in out-of-home institutional settings".[2] Although the IAIU has been moved administratively to the DHS, the unit continues to be governed by policies and procedures effectuated by the DYFS.

The findings of IAIU investigations are integrated into the DYFS' Quality Assurance network through the forwarding of completed reports to appropriate licensing or contracting units. The IAIU also issues requests for corrective action plans along with reports of findings to affected entities and monitors responses to such requests. (The Office of the Public Defender, Law Guardian Unit undertakes conflict investigations, where allegations of abuse are made against DYFS staff or members of their families. This unit also investigates alleged incidents in Vineland and Ewing Residential Treatment Centers and the Woodbridge Child Diagnostic and Treatment Center which are owned and operated by the DYFS). The purpose of their investigative effort is to determine whether children in out-of-home care settings have been abused or neglected[3] and to ensure their safety by requesting corrective actions ameliorating the risk of future harm. The IAIU is comprised of a Central Office and four regional investigative offices – Northern, Southern, Central and Metropolitan.

Once a report is accepted for IAIU investigation, the investigation should be completed and a findings report submitted to the IAIU Statewide Supervisor within 45 days.[4] Within 15 days of receipt of the report, the IAIU Statewide Supervisor and Administrator should review decisions and findings before formally sharing them with the facilities and their supervising authorities. The IAIU Statewide Supervisor and/or Administrator must approve and sign the letter of findings and provide copies to the appropriate parties.[5]

Background Study

Pursuant to a federal class action lawsuit brought in 1999 on behalf of children in out-of-home care by Children's Rights, Inc. against the DHS and DYFS,[6] a similar independent research

[2] DYFS (7-1-1992). IAIU Support Operations Manual, III E Institutional Abuse and Neglect, 302: Out-of-Home Care Setting Defined defines an out-of-home care setting as any facility, public or private, in-state or out-of-state, that provides children with out-of-home care, supervision or maintenance. Out-of-home care settings include but are not limited to, correctional facilities, detention facilities, treatment facilities, schools (public or private), residential schools, shelters, hospitals, camps or day care centers that are licensed or should be licensed, resource family homes and registered family day care homes.

[3] As defined by statute at *N.J.S.A.* 30:40C-12 or 9:6-8.21.

[4] DYFS (4-4-2003). IAIU Support Operations Manual, III E Institutional Abuse and Neglect, 403: Investigation Report - Format.

[5] *See* DYFS (4-14-2003). IAIU Support Operations Manual, III E Institutional Abuse and Neglect, 408(24): Procedures for Investigation and Services When Abuse or Neglect are Alleged in a DYFS Foster Home or Para-Foster Home or an Adoptive Placement Not Yet Finalized; and 701: Monitoring (Corrective Action Process).

[6] *Charlie and Nadine H. et. al. v. McGreevey*, Civ. Action No. 99-3678 (SRC).

review was undertaken in 2003 by the University of Maryland School of Social Work, Center for Families and Institute for Human Services Policy, under the direction of Diane DePanfilis, Ph.D. (hereinafter "DePanfilis study").[7]

The DePanfilis study focused on children placed in DYFS out-of-home care settings including foster homes, residential treatment facilities and group homes. The review, conducted by an independent research team made up of child welfare experts, was conducted on a 10% random sample of the total population of investigative files from the IAIU between 1999 and 2002. The study sample included a total of 195 children in 129 investigations. Readers reviewed and coded information related to the process and IAIU decisions in those cases. The DePanfilis study found a routine failure of IAIU to investigate allegations adequately. The systemic deficiencies identified in the study illuminated concern that children in out-of-home care were at risk of harm in DYFS placements known to be abusive and neglectful, and that no assurances could be given that any child in DYFS out-of-home care was safe.

One of the most dramatic findings from the study related to the quality of IAIU decision-making. The DePanfilis study determined that the IAIU findings decisions were professionally unreasonable 25% of the time. The findings decisions were deemed to be inconsistent with the exercise of reasonable professional judgment thereby leaving children at risk of future harm in settings that remained open DYFS placements.

Additionally, reviewers in the DePanfilis study noted that IAIU routinely conducted overly legalistic and narrow investigations, frequently failing to collect, integrate and critically analyze the available information with reasonable professional judgment. The DePanfilis study concluded that the IAIU was not adequately assessing risk to children in out-of-home care, leaving those children at risk.[8]

Finally, the DePanfilis study determined that investigations were routinely delayed, in violation of DYFS policy and professional standards. The DePanfilis study indicated that 50% of investigations were finalized beyond the 60 day timeframe mandated in agency policy.

Aim of this Study

The present study expands upon the DePanfilis study. The earlier report was limited to investigations of children in residential care settings while the present review includes all children in out-of-home care settings in which there was alleged abuse, including such places as institutions, day care centers and schools. The audit tool and coding procedures were amended to support and account for these differences.

This cross-sectional archival case review was designed to accomplish a three part purpose: (1) to describe the characteristics of reports of alleged child abuse and neglect in out-of-home care in New Jersey, (2) to assess whether the decision-making related to required investigative

[7] DePanfilis, Diane (2003). Final Report: Review of Investigations of Suspected Child Abuse and Neglect in DYFS Out-of-Home Care Settings in New Jersey, University of Maryland School of Social Work, Baltimore, MD.
[8] DePanfilis, pp. 8, 38.

procedures was formed with reasonable professional judgment and (3) to describe the investigative response to the reports.

Section II. Methodology

Sampling Procedures

The OCA audited cases from the IAIU that were referred and accepted for investigation from November 1, 2003 through May 31, 2004. This time frame was selected to allow the DHS six months from the issuance of the DePanfilis study to implement corrective actions in IAIU practice. During the six-month period, the DHS issued a corrective action plan to address the issues raised in the DePanfilis study in July 2003 and provided a status report on the corrective action in October 2003.

The OCA obtained a list of all available child abuse and neglect reports regarding children in out-of-home settings received and investigated by the IAIU during the above time frame. There were 1,613 cases referred and accepted for field investigation during the designated review period. The study encompassed a systematic 10% sample (~161 cases). This sample sizes generates a maximum width of 95% confidence intervals for proportions of binary (i.e., yes, no) of plus or minus 8%. The systematic design of selecting every 10 cases ensured that the sample was representative with respect to the timing of the 1,613 cases. The 1,613 cases were sampled as follows:

- The data base was sorted by IAIU number, which is the order in which the case was filed.
- Starting with the fifth IAIU number, every tenth case was chosen; i.e. beginning with case #5, we took case #5, #15, #25…..#1605 ordered by IAIU number.

During the course of the study there were four occasions when a case had to be replaced due to missing information, yet it was necessary to preserve the sample size. In that event, the study process required a return to the original listing to identify the case needing replacement and selection of the next consecutive case. If a second replacement was required, the protocols required moving to that case's location and again selecting the next consecutive case. For example, if IAIU case #25 needed to be replaced due to missing data, it would be replaced with IAIU case # 26. If the replacement IAIU case # 26 then also had to be replaced due to missing data, the replacement would be case # 27, and so on. This design ensured that each replacement case was selected from the same relative time frame in the designated review period, and thereby practice was likely to have been influenced by corrective measures in progress.

The 161 cases were reviewed by six members of the research team. Each case was randomly assigned to one of these six readers. Cases were read by a second reader if (1) the first reader requested that the case be reviewed by a second reader or (2) if the first reader disagreed with IAIU findings on the case. Forty of the 161 cases were read by a second reviewer for either of these reasons. In addition, a second reader conducted an audit of 20 randomly-selected cases.

Hence, a total of 60 cases were reviewed by two readers. In the 60 cases that were reviewed by two readers, coding by the second reader or the auditor was used for this study. The number of cases coded by each reviewer is presented in Table 1. It should be noted that one reviewer coded more than 42% of the cases used in this study.

Table 1
Number of Cases Coded by Each Case Reviewer (n=161)

Reviewer	# Cases Reviewed	Percent
A. Bonds	68	42.2
A. Jones	34	21.1
F. Lowe	26	16.1
K. Ryan	5	3.1
J. Sabin	10	6.2
W. Waldman	18	11.2
Total	161	100.0

Confidentiality

The case records reviewed for this study contained personal information about the alleged child victims and their families, the alleged perpetrators, and out-of-home-care settings. Unfortunately, the nature of the study and the complexity of the IAIU case records prohibited the removal of identifiers from the reviewed files. Further, redaction of identifying information would have diminished the reviewers' capacity to assess effectively the investigative information.

Several safeguards were employed to protect the privacy of each party in each case. First, the coding sheet and database developed to manage the information extracted from each case through the file review process did not capture any personal identifiers such as name, date of birth or community of residence. Second, a unique number was assigned to each IAIU case by the research team for file tracking purposes. This number was used by case reviewers when recording case information, entering information into the database, and filing hard copies of case materials. Third, prior to accessing any of the files, all researchers and reviewers completed human subjects certification through Rutgers University and signed a confidentiality statement affirming an agreement to not disclose any identifiable information to any person not part of the research team. Fourth, all documents related to this research project were maintained in a locked facility. Only researchers and reviewers involved with this study were granted access to the room. Finally, the Rutgers University Institutional Review Board reviewed the research protocol for this study and approved the procedures through its expedited review process.

Definitions

Definitions and coding procedures were specified for each data element in the coding system (see Appendix B). This included using New Jersey definitions of physical abuse, sexual abuse, neglect, emotional abuse or neglect, and definitions of substantiated, unsubstantiated and unfounded. To identify sub-types of neglect and classify severity of child abuse or neglect, researchers used guidance from New Jersey policy, supplemented by frameworks previously used in the DePanfilis study and the researchers' own experience.

Training for Readers

The six readers selected to conduct the case reviews all have extensive prior experience in investigating allegations of child abuse or neglect. Four of the readers are trained in social work and two hold *juris doctor* degrees. Four readers are staff members from the Office of the Child Advocate. The remaining two readers are affiliated with the School of Social Work at Rutgers University.

To ensure consistency in the reviews, readers attended a day-long training session facilitated by one of the reviewers in the DePanfilis study. The training session covered the purpose and intent of every question on the coding sheet, clarified references to IAIU investigative policies, integrated the knowledge and experience of readers to maximize consistency in interpretation of information, and established procedures to settle potential coding disagreements. In addition, a log book of common questions and concerns was maintained throughout the study to ensure consistency in coding. Finally, a staff member from the Office of the Child Advocate served as the final authority on any questions that arose regarding coding.

Data Analysis

Research staff entered data into a database and analyzed using the Statistical Program for the Social Sciences (SPSS) software. Specific analysis techniques for quantitative data included frequencies, measures of central tendency and cross-tabulations. Due to rounding, percentages reported in tables may not be exactly 100%. Staff analyzed qualitative data using standard content analysis procedures. Particular attention was paid to common themes that emerged in response to each of the questions.

Section III. Findings

Case Demographics

This section provides descriptive information on the sample of cases reviewed in this study. This information includes the geographic location, site of alleged maltreatment, source of the referral, type of alleged maltreatment, designated response time and demographic information on the alleged victims including gender, race and age.

Description of Geographic Region

During the designated review period, the screening unit for IAIU assigned referrals for investigation based upon the DYFS regional designations.[9] As shown in Table 2, there was a relatively equal distribution of cases among the four regions, with the Southern region having 28.6%, slightly more than the others.

Table 2
Number of Cases Reviewed in Each New Jersey Region (n=161)

Region	Frequency	Percent
Central	37	23.0
Metropolitan	41	25.5
Northern	37	23.0
Southern	46	28.6
Total	161	100.0

Description of Child Victims

More than three-fourths of the cases involved only one child, although there were three cases in which the alleged abuse involved five children (see Table 3). Among the 161 cases reviewed, there were 224 children who were alleged victims of abuse and neglect. The average number of alleged victims per case was 1.39. It is important to note that not all children in an out-of-home care setting were allegedly maltreated in each incident.

