OFFICE OF THE CHILD ADVOCATE
REPORT

CHILD FATALITY INVESTIGATIONS
2004

OFFICE OF THE CHILD ADVOCATE
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Introduction

In December 2003, the Office of the Child Advocate committed to conduct in-depth reviews of the child welfare system's interactions with families whose children died due to suspected abuse or neglect in 2004 after an involvement with the New Jersey Department of Human Services (DHS), and its Division of Youth and Family Services (DYFS).[1] The 12 children whose deaths led to this investigation satisfied the criteria. As part of every review, this Office evaluated the performance of DYFS in providing services to the family and the child, as well as the roles played by components of the child welfare system at-large, including schools, health care providers and community agencies. The Office undertook this work to aid the State to identify and respond to lessons learned from each situation. The Office did not investigate the incident of the death to establish conclusively the cause, assign culpability or determine if the death was preventable. Rather, the focus of each investigation was to reveal and understand the efforts of the child welfare system to identify and respond to the needs of families prior to the fatality. The purpose of these reviews is to identify systemic issues in and among the agencies empowered to keep children safe and families strong and to develop recommendations for reform.

DYFS' total involvement with these families occurred before DHS began aggressively implementing its comprehensive reform plan "A New Beginning: The Future of Child Welfare in New Jersey," which promises to remake a long-broken child welfare system and institutionalize changes to strengthen New Jersey families and protect our children. The reform plan is funded in large part by an increased State appropriation to rebuild the child welfare system, which became effective in July 2004. This report is not a reflection of where DHS is headed and is certainly not a verdict on the child welfare reform plan. The report reminds us of the mountainous challenges that confront the public leaders, staff and advocates whose work will define success for children at risk of abuse and neglect.

The findings in this report resoundingly support the need for the child welfare reform plan. Our leaders must stay deeply committed to invest in and monitor the child welfare reform plan now underway throughout State government, and primarily at the Department of Human Services.

At times, this report identifies systemic break-downs in our child welfare system, but the child welfare system did not kill any of these children. We understand the primary responsibility for keeping our children safe and well-nurtured belongs to the family. Tragedies occur, as this investigation sadly documents. When families cannot or will not care for children, it is the government's responsibility to do what is necessary to protect children but also, whenever possible, to strengthen families. This report identifies some areas where the State has opportunities to support families. In almost all instances, this means becoming involved with

[1] The New Jersey Comprehensive Child Abuse Prevention and Treatment Act, (*N.J.S.A. 9:6-88 et seq.)* established the New Jersey Child Fatality and Near Fatality Review Board. The purpose of the Board, in part, is to assure the review of each child fatality or near fatality in order to "identify the cause of the incident, the relationship of the incident to governmental support system as determined relevant by the Board, and methods of prevention."[1] The Child Fatality and Near Fatality Review Board relies largely on the investigation conducted by DYFS for information about the family's involvement with the system. In addition, the Board reports on trends and global systemic issues, rather than on individual fatalities. We hope to explore with the Board how to align our efforts next year. For 2004, our report has relied on independent investigation by OCA, as described in each of the reviews that follow.

families and offering supportive services, such as child-care, medical care, and addiction services before calamity occurs.

For children in the care of the state, such as Jeffrey Johnson, reform means ending the practice of boardering babies in hospitals and building our resource family network, as the reform plan commits to do. For children at risk of harm, such as Kedar Norris and Jmeir White, reform means creating strong local linkages between the healthcare community and DYFS, and teaching pediatricians to spot signs of abuse or neglect. For children with serious mental health needs, like J.A., reform means building a genuine mental health system for children that is accessible to families in every county.

For all of our children, reform means ensuring that in their moment of crisis, New Jersey will deploy a well-trained DYFS staff with manageable caseloads. Reform means those employees will be supported by competent supervisors with a manageable span of responsibility. None of this will be easy, and it could never be fast enough, but we support DHS' efforts to overhaul the child welfare system and we are hopeful for success.