Table 3
Number of Alleged Victims per Report (n=161)

# Alleged Victims	Case Frequency	Percent	Total Alleged Victims
1	123	76.4	123
2	23	14.3	46
3	8	5.0	24
4	4	2.5	16
5	3	1.9	15
Total	161	100.0	224

Almost 60% of the 224 alleged victims were boys and slightly more than 40% were girls (Table 4). Among these children approximately half were Black (50.4%), with the next largest groups

[9] The Central Region includes Hunterdon, Mercer, Monmouth, Ocean and Somerset counties. The Metropolitan Region includes Essex, Union and Middlesex counties. The Northern Region includes Bergen, Hudson, Morris, Passaic, Sussex and Warren counties. The Southern Region includes Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem counties.

being White (20.5%) and Hispanic (8.9%) (Table 5). The mean age for the alleged child victims was 9.4 years old; the median age was 10 years old; and the modal age was in the 11 to 14 year old range (Table 6). More than 47% of the alleged child victims were 9 years old or younger.

Table 4
Gender of Alleged Child Victims (n=224)

Gender	Frequency	Percent
Female	90	40.1
Male	134	59.9
Total	224	100.0

Table 5
Ethnicity Characteristics of Alleged Child Victims (n=224)

Ethnicity	Frequency	Percent
Black	113	50.4
White	46	20.5
Hispanic	20	8.9
Other	20	8.9
Unknown	25	11.1
Total	224	100.0

Table 6
Age of Alleged Child Victims (n=224)

Age	Frequency	Percent
4 or younger	50	22.3
5 to 9	56	25.0
10 to13	56	25.0
14 to17	60	26.7
Missing	2	.8
Total	224	100.0

Description of Placement Settings

In keeping with the mandate of the IAIU to investigate allegations of child abuse or neglect in varied types of out-of-home care settings, this study examined investigations beyond residential settings. At the time of the alleged maltreatment the largest number of children were in resource family homes (33.4%) (Table 7). However, there were also significant numbers in public/private schools (24.5%), congregate care placements (15.6%), and child-care settings (13.3%).

Table 7
Placement Setting at Time of Alleged Incident (n=224)

Placement Setting	Frequency	Percent
Resource (Foster) Family Placement[10]	75	33.4
Corrections	5	2.2
Congregate Care Placement [11]	35	15.6
Hospital	4	1.7
Bus Company	2	.8
After School Program	1	.4
Child Care[12]	30	13.3
School[13]	55	24.5
Detention	14	6.2
DDD	3	1.3
Total	224	100

Source of Reports

The IAIU may receive reports of alleged child abuse or neglect directly from the individual with knowledge of the incident or through an intermediary source. Table 8 captures the nature of original reporting sources and the frequency with which each source made reports to IAIU. The majority of original reports of maltreatment were made by facility staff (19.3%) and DYFS staff (16.8%). Facility administrators and school staff also made a considerable number of referrals. As shown in Table 9, sources of reports to the IAIU (as derived from all original sources) were quite varied with no discernable pattern or trend.

[10] Resource (foster) family placement includes DYFS and contracted resource family homes, relative care homes and pre-finalized adoptive homes.
[11] Congregate care placement includes residential placements, group homes, and children's shelters.
[12] Child care includes child day care and registered family day care homes.
[13] School includes public, private and religious schools.

Table 8
Original Sources of Reports (n=161)

Source of Report	Frequency	Percent
Facility Staff	31	19.3
DYFS	27	16.8
Facility Administration	22	13.7
School	20	12.4
Parent	17	10.6
Other Agency	13	8.1
Health	10	6.2
Anonymous	5	3.1
Police	5	3.1
Correctional Facility	4	2.5
Relative	2	1.2
Friend/Neighbor	2	1.2
Community/Group/Individual	2	1.2
Not Applicable	1	.6
Total	161	100.0

Table 9
Sources of Reports to IAIU (n=161)

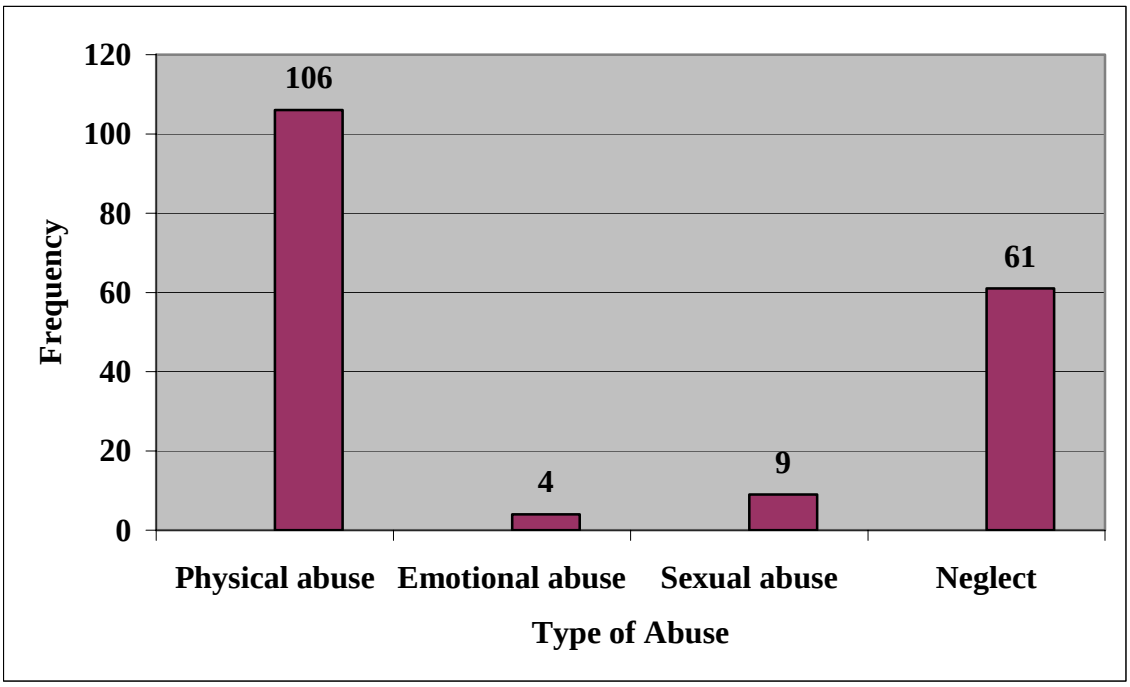
Source of Report to IAIU	Frequency	Percent
DYFS	44	27.3
Office of Child Abuse Control	36	22.3
Residential Facility	6	3.7
Other	75	46.5
Total	161	100.0

Types of Alleged Maltreatment

Each referral to IAIU may encompass a single allegation of abuse/neglect, or it may include allegations of more than one type of child maltreatment. For example, the referent may allege that the child victim was sexually abused and that the caregiver failed to obtain medical care for the child (medical neglect).

As shown in Figure 1, the 161 cases involved 180 types of alleged maltreatment. Most of the cases had only one type of maltreatment alleged. Physical abuse was the most frequent type of alleged maltreatment (58.8%), followed by neglect (33.8%), sexual abuse (5%) and emotional abuse (2.2%).

Figure 1
Type of Alleged Complaint in 161 Reviewed Cases (n=180)



Description of Alleged Perpetrators

As with allegations of types of maltreatment, each referral may include more than one perpetrator. The 161 cases reviewed involved 186 alleged perpetrators (Table 10). In 115 cases (71.4%) there was only one alleged perpetrator. In 26 cases (16.1%) there were two alleged perpetrators. In 15 cases (9.3%) the number of perpetrators was unknown. Among the 182 perpetrators in this sample for whom detailed information was collected, 59 (32.4%) were institutional staff, 53 (29.1%) were teachers or school staff, and 44 (24.1%) were foster parents (Table 11).

Table 10
Number of Alleged Perpetrators in 161 Reviewed Cases (n=186)

Number of Alleged Perpetrators in Reviewed Cases	Frequency	Percent	Total Alleged Perpetrators
1	115	71.4	115
2	26	16.1	52
3	2	1.2	6
4	2	1.2	8
5	1	< 1.0	5
Unknown Number	15	9.3	--
Total	161	100.0	186

Table 11
Type of Alleged Perpetrators (n=186 alleged perpetrators in 161 Reviewed Cases)

Type of Alleged Perpetrator	Frequency	Percent
Foster parent	44	24.1
Adoptive parent	3	1.6
Relative	5	2.7
Teacher/School staff	53	29.1
Institutional staff	59	32.4
Registered day care provider	6	3.2
Other	10	5.4
Unknown	2	1.0
Total	182[14]	100.0

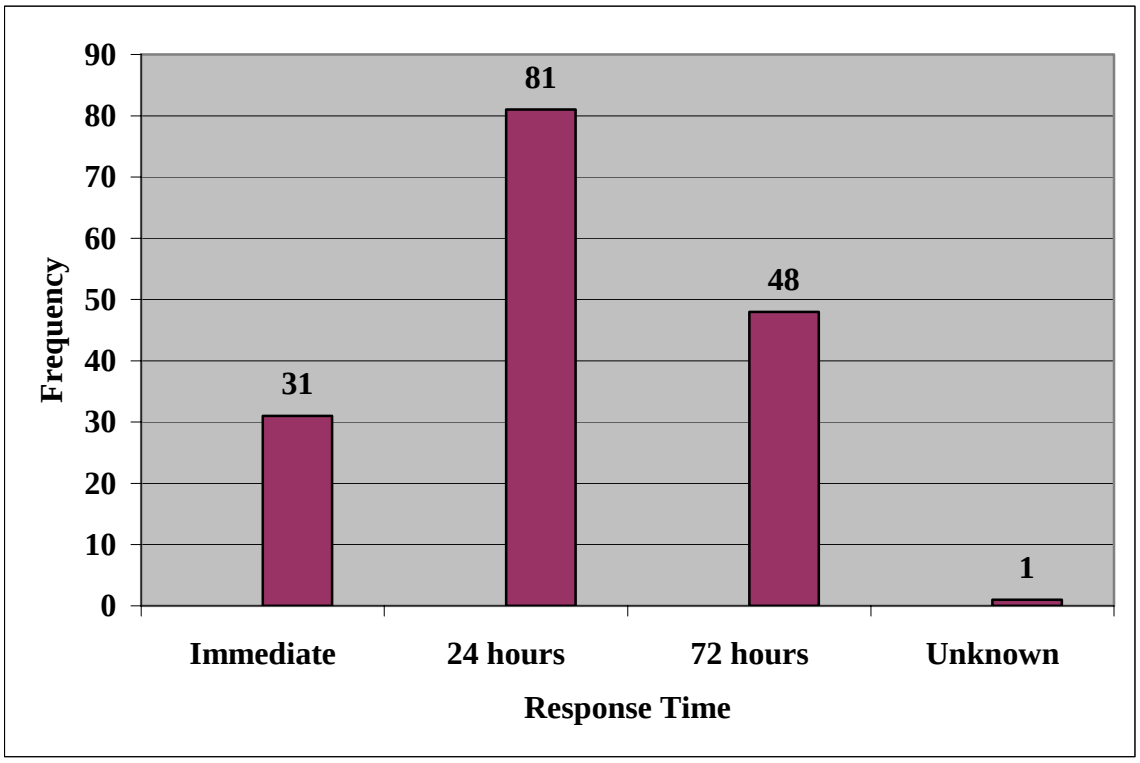
Designated Response Time

Figure 2 provides the designated response time by IAIU at the point of screening. In 31 cases (19.2%), the designated response was immediate. In 81 cases (50.3%), the designated response

[14] Data was collected on a maximum of three alleged perpetrators per case. There were two cases that involved four alleged perpetrators and one case that involved five alleged perpetrators. Hence, four alleged perpetrators are absent from this table.

time was within 24 hours. In 48 cases (29.8%), the designated response time was within 72 hours. In one case the designated response time was unknown.