This final report details our findings and recommendations in connection with 12 families whose children died between January 7, 2004 and August 22, 2004.[2] This report includes investigations with respect to the following child fatalities:

Name	Date of Birth	Date of Death	County
Navon Collins	08/31/2003	01/07/2004	Mercer
Samuel Allen	03/09/1998	02/25/2004	Mercer
Arianna Ellis	02/04/2004	03/05/2004	Mercer
Kedar Norris	09/26/1998	03/29/2004	Monmouth
Jibril Fuller	03/05/2001	04/13/2004	Essex
Ajee Anderson	06/30/1994	04/18/2004	Essex
Sharon Jones	06/11/2002	04/22/2004	Essex
Iliana Wiener	03/07/2002	06/11/2004	Monmouth
Christian Stokes	06/07/2000	07/04/2004	Ocean
J. A.[3]		07/05/2004	
Jeffrey Johnson	03/08/2004	07/24/2004	Monmouth
Jmeir White	06/13/2003	08/22/2004	Monmouth

Common Themes

We recognize that the cases presented in this report are not a statistically significant sample of the population of children and families involved with the child welfare system.[4] However, it is

[2] We investigated four additional cases, not detailed in this report, involving children whose deaths may have been caused by neglect, but we have not yet confirmed those findings.

[3] Death was due to suicide and has not previously been publicly reported. The OCA reviewed the case due to extensive involvement with the child welfare system.

[4] Child fatality due to abuse and neglect is not unique to New Jersey, of course. The National Child Abuse and Neglect Data System (NCANDS) reported a national estimate of 1,400 child fatalities due to child abuse or neglect in 2002. "This translates to a rate of 1.98 children per 100,000 children in the general population. NCANDS defines child fatality as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor."[4] Even as the child welfare system in New Jersey improves its ability to keep children safe and families strong, history tells us that some of our children will die due to abuse or neglect. The promise of The Plan is that it presents real opportunities to minimize those risks to our children.

beneficial to gain a sense of the recurring themes in these cases as one facet of the prism of reform. Just as we learn from families that are thriving how to create supports to build on or sustain their strengths, we can likewise learn from these child fatalities where such opportunities were missed. Our examination of each of the presented cases places the death event into the context of the overall family history with DYFS. For some families, such as Arianna Ellis', the DYFS practice was model. In other instances, it was not. Following are some of the recurring themes and concerns related to case practice.

Investigations and Ongoing Case Management

In several of the cases, the investigations and ongoing case management were shallow and narrowly defined. There was an over-utilization of the child welfare code of "family problem" at the screening phase. Thorough investigation of child protective services allegations, followed by appropriate delivery of services to ameliorate the risk of harm, all begins with accurate screening and coding of the allegations; therefore, the role of the screener is essential to effective intervention with families. Similarly, we often found it difficult to determine if case workers and supervisors were provided with and familiar with families' histories with DYFS and considered presenting allegations in the context of that history. In addition, there is evidence that further training and support is needed in identifying and understanding the risk associated with paramours, domestic violence and substance abuse. DHS has already implemented significant policy changes regarding the assessment of paramours and their role in the family.

Decision Making

We found that decisions were sometimes made in a vacuum without consulting collateral sources to confirm information provided by the family or to probe beneath the surface of information obtained to gain a fuller understanding of the family circumstances. There are also instances where decisions were made contrary to the advice of consulting specialists and absent documented consultation with the immediate supervisor. There was, in several cases, an over-reliance on case plans or service referrals without follow up to assure that the service had been delivered and with little assurance of the efficacy of the service provided. In some instances the DYFS case manager identified the need to have the parent evaluated for psychological or substance abuse counseling but the service was never realized. Finally, the case practice in several cases did not typically reflect an understanding of the impact of physical disability on the ability to parent, or the stress associated with being the sole caregiver for multiple children.

In light of these cases, DHS has taken steps to strengthen the structured decision making protocols, now requiring a full strength and needs assessment of families during initial child protective services investigations. DHS has identified strengthening the role of the supervisor to be critical to the reform efforts, and plans to support the further development of the supervisor as a mentor/coach for case managers. The addition of a Case Practice Specialist to each DYFS District Office will address the need for system accountability at the front line through continuous quality improvement efforts.

Health Issues

Our review of these cases also underscored the haphazard manner in which medical information for children is obtained, assessed and weighed when DYFS makes case management decisions for children. Communication between the medical community and DYFS was inconsistent and often insufficiently probative to inform decision making. We also noted the absence of consistency in medical standards to make child abuse determinations. DHS has advised the OCA of efforts currently underway through the Southern Regional Diagnostic and Treatment Center to address the latter issue. In addition, DHS has recently appointed a medical director, who is both a "pediatrician and an expert in public health, to oversee the development of policies for providing routine and emergency care to children in DYFS' care and creation of data systems to better track the children's medical histories." We are hopeful his oversight and leadership will ensure appropriate medical treatment for children in DYFS' care, consistent with the goals of child welfare reform.[5] The child welfare reform plan embraces strategies to address gaps in the child behavioral health system and to maximize community involvement in identifying and addressing indigenous service needs through the development and support of community collaboratives.

Child Care

Care for children with special needs, day care and respite care, was an issue in the case of Sam Allen. Access to child care for Sam and his siblings was further complicated by the need for the service to be available overnight. The availability of reliable child care for parents who work overnight was a factor in other cases as well. The OCA found that the case manager was sometimes remiss in verifying the child care plan as identified by the parents. This is another area where collateral contact is essential to child safety.

[5] Commissioner James M. Davy, DHS Press Release dated November 29, 2004.

NAVON COLLINS – DATE of DEATH: January 7, 2004

On January 7, 2004, Navon Collins, a 5-month old male child, drowned while unattended in the bathtub. His mother reportedly left him alone for approximately five minutes while she went to prepare a bottle for him. Navon was found floating face down in the bathtub by a relative. Navon died later the same day at a hospital in Philadelphia. At the time of Navon's death, the Collins family was the subject of an open investigation with the Mercer County District Office of DYFS.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The Office of the Child Advocate (OCA) collected information from various sources to conduct an in-depth review of DYFS' involvement with the Collins family prior to Navon's untimely death, including:

i. CCAPTA Notice dated January 8, 2004
ii. Case History prepared by DYFS Staff (undated and preparer's name is omitted)
iii. Copy of DYFS case record (December 2, 2003 - January 7, 2004)
iv. Personnel Files of Case Manager
v. Case Manager's Caseload information (December 2003 and January 2004)
vi. Screening Logs - DYFS Mercer County District Office and Office of Child Abuse Control (OCAC)
vii. Interview with a relative

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

Two referrals were received regarding the Collins family.

Based on a thorough review of the Collins family's DYFS case record along with the screening logs of the Mercer County District Office and OCAC, the below-referenced relevant information was obtained.

Initial Referral - December 2, 2003

The first DYFS referral on this family was made on December 2, 2003. The referent visited the DYFS Mercer County District Office and alleged that the mother admitted to marijuana use on a daily basis and would frequently leave a relative's home, where she resided, for days at a time to be with Navon's father, who did not have stable housing. This allegedly resulted in Navon and his mother frequently moving from place to place. The referral was assigned a 24-hour response time. According to the case record, the Case Manager made an unsuccessful home visit to the Collins family on December 3, 2003. She made a second attempt to meet with Ms. Collins at her home approximately one hour later and again found no one home, at which time she left her DYFS business card.

The case record indicates that the Case Manager made additional unsuccessful visits to the family home on the following dates: December 9th, 19th and 30th, 2003. Similarly, the case record also indicates that the worker made unsuccessful telephone calls to the Collins home on the following dates: December 8th, 11th and 22nd, 2003.

The case record contains a letter dated January 5, 2004, addressed to the maternal grandmother from the worker stating that she had made several attempts to meet with her and the family in an effort to complete the investigation. The record indicates that the letter was sent via regular and certified mail.

Second Referral - Child Fatality - January 7, 2004

On January 7, 2004, the second referral was received regarding Navon. The hospital reported that Navon died by drowning. The Hamilton Police Department and a hospital Social Worker contacted the Mercer County District Office and reported that the mother left Navon unattended in the bathtub while she went to prepare a bottle for him. A relative found Navon floating face down in the bathtub. He died later that day in a Philadelphia hospital.

III. OTHER RELEVANT INFORMATION OBTAINED THROUGH REVIEW OF RELATED DOCUMENTS

A. Personnel and related records regarding the case manager

Personnel files were reviewed for the case manager known to be involved in the initial investigation regarding this family. Review of the records was unremarkable. Staff had appropriate education and experience, and as best can be determined, had satisfactory employment history with the Division.

The initial referral for investigation of the Collins family was received on December 2, 2003, and the last attempted contact with the family via field visit or telephone was December 30, 2003. Between December 6, 2003, and January 3, 2004, the case manager maintained an average caseload of 30 families/54 children.