Figure 2
Designated Response Time by IAIU at Screening (n=161)



Reader Concurrence with IAIU Decision-Making

The degree to which IAIU findings were consistent with the reasonable professional judgment of the readers given the information documented in the investigative files was evaluated**.** IAIU findings are based on the preponderance of credible evidence. During the period for this audit, the IAIU investigator had several findings options available for each type of maltreatment alleged: substantiated, not substantiated (the "not substantiated" finding may be accompanied by child welfare concerns encompassing issues that do not place the immediate safety of the child at risk, but if left unaddressed may cause future harm to the specific child or another child), and unfounded. Appendix B provides definitions and considerations for reaching each of the findings delineated.

IAIU Findings by Region

Among the 161 cases in the sample, IAIU investigators substantiated 10 (6.2%). As shown in Table 12, the number of substantiated cases by region varied considerably, with the Northern

region having the highest percentage (10.8%) and the Southern Region having the lowest percentage (2.2%).[15] As reflected in Table 12, the IAIU had not reached a finding, i.e. the investigation was incomplete, in 30 (18.6%) of the investigations reviewed in this study.

Table 12
Comparison of Investigation Finding by Region (n=161)

	Nature of Finding				
Region	**Substantiated**	**Not Substantiated**	**Unfounded**	**No Finding**	**Total**
Central	3	7	21	6	37
Metropolitan	2	13	11	15	41
Northern	4	12	17	4	37
Southern	1	16	24	5	46
Total State	10	48	73	30	161

Reader Concurrence with IAIU Findings

There was some disagreement between the IAIU investigators and the professional readers. As shown in Table 13, the readers found 11 cases that were not substantiated that they believe should have been, and 10 cases that were unfounded that they believe should have been categorized as either substantiated or not substantiated.

Some examples of professionally unreasonable case findings classified as "Not Substantiated" by IAIU include the following: (1) The investigator found that inadequate staffing and vague policy regarding supervision of children with developmental delays in a group home left the children at risk of harm. The findings letter indicated that the administration was aware of flaws but had taken insufficient steps to remedy problems, leading to one child being left unsupervised with another, who repeatedly bit the victim, including on his buttocks. (2) The IAIU and ARC workers concluded that there were continuous incidents in which the pre-adoptive father beat the children with a belt and the pre-adoptive father admitted it. The investigators determined that the pre- adoptive mother also beat the children. The couple had been repeatedly warned by DYFS and IAIU to refrain from slapping the children. Despite the pre-adoptive father's own admission to beating his foster child with a belt, IAIU did not substantiate abuse. (3) The IAIU investigator concluded that the teacher grabbed a 12 year old boy causing the child's neck to redden and sting. The investigator concluded the actions were inappropriate, unnecessary and unjustified but did not substantiate abuse. (4) An investigator concluded inadequate staffing and vague supervision policies at a secure correctional facility allowed one youth to stab another with a pencil in the head while unmonitored in a basement. (5) The IAIU investigator determined that a juvenile detention officer cut a 14 year old boy on the throat with her fingernail or key, opening a ½ inch wound. Although the investigator determined the use of physical force was unnecessary and inappropriate abuse was not substantiated.

[15] Prior to the commencement of this audit, in the course of daily monitoring of final investigative reports, the OCA determined that the original finding on a case was in error. The OCA contacted the DHS/IAIU to request an administrative review of the finding. The finding was changed from "not substantiated" to "substantiated". This same case presented subsequently within this audit and represents the only substantiated finding for the Southern Region during the audit period.

Some examples of professionally unreasonable case findings classified as “Unfounded” by IAIU included: (1) The investigation revealed that a residential treatment center did not timely respond to an eye injury suffered by the child victim. The child was injured during a basketball game and repeatedly asked to see a nurse or doctor. Further, the facility delayed sending the child to a doctor and delayed obtaining prescribed medicine. The log entry regarding the need for eye surgery was not credible as the entry was made only after the incident was under investigation by IAIU. (2) It was not resolved in the investigation whether injury resulted from horse play (neglect) or a restraint (potential abuse); in either case a finding of "unfounded" is incorrect. Other serious conflicts in testimony were not resolved. (3) The IAIU did not conduct its own investigation, but instead made a finding based on secondary information. There was some evidence that the alleged perpetrator may have punched the child in the face with his keys.

Table 13
Comparison of Reader Agreement with IAIU Investigative Finding (n=161)

	IAIU Investigative Finding				
Reader Agreement	**Substantiated**	**Not Substantiated**	**Unfounded**	**No Finding**	**Total**
Finding Not Reasonable	0	11	10	0	21
Finding Reasonable	10	34	58	0	102
Unable to Determine	0	3	5	0	8
Not Applicable	0	0	0	30	30
Total:	10	48	73	30	161

As reflected in Table 13, the readers agreed with the substantiated decision 100% of the time. Of the 131 investigations where a finding was rendered by IAIU, the readers found the overall IAIU findings decision to be professionally reasonable in approximately 78% of the cases. The readers disagreed with 22.9% of the not substantiated findings and 13.6% of the unfounded findings. Forty-four (44) of the 48, or 91.6%, of the unsubstantiated investigations were “not substantiated with concerns”. Of these 44 cases, the readers disagreed with the IAIU in 11 (25%) investigations and determined that the allegations should have been substantiated. The IAIU had not reached a finding, i.e. the investigation was incomplete, in 30 (18.6%) of the investigations reviewed in this study. In 8 of the 131 (6.1%) investigations where a finding was rendered by IAIU, the readers found insufficient documentation to determine agreement or disagreement with the finding.

Abuse and Neglect Identified by Readers

As shown in Table 14, readers identified one type of abuse or neglect in 68 cases. In 15 cases, readers identified two types of abuse or neglect. In one case, readers identified three types of abuse or neglect.

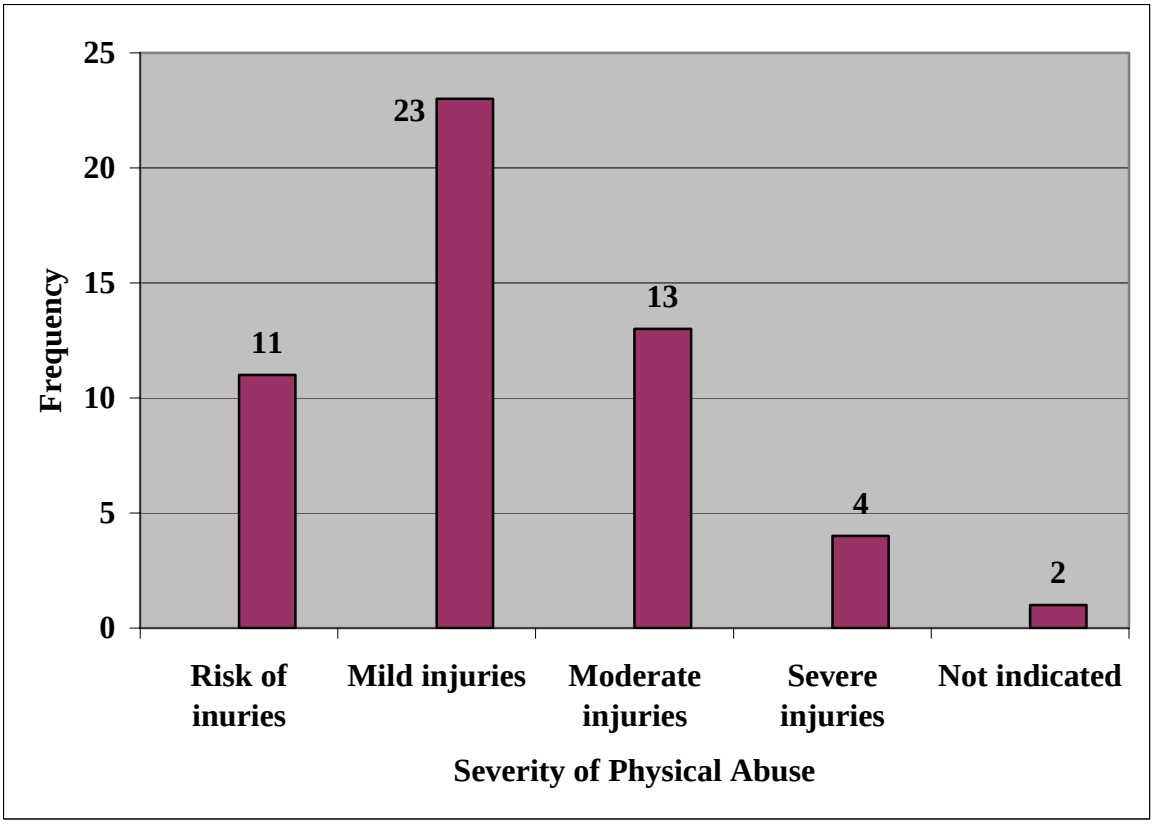
Table 14
Types of Abuse or Neglect Identified by Readers (n=84)

Types of Abuse	Number of Cases	Percentage
Physical abuse only	38	45.2
Sexual abuse only	2	2.4
Neglect only	25	29.8
Emotional abuse/emotional neglect only	3	3.5
Physical abuse and neglect	9	10.7
Physical abuse and emotional abuse	5	6.0
Neglect and emotional abuse	1	1.2
Physical abuse, neglect and emotional abuse	1	1.2
Total cases in which readers identified abuse or neglect	84	100.0

Cases Involving Physical Abuse

As shown in Table 14, readers identified 53 cases involving physical abuse (38 cases involving physical abuse alone; 9 cases involving physical abuse and neglect; 5 cases involving physical and emotional abuse and 1 case involving physical abuse, neglect and emotional abuse). As shown in Figure 3, 17 of these 53 cases (32%) were classified as either "moderate" or "severe" abuse based on documentation of excessive force or inappropriate caregiver action that resulted in injuries that required medical care. Cases were coded as having a "risk of injury" if information in the investigative file documented excessive force or inappropriate caregiver action that suggested a risk of injury but no injuries were sustained. Cases were classified as having "mild consequences" if there was documentation of excessive caregiver force or inappropriate action resulting in superficial injuries that did not require medical care.

Figure 3
Severity of Physical Abuse (n=53)



Using New Jersey's definition of physical abuse, the readers and IAIU came to different conclusions regarding the findings in 13 cases. In nine cases IAIU classified the alleged maltreatment as "not substantiated with concerns" whereas the readers would have substantiated the allegations. In three cases IAIU concluded that the allegations were "unfounded" while the readers would have classified the allegations as "not substantiated". In the remaining case where the IAIU finding was unfounded, readers concluded the finding should have been substantiated (Table 15). The IAIU had not reached a finding, i.e. the investigation was incomplete, in 16 (30.1%) of the physical abuse investigations reviewed in this study.