IV. OCA'S FINDINGS AND CONCERNS

1. DYFS did not conduct an investigation of the Collins family.

Although the initial referral was coded for a 24-hour response, no one from the Mercer County District Office ever actually made contact with this family until after Navon's death. Given the nature of the allegations, which included parental substance abuse and potential neglect of an infant, the case warranted treatment as a high risk case[6] until initial contact with the family could be established and an assessment of the risk to Navon could be made.

During the course of an intake investigation, the supervisor is responsible for conferencing the status of the investigation and directing the intake worker regarding next steps. There is no documentation in the DYFS record of any case conference between the case manager and her supervisor to discuss her inability to make contact with the family and consider alternate strategies to complete the investigation.

[6] As defined in the *District Office Case Handling Standards for Screening, Investigation & Initial Child Welfare Assessment* (March 1996 - page 16).

Additionally, review of the written investigation by the supervisor was not possible as it had not been transcribed. The Mercer County District Office file for the case manager includes four Technical Audit Intake Case Review Forms. The audit forms reflect that the supervisor reviewed the initial response write-up in these cases from 9 days to almost two months after completion by the case manager. Although these four cases are not a significant sample of the caseload, they suggest that the supervisor may have provided the case manager with minimal supervisory oversight in some cases.

a. Record keeping protocols must be adhered to at all times.

Case notes on the initial investigation were not written contemporaneously. Case activity that reportedly occurred during December 2003 was not documented in the case record until after Navon's death. This raises questions regarding the accuracy and integrity of the account as noted in the record given the delay in transcription and the degree to which the death of the child influenced the content of what the investigator documented.

Delays in documentation are potentially problematic if a case manager unfamiliar with the case had to intervene without the benefit of direct contact with the assigned case manager or supervisor. Notably in this case, the covering supervisor clearly accessed, at a minimum, the computer history on the family and was able to direct a thorough investigation of the incident of Navon's death.

2. DYFS did not make collateral contacts in furtherance of the initial investigation.

The DYFS Manual entitled *District Office Case Handling Standards for Screening, Investigation & Initial Child Welfare Assessment* (March 1996) specifies procedures for locating and making contact with the family. Relevant procedures include case manager consultation from the field with the supervisor, follow-up with the referent and/or contact with identified collaterals for additional information. Specifically, the Case Handling Standards Manual states:

> *If the worker has problems finding the family or in making personal contact for some reason, the worker consults from the field with the Supervisor. The worker or the Supervisor contacts the person making the report or contacts identified collateral for additional information. The worker documents any unsuccessful attempts to make personal contact with the family and/or any circumstances that make personal contact impossible on the DYFS 9-7 or in attachments to it. The worker documents the extra steps or strategies she or he uses to try to make personal contact when traditional techniques or approaches do not work.* (p. 20)

The DYFS case record indicates that several attempts were made to contact the referent to follow up on her initial referral. However it appears that there was at least one other resource available to the case manager that was not pursued. Although the initial referral listed a cellular telephone number for the biological father there is no indication in the record that any attempt was made to contact him. Speaking with the father could have

proved helpful in attempting to contact and locate the mother and Navon since the referral alleged that she spent a significant amount of her time with him. Additionally, the father presumably could have provided information useful in assessing the safety and risk of harm to Navon, and should have been engaged in formulating the case plan to assure safety and stability for his son as deemed appropriate.

The screener of the initial referral gathered superficial information regarding the nature and extent of the presenting problems and did not gather much collateral information. Doing so could have provided other sources of collateral information regarding Navon and the family situation.

3. Validity of attempted contacts with the family:

a. Certified letter

The DYFS Case record includes a letter dated January 5, 2004 that the record states was mailed by regular and certified mail to a relative. The record indicates that the letter was mailed two days before Navon's death. The OCA investigation included a check with the United States Post Office's Track & Confirm Service to ascertain the status of the letter, but there is no record of the referenced certified letter being mailed.

b. OCA's interview with a relative

OCA staff made telephone contact with a relative who lived in the household on May 17, 2004. The relative reported that no one from DYFS made any attempt to contact her or left contact information until the week of December 9, 2003. Phone messages and the business card left at the home were acknowledged, but the relative maintained that the efforts to establish contact did not begin until later than noted in the DYFS file.