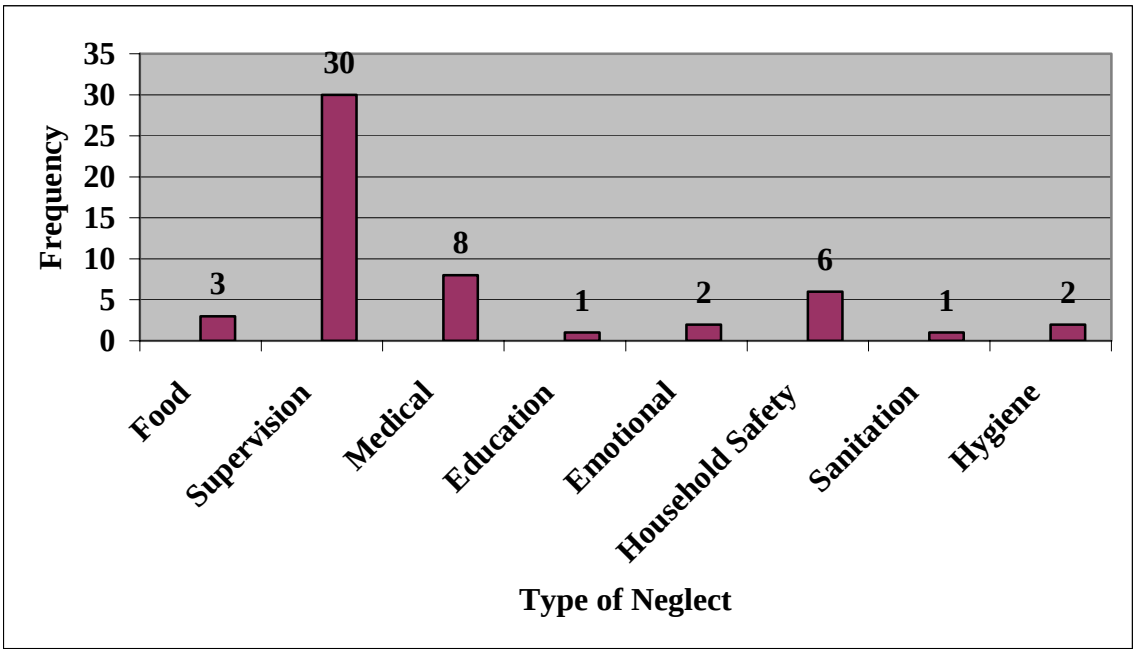
Table 15
Comparison of Reader Agreement with IAIU Finding for Cases in Which Readers Identified Physical Abuse (n=53)

	IAIU Investigator Decision				
Reader Agreement with IAIU Investigator Decision	**Substantiated**	**Not Substantiated**	**Unfounded**	**No Finding**	**Total**
Finding Was Not Reasonable	0	9	4	0	13
Finding Was Reasonable	8	13	2	0	23
Unable to Determine	0	0	1	0	1
Not Applicable – no finding by IAIU	0	0	0	16	16
Total	8	22	7	16	53

Cases Involving Neglect

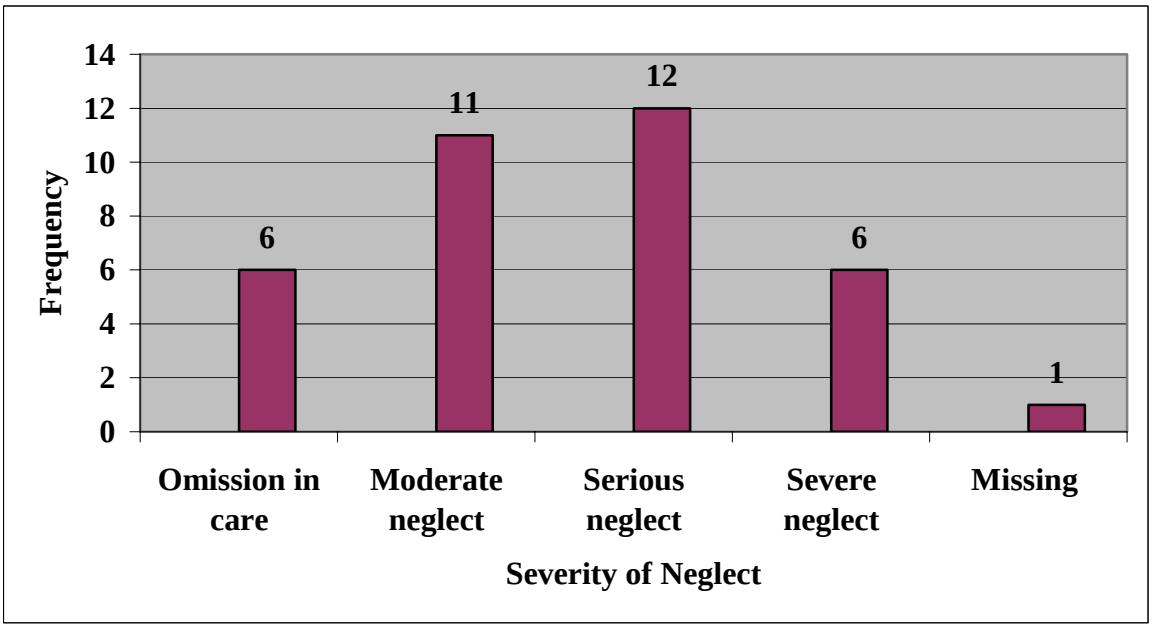
As previously shown in Table 14, readers identified neglect in 36 cases (25 cases involving neglect only; nine cases involving physical abuse and neglect; one case involving neglect and emotional abuse; and one case involving physical abuse, neglect and emotional abuse). Figure 4 provides details on types of alleged neglect by out-of-home caregivers. Among the 36 cases, readers identified 53 allegations of neglect. Hence, some cases involved more than one type of neglect. Thirty cases involved a lack of supervision, while 6 cases involved medical neglect. There were no allegations of neglect to shelter or clothing.

Figure 4
Types of Neglect by Out-of-Home Caregivers (n=53)



The severity of neglect also was evaluated using New Jersey's definition of neglect. As shown in Figure 5, 18 cases (50%) were coded as involving severe or serious neglect, 11 cases (30.5%) were found to involve moderate neglect, and six cases (16.6%) were identified as involving an omission in care. The severity of neglect was not reported for one case.

Figure 5
Severity of Neglect (n=36)



Using New Jersey's definition of neglect, professional readers and IAIU investigators came to different conclusions regarding the findings in 13 cases (Table 16). In three cases the IAIU concluded that the allegations of neglect were "unfounded" while professional readers would have classified the allegations as "substantiated". In five cases the IAIU concluded that the allegations of neglect were "unfounded" while professional readers would have classified the allegations as "not substantiated". In the five unsubstantiated cases, IAIU investigators issued a finding of "not substantiated with concerns" while the professional readers would have substantiated the allegations. The IAIU had not reached a finding, i.e. the investigation was incomplete, in 7 (19.4%) of the neglect investigations reviewed in this study

Table 16
Comparison of Reader Agreement with IAIU Finding for Cases in Which Readers Identified Neglect (n=36)

	IAIU Investigator Decision				
Reader Agreement with IAIU Investigator Decision	**Substantiated**	**Not Substantiated**	**Unfounded**	**No Finding**	**Total**
Finding Was Not Reasonable	0	5	8	0	13
Finding Was Reasonable	4	7	2	0	13
Unable to Determine	0	1	2	0	3
Not Applicable – no finding by IAIU	0	0	0	7	7
Total	4	13	12	7	36

Cases Involving Both Physical Abuse and Neglect

The readers and IAIU investigators came to different conclusions regarding the findings in five of the nine cases involving both physical abuse and neglect. In one case, IAIU investigators concluded that the allegations were "unfounded," while professional readers would have classified the allegations as "not substantiated". In one case, the IAIU concluded that the allegations were "unfounded" while professional readers would have classified the allegations as "substantiated". In three cases, IAIU investigators issued a finding of "not substantiated with concerns" while professional readers would have substantiated the allegations.

Cases Involving Emotional Abuse, Emotional Neglect or Sexual Abuse

Readers identified emotional abuse or emotional neglect in three cases and sexual abuse in two cases. There was no disagreement between the IAIU and the readers.

Compliance with IAIU Policies and Procedures

This section provides descriptive information on the degree to which the reviewed cases complied with IAIU policies and procedures. Specific information was collected on the timeliness of interviews with the child victim, the timeliness of case completion, investigation of alleged perpetrators involvement in previous allegations of child maltreatment and interviews with witnesses and involved parties.

Timeliness of Interviews with Child Victims

New Jersey policy and professional standards require that the child who was allegedly abused be interviewed face-to-face and privately. This was done in 143 (88.8%) of the 161 cases reviewed. No interviews were done in 13 cases (8.1%). In one case there was both a telephone interview and a face-to-face interview, in two cases a telephone interview only, and in two cases the data was missing.

Information was coded with respect to the timeliness of IAIU interviews with the alleged child victim. During the period covered by this review, New Jersey policy (DYFS 1996) outlined the circumstances that require an immediate, 24-hour, 72-hour or 10-day response time. IAIU screening staff and supervisors designate the response time based upon such factors as the seriousness of the alleged maltreatment, the age and vulnerability of the child, the availability of others in the setting who can protect the child, and the expected cooperation of the alleged perpetrator and others who must be interviewed as part of the investigation (DePanfilis and Salus, 1992; Wells, 2000). The assigned IAIU investigator is required to respond within the designated time frame.

The readers evaluated the extent to which IAIU investigators met the established response time in terms of both hours and calendar days (see Table 17). When reviewing investigator compliance with the designated response time in terms of hours, the readers found that the IAIU

failed to conduct a face-to-face interview with the identified child victim within the designated response time in 81 (50.3%) of the cases. The IAIU conducted face-to-face interviews with the identified child victim within the designated response time in 74 (46%) of the cases. Data was missing in six cases. Similarly, when reviewing investigator adherence to designated response time in terms of calendar days, the readers study determined that the IAIU failed to complete a face-to-face interview with the identified child victim within the designated response time in 81 cases (50.3%) and completed the face-to-face interview with the identified child victim within the designated response time in 77 (47.8%) of the cases. Data was missing in three cases.

Table 17
Attempted Face to Face Contact with Child Within Designated Response Time

	Frequency	Percent
Within Designated Response Time (Hours)		
No	81	50.3
Yes	74	46.0
Missing	6	3.7
Total	161	100.0
Within Designated Response Time (Work Days)		
No	81	50.3
Yes	77	47.8
Missing	3	1.9
Total	161	100.0

Child Abuse Registry Inquiry Regarding Alleged Perpetrators

The DYFS maintains a central Child Abuse Registry of the findings of each report of child abuse or neglect with respect to each alleged perpetrator. The DHS/DYFS policy requires the completion of a Child Abuse Registry Information (CARI check) during the course of each investigation to determine if the alleged perpetrator has previous history of child maltreatment. The CARI check is generally completed and the findings recorded during screening. The CARI check is important during the investigation to view the current allegations against the perpetrator in the context of his/her past recorded behavior. The best predictor of child abuse and neglect is a prior record of such abuse (DePanfilis & Zuravin, 1999a; DePanfilis & Zuravin, 1999b). The professional readers searched the reviewed cases for evidence of a completed CARI check. There was no evidence of a completed CARI check in the file for 108 of the 199 alleged perpetrators (53.2%) (Table 18).

Table 18
CARI Check Conducted on Alleged Perpetrators (n=199)

CARI Check Conducted	Number	Percent
Yes	91	45.7
No	105	52.7
No Indication	3	1.5

The readers determined that of 91 alleged perpetrators for whom IAIU conducted a CARI check, 22 (24.1%) had a prior allegation (Table 19). Of the 22 alleged perpetrators with a prior allegation, 13 had one such report, and 8 had two or more such reports. Six of those reports for four perpetrators had been substantiated (Tables 20 and 21).

Table 19
Prior Reports of Child Abuse and Neglect Against
Alleged Perpetrators with CARI Checks Completed (n=91)

Prior Reports	Number	Percent
Yes	22	24.1
No	64	70.3
No Indication	3	3.2
Not able to determine	2	2.1
Total	91	100

Table 20
Number of Prior Allegations Against Perpetrators with Prior Reports (n=22)

Number of Alleged Perpetrators	Number of Prior Allegations	Percent	Total Prior Allegations
13	1	59.0	13
5	2	22.7	10
2	3	9.1	6
1	4	4.5	4
1	Missing	4.5	--
Total 22	10	100	33

Table 21
Number of Prior Substantiated Reports for Alleged Perpetrators with Prior Reports (n=22)

Number of Prior Substantiated Reports per Caregiver with Prior Substantiated Reports	Total Number of Substantiated Reports	Number of Alleged Perpetrators	Percent
1	2	2	9.1
2	4	2	9.1
0	0	14	63.6
Missing		4	18.1
Total	6	22	100

Use of Contextual Information During Investigation

In addition to considering prior allegations regarding the caregivers, New Jersey policy requires the investigator to pursue other contextual information that is available to ensure a proper assessment of the alleged incident and the out-of-home care setting. The DHS/DYFS policy states:

> "It should be noted that incidents seldom occur in a vacuum and seldom occur without precipitating factors. The investigator reads charts and anecdotal records, and asks questions about time periods prior to the incident (as institutional and ecological systems sometimes play a part in the incident)". (IIIE.405.9 - DYFS, 1995).