The case record states that the case manager made two unsuccessful attempts to contact the family at their home on the day after the referral was made (December 3, 2003) and left contact information. The family contends someone was home that entire day and no one from DYFS went to her home. The record indicates that seven adults, including the mother and relative, resided in the home at the time of the initial referral to the agency.

4. The Case Manager had an excessive caseload.

During the month of December 2003, the month prior to Navon's death, the case manager handled an average caseload of 30 families/54 children. The Case Manager was clearly overburdened with an excessive number of families and children in her investigative caseload. Handling a caseload with so many children makes it extremely difficult, if not impossible, for a case manager to thoroughly investigate and provide quality services to the families under her supervision. The commitment by DHS to sharply lower caseloads statewide is vital to the success of reform.

SAMUEL ALLEN – DATE of DEATH: February 25, 2004

On February 25, 2004, Samuel Allen, a 5-year old male child with autism, was found dead at home in the bathroom, bearing suspicious bruises on both of his shoulders. Samuel also had visible burns on his legs and lower body from massive scalding injuries. Police believe Samuel, while playing in the bathroom, was fatally scalded when he turned on the tap water. Investigators speculated that Samuel, due to his autism, was unable to turn off the tap and passed out due to the severity of his burns. At the time of the incident Samuel's mother, Alicia Day, a 29-year old single parent of four children, R.A., age 9, Samuel, age 5, J.A., age 3, and J.A., age 2, had reportedly left the children home in the care of her 10-year-old niece while she worked the night shift. The Mercer County Prosecutor's Office has charged Ms. Day in connection with Samuel's death.

I. DOCUMENTS AND INFORMATION USED TO CONDUCT THE OCA REVIEW

The Office of the Child Advocate (OCA) collected information from various sources to conduct an in-depth review of DYFS' involvement with the Allen/Day family prior to Samuel's untimely death, including:

i. CCAPTA Notice dated February 25, 2004
ii. Case Chronology prepared by DYFS Staff (date and preparer's name omitted)
iii. Copy of DYFS case record (October 2003 - March 2004)
iv. Personnel Files and Caseload Information of DYFS Case Manager
v. Discussion with Attorney James Sacks-Wilner, representing Alicia Day

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

Prior to Samuel's death, two referrals had been received by DYFS regarding the Day/Allen family.

First Referral: October 25, 2003

The first allegations were made to the Office of Child Abuse Control (OCAC) on October 25, 2003, by an anonymous caller who reported that Samuel was running around the housing complex in the cold unclothed. The referral was flagged for an immediate response.

On the same date, a DYFS Special Response Unit (SPRU) investigator visited the Day/Allen home and interviewed Ms. Day, who reported that Samuel was autistic and wore Pampers which he liked to take off and put back on. She stated that she was right outside of the house at the time and that Samuel ran outside looking for her. The Case Chronology prepared by DYFS after Samuel's death indicates that he was non-verbal and could not be interviewed at the time. According to Ms. Day, her 9-year-old son, R.A., and her two nieces were in the house watching the children while she was outside. There is no evidence DYFS interviewed R.A. or the nieces to determine how frequently Ms. Day relied on them to watch the children. There also is no evidence that there were any collateral contacts or interviews with the other children in the home.

During the interview, Ms. Day reportedly informed the SPRU investigator that she worked from 10:00 p.m. until 6:00 a.m., Mondays through Fridays, and that either her neighbor or the children's aunt cared for the children while she worked. There is no evidence in the case record that anyone from DYFS followed up with the neighbor or the aunt to confirm these child care arrangements. Ms. Day further indicated she was aware that she needed to keep a closer eye on Samuel so this type of incident did not recur. The SPRU investigator described Ms. Day as "acting appropriate[ly]" during the entire interview; the family home was clean and the children appeared clean, healthy and dressed appropriately for bed. There were no problems noted with any of the children.

The SPRU Investigator completed a New Jersey Child Safety Assessment regarding Samuel's safety, indicating that he was safe. Neglect was not substantiated and a Findings Report form was completed. The SPRU Investigator recommended that the case be closed and that "[t]he family [was] not requesting any services from DYFS." A letter dated October 27, 2003 was drafted to be typed and sent to Ms. Day informing her that DYFS would not be providing her with any further services. As of December 11, 2003, this referral had still not been entered into the Service Information System (SIS), DYFS' child welfare data management system.