Some examples of historical information considered in audited IAIU investigations included (1) findings of previous allegations of neglect and physical abuse, review of the foster home file; (2) consultation with the DYFS Foster Care Unit to ascertain if there were any previous concerns with the home that was under investigation; and (3) consultation with the DHS Office of Licensing regarding previous violations of the Manual of Standards and compliance with abatement/corrective actions.

Interviews During Investigation

New Jersey policy also requires IAIU to interview parties who may have information about reports of alleged child abuse and neglect during the course of the investigation. In the case of a foster home, for example, there should be documentation that all residents in, and persons frequenting, the home were interviewed. In addition, witnesses and collaterals should be interviewed as appropriate based on the specific nature of the allegations.

Table 22 indicates that in 44 cases it was clear that other persons frequenting the setting should have been interviewed to complete the investigation. In 10 of these 44 cases (22%) these interviews were not completed. Some examples of others who should have been interviewed but were not included the adult birth children of the foster parent and other alternate caregivers for the children. For the purposes of this study the requirement to interview all parties frequenting the care setting was deemed not applicable for all congregate care and school settings.

Table 22
Interviews with All Persons Frequenting the Setting (n=161)

	Frequency	Percent
No	10	6.2
Yes	34	21.1
Unclear	6	3.7
Not Applicable	111	68.9
Total	161	100

Among the 161 cases there were 145 cases in which it was clear that witnesses should be interviewed. In 10 of these cases (6.8%) none of the identified witnesses were interviewed and in 29 cases (20%), only some witnesses were interviewed. However, it should be noted that there were 100 cases (68.9%) in which all identified witnesses were interviewed (Table 23.).

In one instance, an IAIU investigator thwarted an apparent cover-up by a school principal regarding a physically abusive aide who had open-hand slapped a child, without provocation. Hearing from sources the principal had ordered faculty and staff to be uncooperative with the IAIU, the investigator set up after-hours and off-site meetings with all witnesses to the incident, verified that the abuse had occurred and confirmed the cover-up attempt by the principal. During the course of the investigation, the IAIU investigator discovered from faculty that the aide had a volcanic temper and was frequently abusive to children, but her close relationship to the principal had essentially paralyzed the rest of the staff. The investigator went to great lengths to document a pattern of abusive behavior toward children, ultimately leading to the aide's termination.

In another case, the IAIU investigator responded to a neglect of supervision allegation that foster parents had left three small children unattended near a busy thorough-fare by going to great lengths to interview all witnesses, including the foster parents, all children within the home, local police officials who reported the allegation, and, by canvassing the neighborhood, several neighbors who had observed the alleged incident, but who were unknown even to the police. In this way, the IAIU investigation was even more thorough than the local police investigation and uncovered witnesses unknown at the time of the original referral.

Table 23
Interviews with All Witnesses (n=161)

	Frequency	Percent
No witnesses interviewed	10	6.2
All witnesses interviewed	100	62.1
Some witnesses interviewed	29	18.0
Unclear from documentation	6	3.7
Not applicable	16	9.9
Total	161	100

Collaterals are persons who are likely to have knowledge about the alleged abuse or neglect but did not actually witness it, i.e. a school teacher who noticed bruises on a child when he arrived at the classroom in the morning, or a physician who examined a child who was injured. The IAIU is required to interview all such persons. Among the 161 cases, there were 149 cases in which it was clear that collaterals should have been interviewed. The readers noted that in 14 cases (9.3%) none of the appropriate collaterals were interviewed and in 61 cases (40.9%) only some of the appropriate collaterals were interviewed. In 70 cases (46.9%) all appropriate collaterals were interviewed (Table 24).

Table 24
Interviews with All Collaterals (n=161)

	Frequency	Percent
No collaterals interviewed	14	8.7
All collaterals interviewed	70	43.5
Some collaterals interviewed	61	37.9
Unclear from documentation	4	2.5
Not applicable	12	7.5
Total	161	100

Examples of collateral sources of information who should have been interviewed include other child residents who signed letters of complaint against the alleged perpetrator; DYFS case managers for the alleged child victims; law enforcement and licensing authorities; and medical personnel who examined the child victim contemporaneously with the incident.

Finally, there are others who should also be interviewed who are not witnesses, residents in the home or collaterals. This category primarily includes administrators, social workers or other professionals who have had some responsibility for the child or some past association with the perpetrator. In 20 of the 161 cases (12.4%) such persons had not been interviewed (Table 25).

Examples of others who should have been interviewed to investigate fully include staff from other agencies that may have some prior knowledge of the child or the alleged perpetrator who could put the alleged incident in historical context.

Table 25
Interviews with All Others (n=161)

	Frequency	Percent
No	20	12.4
Yes	141	87.6
Total	161	100

Timeliness of Investigation

IAIU policy requires that investigations be completed within 60 days of the IAIU referral. Of the 161 cases included in this review, 51 cases (31.7%) were completed within the 60 day limit. An additional 66 cases were completed in 61 or more days. Forty-four cases, or 27.3%, all of which should have been completed, remained open investigations at the time of this review (Table 26). It is noteworthy that IAIU investigators rendered a finding in 131 cases however there was supervisor sign-off in 117 of these cases. Failure to complete investigations in a timely manner potentially leaves children at risk of harm, and has been demonstrated to create staffing difficulties in congregate care settings where the alleged perpetrator should be barred from contact with the children pending the outcome of the investigation.

The readers identified 44 incomplete investigations. Of the 44 investigations, the shortest case remained open for 110 days and the longest incomplete investigation was open for 278 days. The average number of days the investigations remained open was 173.3 days.[16]

Table 26
Investigations Completed within 60 Days of IAIU Referral (n=161)

	Number	Percent
Investigations Completed within 60 days	51	31.7
Investigations Completed in 61 or more days	66	41.0
Not applicable*	44	27.3
Total	161	100.0

*Investigations were not completed.

[16] As of September 14, 2004.

IAIU Recommendations to Remove Children from Placement Setting

There were two cases in which the readers disagreed with the IAIU recommendation regarding the child's removal from the out-of-home care setting. In addition, there were nine cases in which readers were unable to determine whether the IAIU recommendation regarding the child's removal from the out-of-home care setting was reasonable.

IAIU Recommendations to Suspend or Revoke License

There were two cases where professional readers disagreed with IAIU recommendations regarding suspension/revocation of the license due to the incident. In ten cases readers could not determine whether the decision was reasonable.

IAIU Recommendations for Corrective Action

There were five cases in which professional readers disagreed with IAIU recommendations regarding corrective action.

Previous IAIU Corrective Actions

As previously indicated, the DePanfilis study was released in May 2003. Contemporaneous with the release of the study the DHS was preparing for the administrative transfer of the IAIU from the DYFS Central Office to the DHS Office of Program Integrity and Accountability/Office of Program Compliance and Public Safety. In preparation for the reorganization, the IAIU prepared a corrective action plan [17] that addressed the issues raised by the DePanfilis study. Specifically, the corrective action plan was targeted to address a significant number of overdue incomplete investigations and corrective action plans dating back to 2001.

The IAIU corrective action plan identified staffing shortages as a contributor to IAIU inefficiencies to be remediated by hiring administrative assistants and investigators by September 2003. The progress report on the corrective action plan (Appendix C) indicates that by October 2003 only minimal gains had been realized relative to hiring the additional staff.

The implementation of the IAIU corrective action plan provided a measure of success in alleviating the existing backlog of investigations, i.e. cases where investigative activity had been initiated but completion was pending past 60 days. In July 2003, the plan indicated that the IAIU had 629 incomplete investigations that were open more than 45 days; 197 of these investigations were from 2001/2002. By October 1, 2003 the overdue investigations had decreased to 215 with 45 remaining from 2001/2002. The established time frame to complete the overdue investigations was December 31, 2003.

[17] Plan to Address Backlogs in the Institutional Abuse Investigation Unit, DHS Office of Program Integrity and Accountability – Office of Program Compliance and Public Safety, July 15, 2003. A status report was issued on October 3, 2003.

As part of ongoing monitoring activity the OCA receives an IAIU monthly report that delineates open investigations and identifies which investigations are open beyond 60 days. The December 2004 Monthly Report indicates that as of November 30, 2004, the IAIU had a total active caseload of 1125 investigations, with 838 investigations open beyond the 60 days for completion permitted by policy. Adjusting for consistency with the previous 45-day time frame for completion of investigations, there were 956 investigations that were past due as of November 30, 2004. This represents an increased backlog of 444.6% from October 1, 2003 to November 30, 2004 (Table 27 – prepared by the OCA).

The DHS indicated that from July 15, 2003 (629 overdue investigations) to October 3, 2003 the IAIU was able to decrease overdue investigations to 215 reports without additional staff support or resources. The IAIU experienced a significant increase in referrals beginning on or about October 27, 2003 (due in-part to publicity surrounding the Jackson child abuse and neglect case). The IAIU expanded its screening criteria to be more inclusive of referrals traditionally considered marginal given the nature of the allegations in the Jackson case. No additional resources were assigned to the unit to address the increased responsibilities of the unit leading to a quadrupled increase in the IAIU investigations that were past due in the last year.

Table 27
IAIU Open Investigations

Region	Open Investigations Beyond 45 days 10/1/03*	Open Investigations 11/30/04	Open Investigations Beyond 60/45 days 11/30/04**	% Investigations Open Beyond 60/45 days 11/30/04**	% change from 10/03 to 11/04*
Central	17	124	63 (81)	50.8 (65.3)	476.4
Metropolitan	62	297	233 (255)	78.4 (85.8)	411.2
Northern	50	267	200 (226)	74.9 (84.6)	452.0
Southern	86	437	342 (394)	78.2 (90.1)	458.1
Total	215	1125	838 (956)	74.4 (84.9)	444.6

* Data was drawn from the October 2003 update on the IAIU corrective action plan.
**Parenthetical numbers represent adjustment to 45 days based on the monthly report submitted. The percentage change from 10/03 to 11/04 was calculated using these numbers for consistency of reporting.

The DHS has indicated that during the OCA audit period of November 2003 to May 2004, investigators completed investigations at a rate of about 70% compared to the number of new referrals received each month. However, the workload continued to outnumber the investigative staff.

In addition to the staffing issues, the IAIU October 2003 corrective action plan also identified a number of systemic issues to be addressed in any long term effort to strengthen and improve

standard practice of the unit. Such issues included the need to (1) increase accountability; (2) provide additional training; (3) make changes in the investigative model and format; and (4) develop protocols with law enforcement agencies. The findings of this study support the need to strengthen IAIU operations in these key areas.

Conclusions

Professional Judgment

The exercise of sound professional reasoning to guide the course of an investigation and sound professional judgment when assessing the evidence collected during the investigation and rendering a finding are essential to ameliorate the risk of harm to children in out of home care settings. Some of the areas of professional reasoning encompass decisions regarding whom to interview (alleged victim, alleged perpetrator, witnesses, collaterals, etc.) and when, what to ask during interviews and corroborating information gathered, confirming the safety of the alleged victim and other potential victims, assessing the presenting incident in the context of the history of the alleged perpetrator and the out-of-home care setting.

The quality of the investigation is integrally linked to professional reasoning and judgment. Investigations that are thorough include gathering information from all known sources and making assessments regarding the credibility and reliability of the source. The readers found that the IAIU interviewed some or all witnesses in 80.1% of the investigations, some or all collaterals in 88% of the investigations and others who may have information about the incident, setting or alleged perpetrator in 87.6% of the investigations.

Overall, the IAIU has shown a measure of improvement in the area of professional judgment related to investigative findings since the release of the DePanfilis study. The readers in this study agreed with the IAIU findings in 77.8% of the 131 completed investigations. It is possible that the rate of agreement between IAIU and readers in the study could have been as high as 84% if the documentation in the eight "undetermined" cases had been stronger (Appendix A, Table 13A).

Timeliness of Investigation

Timeliness of investigation includes the screener assigning the appropriate response time, the investigator initiating the investigation within the assigned time frame and concluding the investigation within the 60 days permitted by agency policy. This study revealed that the IAIU did not initiate the investigation within the designated response time in 50.3% of the investigations. This finding represents slippage in investigative practice since the DePanfilis study when the designated response time in hours was met in 70% of the investigations and the designated response time in calendar days was met in 78% of the investigations (Appendix A, Table 17A). In addition, the current study found less than a third (30.1%) of the investigations were concluded within the 60 days allotted in agency policy. These two factors contribute to the backlog of incomplete investigations previously noted and potential safety threats for children in out-of-home care.

Prior Reports of Abuse or Neglect Against Alleged Perpetrators and Corrective Action

As previously indicated, the best predictor of child abuse and neglect is a prior record of such abuse. The IAIU has made no documented improvement since the DePanfilis study in the practice of conducting a CARI check to determine the history of the alleged perpetrator. In the current study there was no evidence of a completed CARI check in the file for 108 of the 199 alleged perpetrators. This critical evidence was not accessed or evaluated in the investigative process in these cases, nor was it utilized to inform the need for corrective action.

Of the 91 alleged perpetrators for whom IAIU conducted a CARI check, 13 alleged perpetrators had one prior allegation and eight alleged perpetrators had two or more such reports. Six of those reports for four perpetrators had been substantiated. The DYFS and the DHS Office of Licensing (OOL) have established protocols for granting a waiver of CARI check information when granting a license to provide care and taking a negative enforcement action. These findings raise concerns about the agency response to IAIU recommendations for suspension or revocation of a license and or corrective action requests. It is imperative corrective actions requested from settings that are not licensed or regulated by the DHS OOL are timely submitted, implemented, and closely monitored to assure safety of children.

The Assistant Commissioner of the DHS, Office of Program Integrity and Accountability is the final authority on any enforcement action against a license. When an allegation is made against a caregiver in a home setting the OOL automatically suspends the resource family home for additional placements pending the outcome of the investigation. The DYFS case manager for the child, with supervisory input, decides if removal of the child from the home is required to assure his safety. Similarly, the IAIU requests that facility staff identified as the alleged perpetrator are separated from all contact with the alleged victim pending the outcome of the investigation. The suspension of the home, or separation of the alleged perpetrator from the alleged victim in facility settings, does not necessarily shield other children in the home/facility from potential maltreatment at the hands of the alleged perpetrator.

Recommendations

The OCA fully supports the strategies identified in the Child Welfare Reform Plan related to strengthening the practice of the IAIU and makes the following additional recommendations:

1. Full implementation of the hiring plan in Child Welfare Reform Plan. The human resource plan should include measures to be taken when identified case load standards are exceeded by more than 10% based on caseload averages, and strategies targeted at staff retention.

2. The absence of a documented CARI check for the majority of the alleged perpetrators is a grave concern. According to the DHS, the new centralized screening protocols require the screener to complete a CARI check before proceeding any further with the case. The DHS should establish protocols to assure that each alleged perpetrator subsequently identified during the course of the investigation is the subject of a documented CARI

check. The continuous quality improvement measures should assure that a CARI check is conducted on each (100%) alleged perpetrator, that investigators recognize the importance of the history of the alleged perpetrator, and that information gathered from routine CARI checks is integrated into the overall assessment of the alleged perpetrator and his/her role in the presenting incident.

3. The DHS should review and revise policy and procedure related to the DYFS response to IAIU recommendations for corrective action in DYFS placement settings. In addition, the DHS should review and revise policy and procedure related to issuing a waiver of substantiated abuse and neglect allegations in settings licensed or regulated by the DHS OOL to strengthen protections for children.

4. The case files were generally poorly organized, hand-written and contained multiple copies of the same document. In addition, there was evidence that information was not consistently recorded contemporaneously. The OCA recommends that the DHS take appropriate measures to assure accurate and credible record keeping in the IAIU.

5. The investigative files, with rare exception, bore little evidence of supervisory consultation during the investigative process. The OCA recommends that the DHS revise the IAIU Manual of Operations as needed to require the following:
    a. Supervisory consultation throughout the course of the investigation.
    b. Supervisory requirement to assure CARI checks are completed on each alleged perpetrator prior to initiation of the field investigation.
    c. Supervisory requirement to assure the investigator considers the allegations in the context of the history of the placement setting and caregivers.
    d. Supervisory review and approval of appropriate collaterals.
    e. Supervisory guidance regarding the progression of interviews and review/approval of interview content to assure appropriate follow up questions are asked and information gathered is verified.

6. Develop a plan to remediate the existing backlog of IAIU investigations, and establish procedures to minimize accrual of backlog in the future. Such procedures to include establishing consistent protocols with law enforcement agencies regarding information sharing when honoring requests not to interview key proponents in the investigation. The IAIU should establish protocols to assure that the reasons for delay in completing the investigation are accurately documented in the investigative file and that any preliminary findings are shared with the alleged perpetrator and facility administration in a timely manner to support effective operations of the setting.

7. Establish training to assure consistent application of the comprehensive investigative standards and tenets for supporting a finding of substantiated or unfounded within the designated time frame. Assure ongoing review of some proportion of unfounded investigations by the Chief of Investigations.

8. The IAIU prepares a comprehensive final report for each investigation resulting in a substantiated finding. The IAIU does not prepare a comprehensive final report for

completed investigations resulting in not substantiated or unfounded findings. The OCA recommends that a comprehensive final report be required for each completed investigation to establish the foundation and rationale for the findings, and that all investigative findings receive prompt supervisory review and approval prior to notification of the alleged perpetrator and other concerned parties.

9. Maximize opportunities for cross training and community education with law enforcement to promote common understanding and collaborative investigations.

10. Establish ongoing quality assurance and continuous quality improvement efforts based on best and promising practices to enhance investigative quality and assure adherence to agency policies established to guide and support practice.

APPENDIX A
COMPARISON WITH SELECTED DEPANFILIS FINDINGS

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Appendix A

The OCA made some comparisons of the findings of the current study with the findings of the DePanfilis study which was released in May 2003. Comparisons were made relative to degree of concurrence with the IAIU investigative findings decision (Table 13), rates of compliance with the designated response time for initial face-to-face contact with the alleged child victim and (Table 17) and compliance with the requirement to conduct a CARI check on each alleged perpetrator (Table 19).

As previously indicated, the DePanfilis study was based on 129 investigative files. As reflected in Table 13A, the readers in the current and the DePanfilis studies agreed with the substantiated decision 100% of the time. The DePanfilis readers found the overall IAIU findings decisions to be professionally unreasonable 25% of the time; disagreeing with 58.1% of the not substantiated findings and 17.1% of the unfounded findings.[18] Of the 131 investigations in the current study where a finding was rendered by IAIU, the readers agreed with the IAIU findings 77.8% of the time, finding the overall IAIU findings decisions to be professionally unreasonable in 16% of the 131 cases where a finding was rendered and unable to determine the reasonableness of judgment in 6 % of the cases. This finding represents some improvement in the professional decision-making of IAIU investigators. Readers in the current study disagreed with 22.9% of the not substantiated findings and 13.6% of the unfounded findings. In the current study 44 of the 48, or 91%, of the unsubstantiated investigations were "not substantiated with concerns". Of these 44 cases, the readers disagreed with the IAIU in 11 investigations (25%) and determined that the allegations should have been substantiated. (The DePanfilis data does not account for the 7 missing cases).

Table 13A
Comparison of Reader Agreement with IAIU Investigative Finding

	IAIU Investigative Finding								
Reader Agreement	**Substantiated**		**Not Substantiated**		**Unfounded**		**No Finding**	**Total**	
	Current	DePanfilis	Current	DePanfilis	Current	DePanfilis	Current	Current	DePanfilis
Finding Not Reasonable	0	0	11	18	10	13	0	21	31
Finding Reasonable	10	15	34	13	58	63	0	102	91
Unable to Determine	0	–	3	–	5	–	0	8	–
Not Applicable	0	–	0	–	0	–	30	30	–
Total:	10	15	48	31	73	76	30	161	122

[18] DePanfilis, Diane (2003). Final Report: Review of Investigations of Suspected Child Abuse and Neglect in DYFS Out-of-Home Care Settings in New Jersey, University of Maryland School of Social Work, Baltimore, MD., pp. 19 - 20.

The readers in the current and DePanfilis studies evaluated the extent to which IAIU investigators met the established response time in terms of both hours and calendar days (Table 17A). When reviewing investigator compliance with the designated response time in terms of hours, current study readers found that IAIU investigators failed to conduct a face-to-face interview with the identified child victim within the designated response time in 81 (50.3%) of the cases, compared to a 30% rate of noncompliance in the DePanfilis study.[19] In the current study the IAIU conducted face-to-face interviews with the identified child victim within the designated response time in 74 (46%) of the cases. Data was missing in six cases. Similarly, when reviewing investigator adherence to designated response time in terms of calendar days, the current study determined that IAIU failed to complete a face-to-face interview with the identified child victim within the designated response time in 81 cases (50.3%), compared to a 22% rate of noncompliance in the DePanfilis study.[20] In the current study the IAIU completed the face-to-face interview with the identified child victim within the designated response time in 77 (47.8%) of the cases. Data was missing in three cases. (The DePanfilis data does not account for the 9 missing cases).

Table 17A
Attempted Face to Face Contact with Child Within Designated Response Time

	Frequency		Percent	
Within Designated Response Time (Hours)				
	Current	DePanfilis	Current	DePanfilis
No	81	36	50.3	30.0
Yes	74	84	46.0	70.0
Missing	6		3.7	
Total	161	120	100.0	100.0
Within Designated Response Time (Work Days)				
	Current	DePanfilis	Current	DePanfilis
No	81	26	50.3	22.0
Yes	77	94	47.8	78.0
Missing	3		1.9	
Total	161	120	100.0	100.0

[19] DePanfilis, pp. 31-32; Table 16.
[20] DePanfilis, pp. 31-32; Table 16.

The readers in the current study determined that of 91 alleged perpetrators for whom IAIU conducted a CARI check, 22 (24.2%) had a prior allegation. The DePanfilis study found that of the 105 perpetrators for whom IAIU conducted a CARI check, 26 (24.7%) had at least one prior allegation (Table 19A). The data reflect no meaningful change in the rate of compliance in this area of practice.

Table 19A
Prior Reports of Child Abuse and Neglect Against
Alleged Perpetrators with CARI Checks Completed

Prior Reports	**Number**		**Percent**	
	Current	DePanfilis	Current	DePanfilis
Yes	22	26	24.2	24.76
No	64	79	70.0	75.20
No Indication	3	--	3.3	
Not able to determine	2	--	2.2	
Total	91	105		

Appendix B
Definitions

Finding: The official determination by the Division (DYFS) of the results of a child protective investigation. (N.J.A.C. 10-129A-1.4)

Substantiated: The available information as evaluated by the Division representative indicates that a child is an abused or neglected child as defined in N.J.A.C. 10:133-1.3 because the child has been harmed or placed at risk of harm by a parent, caregiver, temporary caregiver or institutional caregiver (N.J.A.C. 10:129A-3.3(a).

Not Substantiated: The available information, as evaluated by the Division representative provides some indication that a child was harmed or placed at risk of harm, but does not indicate that the child is an abused or neglected child as defined in N.J.A.C. 10:133-1.3 (N.J.A.C. 10:129A3.3(a).

Unfounded: Either i. there is no evidence of conduct that would pose risk to the child; ii .there is no evidence that a parent, caregiver, temporary caregiver, or institutional caregiver or child was involved; or iii. the available information indicates that the actions of the parent, caregiver, temporary caregiver, or institutional caregiver were necessary and reasonable and the incident was an accident (N.J.A.C. 10:129A-3.3(a)).

Emotional abuse or neglect: Conduct by a child's parent or caretaker toward the child which contributes to, causes, allows, or permits: significant or persistent emotional pain, harm, or impairment; and/or significant vulnerability to or risk of such pain, harm, or impairment; and/or significant exacerbation of a child's existing emotional pain, or impairment (II Field Operations Casework Policy and Procedures Manual, C.307, Emotional Abuse or Emotional Neglect, 2-27-97).

Physical abuse: A child who is physically injured or at risk of physical injury due to a parent's/caretaker's action or inaction that was neither necessary nor justified, neither reasonable nor appropriate, is an abused child (II Field Operations Casework Policy and Procedures Manual, C.304, Physical Abuse, 2-27-97).

Sexual abuse: Contacts or interactions are considered to be sexual abuse when they occur between a child and a parent/caretaker, as defined in N.J.S.A. 9:6-8.21 for the purpose of sexual stimulation of either that person or another person. The term additionally encompasses activities which are defined as sexual exploitation, i.e., utilizing children to perform or engage in sexual activity for the purpose of realizing a profit or gaining favor or power. (II Field Operations Casework Policy and Procedures Manual, C.305, Sexual Abuse (12-22-97).

Neglect: A child is considered neglected when a parent or parent substitute fails to provide for his basic needs such as food, clothing, shelter, supervision, medical care, education, and emotional well-being although having, or being provided with, the means to do so (II Field Operations Casework Policy and Procedures Manual, C.306, Neglect, 2-27-97).

Chronic truancy: this occurs when a child is not enrolled in school or habitual truancy occurs (minimum of 20 days) without a legitimate reason (Adapted from U.S. Department of Health and Human Services, 1988: Zuravin and DePanfilis).

Delay in obtaining needed mental health care: a child is not provided needed treatment for an emotional or behavioral impairment (Adapted from U.S. Department of Health and Human Services, 1988; Zuravin and DePanfilis, 1966).

Inadequate clothing: chronic inappropriate clothing for the weather conditions (Adapted from Magura and Moses, 1986).

Inadequate Food, Nutrition: failure to provide a child with regular and ample meals that meet basic nutritional requirements or when a caregiver fails to provide the necessary rehabilitative diet to a child with particular types of physical health problems (Adapted from Zuravin and DePanfilis, 1996).

Inadequate/delayed health care: failure of a child to receive needed care for physical injury, acute illnesses, physical disabilities, or chronic condition or impairment that if left untreated could result in negative consequences for the child (Adapted from Magura and Moses, 1986; U.S. Department of Health and Human Services, 1988; Zuravin and DePanfilis, 1996).

Inadequate nurturance or affection: marked inattention to the child's needs for affection, emotional support, attention, or competence; being detached or uninvolved, interacting only when absolutely necessary; failing to express affection, caring and love for the child (Adapted from the American Professional Society on the Abuse of Children, 1995; U.S. Department of Health and Human Services, 1988).

Inadequate supervision: child left unsupervised or inadequately supervised for extended periods of time or allowed to remain away from home overnight without the caregiver knowing the child's whereabouts (Adapted from U.S. Department of Health and Human Services, 1988).

Inappropriate substitute caregiver: failure to arrange for safe and appropriate substitute child care when the caregiver leaves the child with an inappropriate caregiver (Adapted from Magura and Moses, 1986; Zuravin and DePanfillis, 1996).

Poor personal hygiene: failure to attend to cleanliness of the child's hair, skin, teeth and clothes (Adapted from Magura and Moses, 1986; Zuravin and DePanfilis, 1996).

Unmet special education needs: a child fails to receive recommended remedial educational services or treatment for a child's diagnosed learning disorder or other special educational needs, or problems of the child (Adapted from the American Professional Society on the Abuse of Children, 1955: U.S. Department of Health and Human Services, 1988).

Unsafe household conditions: presence of obvious hazardous physical conditions in the home that could result in negative consequences for the child(ren); presence of obvious hazardous unsanitary conditions in the home that could lead to negative consequences for the children (Adapted from Magura and Moses, 1986; Zuravin and DePanfilis, 1996).

Appendix C

DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY

PLAN TO ADDRESS BACKLOGS IN INSTITUTIONAL ABUSE INVESTIGATION UNIT STATUS REPORT

OFFICE OF PROGRAM COMPLIANCE AND PUBLIC SAFETY
OCTOBER 3, 2003

OVERDUE INVESTIGATIVE REPORTS AND FINDINGS

Brief Statement of the Issue

The Institutional Abuse Investigative Unit (IAIU) has, in recent years, experienced consistent and significant staffing shortages. The Metropolitan Regional Office (MRO) and the Southern Regional Office (SRO) have routinely operated with two to three less investigators each, due to difficulty attracting and retaining suitable staff. Investigator availability is further reduced by various approved leaves of absence, i.e., maternity, educational, and removal from new case assignment rotation due to heavy caseloads and overdue reports. In addition, when regions have received a particularly high number of investigations in two consecutive months, they seldom recover. As a result, extensive backlogs have developed.

Extent of the Backlog

Table 1 illustrates the current backlog of investigative reports by region, by year.[21]

Table 1	CRO	MRO	NRO	SRO	TOTAL
2001	0	2	9	28	39
2002	3	16	41	98	158
2003	73	169	92	98	432
TOTAL	76	187	142	224	629

The overdue reports primarily fall into one of the following four general categories:

- Investigation Complete/Awaiting Investigator Submission
- Investigation Complete/Awaiting Supervisor Review
- Investigation Incomplete
- Prosecutorial/Law Enforcement Involvement

Short Term Plan

The immediate plan is to submit all 2001 and 2002 outstanding reports by October 1, 2003. Investigations that cannot be closed due to prosecutorial or law enforcement involvement, or the unavailability of critical information, will be submitted for review to the Program Compliance and Public Safety Director, who will approve or disapprove any continued delays. The regions will

[21] Cases accepted for investigation by IAIU as of May 31, 2003 are considered overdue since reports should have been submitted for review within 45 days, July 15, 2003, in accordance with policy.

begin to address the backlog of 2003 cases upon completion of the prior years' cases, utilizing existing staff, with a target completion date of December 31, 2003. However, in order to realize an immediate and significant reduction in the current year's backlog additional staff support is required. The hiring of administrative assistants and investigators by September 2003, if possible, is critical since schools will re-open and the influx of new investigations will increase exponentially.

Individualized plans have been developed for each region commensurate with their current staff levels and their proportionate share of the backlog, as follows:

Central Regional Office (CRO)

Since CRO has no 2001 and only three 2002 reports overdue, they will handle all new investigations occurring in Burlington County (Southern Region), except for those involving foster homes, until October 1, 2003. SRO will thereby be relieved of this additional workload while they address their substantial backlog. CRO will also read and approve 15%, or 21 SRO cases in which the investigation is complete but is awaiting submission by the investigator.

Metropolitan Regional Office (MRO)

The Regional Supervisor and the Assistant Regional Supervisor currently supervise four and three investigators, respectively. The Regional Supervisor will supervise all seven investigators until October 1st so the Assistant Regional Supervisor can review, package and/or complete the 18 outstanding 2001 and 2002 investigations.

Northern Regional Office (NRO)

The Assistant Regional Supervisor has already assumed the responsibility of reviewing, submitting and documenting justified delays for the 50 outstanding investigations for 2001 and 2002, by October 1, 2003.

Southern Regional Office (SRO)

The Regional Supervisor has devised a schedule to remove two of the eight investigators from new case assignment rotation during July in order to submit overdue reports. The Regional Supervisor and Assistant Regional Supervisor will read and approve 105 cases from 2001 and 2002, with the assistance of two investigators, as available. The CRO Supervisor will read and approve the remaining 21 cases for prior years.

Long Term Solution

The long term solution to this problem will require a more extensive systems review. Clearly, maintaining adequate staffing levels is an essential component. However, increased accountability, additional training, changes in the investigation model and format, and developing protocols with prosecutorial and law enforcement agencies may also enhance the efficiency, timeliness and effectiveness of IAIU operations.

Status of Backlog Plan

Table A illustrates the considerable progress made on the backlog of investigative reports that existed on May 31, 2003 and reflects the remaining overdue reports from the backlog as of October 1, 2003.

Table A	**CRO**		**MRO**		**NRO**		**SRO**		**TOTAL**	
	5/31/03	10/1/03	5/31/03	10/1/03	5/31/03	10/1/03	5/31/03	10/1/03	5/31/03	10/1/03
2001	0	0	2	0	9	1	28	10	39	11
2002	3	1	16	1	41	4	98	28	158	34
2003	73	16	169	61	92	45	98	48	432	170
TOTAL	76	17	187	62	142	50	224	86	629	215

Central Regional Office (CRO)

The only outstanding 2002 case from this region involves the XXX. The referral was received by IAIU on December 18, 2002. The investigator has had difficulty completing this investigation because the allegations occurred two to three years prior to IAIU receiving the case; the administration has not been very cooperative; and most of the students who were allegedly involved with the incident are not longer at the school. The case has not been closed to date because, because on the information the investigator has been able to obtain, there appears to be some truth to the allegations. The investigator has had difficulty locating witnesses but intends to make one final attempt through the school administration before closing this case.

Metropolitan Regional Office (MRO)

The outstanding case from this region involves the X foster home. The case was submitted to the Regional Supervisor, who reviewed and returned the case to the investigator for revisions.

Due to the complexity of the case, it may require additional revisions but it will be submitted to IAIU Central Office for review immediately upon completion.

Northern Regional Office (NRO)

The one 2001 and four 2002 overdue investigations from this region are as follows:

Southern Regional Office (SRO)

There are a total of 10 cases from 2001 and 29 cases from 2002 that still need to be completed by this region, 22 of which will be submitted by October 24, 2003. The Regional and Assistant Regional Supervisor will continue to work diligently to complete the remaining 17 cases as soon as possible.

Staffing shortages continue to plague MRO with one investigator on maternity leave and one on educational leave. Despite a statewide posting to fill these two positions on an interim basis, only one interested candidate responded. Similarly, a statewide posting for a NRO investigator yielded limited interested candidates. Further, although five Administrative Support positions have been promised to IAIU, these positions have not been announced, and consequently none have been hired.

In addition to staffing shortages, IAIU has been actively participating, on nearly a daily basis from August 25th to date, in the congregate care safety assessments required by the Panel monitoring the Settlement Agreement in the Children's Rights lawsuit. Designated IAIU staff will remain involved in this project until its conclusion on October 23rd. Moreover, new referrals continue to be assigned to the regional offices for investigation. CRO received 151 cases between June 1st and September 30th; MRO received 140 cases during the period; NRO received 120 cases; and SRO received 129 cases since June 1st. CRO received 142 cases between June 1st and September 30th; MRO received 134 cases during the period; NRO received 100 cases; and SRO received 113 cases since June 1st. The significant increase in CRO investigations is likely due to the fact that they covered Burlington County for SRO during the period and began accepting investigations in MRO to offset their chronic staff shortage. IAIU staff should be commended for the significant strides made to eliminate the 2001/2002 investigative report backlog within the prescribed deadline.

In order to increase accountability, the Director of the Office of Program Compliance and Public Safety (OPC&PS) meets weekly with the IAIU Administrator to discuss emerging issues, the

IAIU Chief of Investigations attends OPC&PS Comp-Stat bi-weekly to review pertinent unusual incidents with the Program Review Unit and the Human Services Police, and a notification protocol has been established to ensure that the OPC&PS Director is immediately made aware of critical incidents that may require reporting up to the Commissioner. As an added accountability measure, OPC&PS will begin holding Investigative Comp-Stat regionally, effective January 2004 with the MRO and NRO investigators together and the CRO and SRO investigators together, on an alternating bi-weekly basis, to better monitor the status and progress of their investigations. A specialized training curriculum is currently being developed for IAIU investigators in collaboration with the Office of the Public Defender and the Office of the Attorney General. Relevant external training opportunities have also been made available to investigators on two occasions so far. Finally, a review of the investigative findings letter is underway so appropriate semantic and legally sufficient revisions can be made.

OVERDUE CORRECTIVE ACTION PLANS

Brief Statement of the Issue

Corrective action is typically recommended by IAIU investigators in most substantiated cases and in some not substantiated and unfounded cases. The authority to require a remedial plan is found in Title 9 of the *New Jersey Statutes*. It provides that if child abuse or neglect is found, the administrator of the institution may be requested by the Division of Youth and Family Services to formulate a plan of remedial action. Within 30 days of the request, the administrator shall respond in writing on the progress of preparing the plan and the plan shall be complete within 90 days of the date requested. If the administrator of the institution does not formulate or implement a remedial plan or make any changes requested, the Division may recommend to the authority which licenses, oversees, approves or authorizes the operation of the institution that appropriate sanctions or actions be enforced. It is important to note that the authority to require a remedial plan has been construed by the Appellate Division as being limited to substantiated cases only. Moreover, the court took the position that, even in substantiated cases, IAIU did not have authority to order a school district to take specific corrective action or submit a remedial plan since a school district is not an "institution". Therefore, IAIU's ability to compel compliance with this provision in substantiated cases involving school districts, and in any not substantiated and unfounded cases, is fictional. However, the unit should still make recommendations when warranted and request voluntary compliance, as appropriate.

A separate issue is presented by the unit's inability to obtain Corrective Action Plans (CAP) from the Department's own Regional Foster Care Units. A full 52% of the outstanding plans involve foster homes. When an investigative report containing recommendations for remedial action is sent to the respective Foster Care Unit, it requests that a CAP be submitted within 30 days. If no CAP is received, a reminder is sent to the Administrator and the Regional Supervisor of the Foster Care Unit requesting a response be submitted within two weeks. Another reminder is sent if no response is received within the specified time frame. No reminder notices have been sent by IAIU since March 11, 2003. A list of Outstanding Plans and Not Accepted Plans are sent to the Regional Foster Care Units quarterly as an additional reminder. Noteworthy is the fact that foster homes with outstanding plans may remain suspended, and thus barred from accepting new foster placements pending receipt of an approved plan, unless a waiver has

been obtained. IAIU is virtually powerless to mandate compliance by the Regional Foster Care Units.

Extent of the Backlog

Table 2 reflects the number of overdue Corrective Action Plans as of June 30, 2003.

Facility Type	Total	2001	2002	2003
Adoptive Home	4	1	1	2
After School Program	4	1	2	1
Bus Company	14	3	7	4
Child Day Care	41	12	22	7
Children's Shelter	3		2	1
Contracted Foster Home	9	2	3	4
Corrections	3	2		1
DDD	1		1	
Detention	17	9	4	4
Foster Home	123	48	55	20
Group Home	5		5	
Juvenile Family Crisis Shelter	3	1		2
Other	5	1	1	3
Registered Day Care Provider	5		4	1
Residential	6	1	2	3
Totals	243	81	109	53

Short Term Plan

A special notice will be sent by the Director of Program Compliance and Public Safety to institutions with outstanding remedial action plans requiring compliance by a date certain and advising that failure to comply will result in notification to the appropriate licensing or regulatory body. This approach may yield a better result from institutions in violation of the statute. Enforcement action should be initiated against non-compliant institutions. Likewise, a memorandum will be sent from the Program Compliance and Public Safety Director to the Foster Care Unit, mandating compliance by a date certain and advising that failure to comply will result in notification to the Office of Licensing, for appropriate action.

IAIU should immediately fill the Corrective Action Coordinator vacancy resulting from the retirement of Anne Creter on July 1, 2003. Interviews have already begun and a suitable candidate should be identified by August 15, 2003. Presently, the foster home corrective action plans are being reviewed by the respective IAIU Regional Supervisor, on an as needed basis.

Long Term Solution

First, to increase accountability, all reminder notices and Overdue and Not Accepted CAP lists involving foster homes will be copied to the Office of Licensing, the DYFS Director and the Special Deputy Commissioner for Children Services, so they are cognizant of the problem and can assure compliance. Secondly, institutional reminder notices should be copied to any appropriate licensing or regulatory body, so that appropriate sanctions or actions may be enforced or taken. Finally, after the backlog has been addressed and the new Corrective Action Coordinator (CAC) has assumed the responsibilities of the position, the role of the CAC will be evaluated to determine whether a broader spectrum of duties could be added without allocating additional resources. Some of the expansion areas to be considered for the position may include the capacity to conduct more systematic and proactive identification of problem facilities; to provide technical assistance to IAIU supervisors and investigators in formulating more detailed and relevant recommendations to address concerns; and to coordinate more closely with the Office of Licensing, and the Foster Care and Contracting Units on a regular basis to enhance communications and share information on facilities.

Status of Backlog Plan

There has been little progress in reducing the backlog of overdue corrective action plans. Table B depicts the number of plans that remain outstanding from the June 30th backlog:

Facility Type	Total		2001		2002		2003	
	6/30/03	**10/1/03**	6/30/03	**10/1/03**	6/30/03	**10/1/03**	6/30/03	**10/1/03**
Adoptive Home (AH)	4	**4**	1	**1**	1	**1**	2	**2**
After School Program	4	**4**	1	**1**	2	**2**	1	**1**
Bus Company	14	**11**	3	**3**	7	**6**	4	**2**
Child Day Care	41	**41**	12	**13**	22	**22**	7	**6**
Children's Shelter	3	**3**	0	**0**	2	**2**	1	**1**
Contracted Foster Home	9	**5**	2	**1**	3	**1**	4	**3**
Corrections	3	**3**	2	**2**	0	**0**	1	**1**
DDD	1	**1**	0	**0**	1	**1**	0	**0**
Detention	17	**16**	9	**9**	4	**4**	4	**3**
Foster Home (FH)	123	**95**	48	**38**	55	**44**	20	**13**
Group Home	5	**5**	0	**0**	5	**5**	0	**0**
Juvenile Family Crisis Shelter	3	**3**	1	**1**	0	**0**	2	**2**
Other	5	**4**	1	**1**	1	**1**	3	**2**
Registered Day Care Provider	5	**2**	0	**0**	4	**2**	1	**0**
Residential	6	**4**	1	**1**	2	**2**	3	**1**
Totals	243	**201**	81	**71**	109	**93**	53	**37**

As outlined in the backlog plan, a special notice was to be sent by the Director of Program Compliance and Public Safety to the Foster Care Unit and institutions with outstanding remedial action plans requiring compliance by a date certain. After further review and discussion, it appears that the authority to require submission of a corrective action plan (CAP) in substantiated cases rests with the DYFS Division Director. The DYFS Director has been recently made aware of this issue and will work with IAIU to develop an appropriate notice to be sent to institutions and the Foster Care Unit to obtain the outstanding reports. A separate letter will also be drafted to "request" submission of outstanding plans in cases with a finding of not substantiated. This office will work with the DYFS Director to craft a plan to address this problem prospectively.

A new Corrective Action Coordinator began working on August 25th. He has already finished updating the CAP database and has begun reviewing the internal IAIU CAP process to determine where improvements are needed.

SERVICE INFORMATION SYSTEM DATA ENTRY

Brief Statement of the Issue

The IAIU has consistently been understaffed with regards to clerical positions in the Screening Unit. As a result, extensive backlogs of data entry have developed. Prior to January 2003, the Screening Unit, consisting of nine professional staff, was without an assigned clerical position. That function was being performed by the Chief Administrator's secretary and a rotation of clerical staff from CRO, in addition to them performing their primary function and responsibilities. Over the years, matters have reached a critical level at which point the IAIU Central Office Administrative Assistant was assigned to assist with the backlog data entry into the Service Information System (SIS). As of January 2003, a temporary part-time clerical position was assigned to the Screening Unit with a primary function of answering incoming screening calls, data entry and other clerical duties (i.e. filing, mail, etc.).

Extent of the Backlog

Table 3 illustrates the current backlog of data entry into SIS.

Table 3	Total 9-7s to be Entered	Abuse 9-7 with Regional Field Investigations	Abuse 9-7s that were investigated by SPRU	Resolved in Intake 9-7s including K8 entry and case closings
February	15			15
March	68			68
April	55		4	51
May	81	11	9	61
June	168	100	10	58
July	7	7		
Totals	394	118	23	253

Since some of the 9-7s for entry are months old, open cases may have been closed by the Division of Youth and Family Services (DYFS) District Office before IAIU had the opportunity to enter its 9-7. When this occurs, the Office of Information Systems (OIS) has to reopen the case before IAIU can enter a 9-7 and/or a K-8. It can take up to three weeks for OIS to respond to

these requests. Therefore, there may be some 9-7s and K-8s that do not meet the entry deadline.

Short Term Plan

The immediate plan is to augment the training of clerical staff in CRO and NRO on the entry of 9-7s and K-8s by July 11, 2003. Once trained by the IAIU Central Office Administrative Assistant, the two CRO clerical staff will be utilized to input into SIS all "Abuse 9-7s with Regional Field Investigation" cases by July 18, 2003 and all "Abuse 9-7s that were Investigated by SPRU" by July 25, 2003. This amounts to 118 and 23 entries, respectively. The one NRO clerical staff will begin inputting into SIS the 253 backlogged "Resolved in Intake 9-7s including K-8 entry and case closings" data. Once CRO has completed their entries they will assist NRO clerical staff. All backlogged information will be entered by August 1, 2003.

The current temporary part-time screening clerical staff will be hired as a full-time permanent employee by July 12, 2003. This person will be responsible for inputting all the newly accepted "Abuse 9-7 with Regional Field Investigations" and the "Abuse 9-7s Investigated by SPRU" cases on a regular and ongoing basis. In addition, the six Screeners will begin entering their own 9-7s and K-8s in the "Resolved in Intake 9-7s including K-8s entry and case closings" category. This will be initiated after SIS/Data Entry training is provided to the Screeners by August 15, 2003.

Long Term Solution

The long term solution to this problem will require additional review. Recruiting and filling the present vacant Screening professional position, as well as obtaining a second clerical position, which could immediately be addressed by back filling the temporary clerical position being vacated on July 12, 2003, are essential. Maintaining adequate staffing levels once the vacancies are filled will assure backlogs do not develop. In addition, representatives of the Information and Technology (IT) Unit will meet with IAIU staff to determine needs, to computerize the screening log which is currently in a manual format and to work on a more user friendly format of the computerized 9-7. Ultimately, the screening staff will begin entering all their own 9-7s and K-8s, in preparation for SACWIS.

Status of Backlog Plan

Utilizing clerical staff from CRO and NRO, the backlog in SIS entries has been eliminated. The Screening Unit investigators have been trained on SIS data entry and have begun entering 9-7 Referral Response Reports and K-8 Case Closing Reports generated by them. As of October 1, 2003, there were seven current reports awaiting entry into SIS.

Authorization was granted for a second temporary clerical position in the Screening Unit by back filling the temporary clerical position vacated on July 12th. The IAIU Administrator is currently interviewing to identify a suitable candidate. The vacant Screening professional position will be filled shortly.

Appendix D

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