Second Referral: December 11, 2003

A second referral was received on the Day/Allen family on December 11, 2003, alleging that R.A. had said that his mother would beat him as she had done in the past when she learned R.A. had been disciplined in school. This referral was coded for an immediate response in the Mercer District Office and was assigned to a DYFS Case Manager to investigate.

The Case Manager responded to this referral on December 12, 2003. R.A. reportedly stated that his mother did not beat him for being disciplined at school and that she had not beat him in the past. Ms. Day reportedly said that she would "beat R.A. but only when it is something serious, like getting suspended from school." She reportedly said "she didn't beat him [that time] but ha[d] decided not to give him everything he want[ed] for Christmas." It is unclear from the DYFS case record whether R.A. was interviewed in the presence of his mother or alone. No other problems were noted during the visit and the other children were reportedly doing well. According to the case record, none of the other children in the home were interviewed regarding the allegations.

The Case Manager completed a New Jersey Child Safety Assessment and listed Ms. Day and all four of her children. Physical abuse was not substantiated and the DYFS Case Manager recommended closing the case "to allow natural parents to discipline their children when necessary and as needed." This comment was not explained any further. The Child Safety Assessment indicates that the children were safe and that the case "could be closed with positive collaterals." A Case Plan In-Home was signed by Ms. Day in which she agreed to provide for very routine and basic needs of the children. Among other things, the Case Plan In-Home, dated December 12, 2003, notes that Ms. Day "must use appropriate method of disciplining child(ren)."

On December 18, 2003, a letter was mailed to Ms. Day by the Case Manager stating that physical abuse was unsubstantiated and DYFS would not be providing further services to the family. Another letter was mailed to Ms. Day on the same date stating that the Division had

completed its assessment of the Day/Allen family and determined that "no need for services or further services [was] indicated" and that the agency's involvement with the family would be terminated. A Case Summary for Closing was prepared and signed by the Case Manager on December 18, 2003. This form was not signed by a supervisor.

On December 19, 2003, the Case Manager faxed a school reference to the Guidance Department at Parker School Annex in Trenton, New Jersey. The language at the top of the list of questions states that DYFS was "currently in the process of assessing the need for child welfare services for [R.A.]" and requested that the school complete the questionnaire. This letter was faxed to the Guidance Department at the school the day *after* the letter was mailed to Ms. Day stating that DYFS had determined that the case was closed and she was not in need of services. On December 23, 2003, a completed reference with answers was faxed back to DYFS.

The DYFS case record contains one page of Supervisory Notes dated February 21, 2004, outlining DYFS management concerns about how the case had been handled and what needed to be done before the case record would be closed safely. Follow-up instructions included making an MVR (Monthly Visitation Requirement) to the Day/Allen family to interview the children separately; obtaining collaterals including the children's pediatrician and contacting babysitters to see if they were certified, licensed, or registered on SIS; and speaking with the children's school teachers.

Third Referral: Child Fatality - February 25, 2004

On February 25, 2004, detectives from the Trenton Police Department reported that Samuel had been found dead in his home sitting on the toilet and had suspicious bruises on both of his shoulders. Samuel died from massive scalding injuries. His mother, Alicia Day, had left the children home in the care of her 10-year-old niece while she worked the night shift at her job. This was the same niece who was watching Samuel during the first referral incident.

At the time of Samuel's death, the Day/Allen family was not receiving services. Although the case record remained open in the Mercer County District Office of DYFS, the Case Manager considered the December 2003 investigation to be completed and prepared for closing.

III. OTHER RELEVANT INFORMATION OBTAINED THROUGH REVIEW OF RELATED DOCUMENTS

A. Training and Experience

According to information contained in the Case Manager's personnel records, he began his employment with DYFS' Mercer County District Office in August 1998 as a Family Service Specialist Trainee and was promoted to a Family Service Specialist III in August 1999. As of September 2003, he held the title of Family Service Specialist I. His tenure with DYFS has been with the Mercer County District Office. Examination of his Performance Assessment Reviews (PAR) reveals that he has enjoyed favorable performance ratings throughout his employment with DYFS.

The personnel record does not contain any information regarding training.

According to information provided by DYFS, between the months of October 2003 and March 2004, the Case Manager maintained an average caseload of 53 children. His caseload increased continually from 31 children in October to 77 children in March 2004, with an increase each month. In December 2003, the Case Manager's last contact with the Day/Allen family, he had a total of 34 children on his caseload.

IV. OCA's FINDINGS AND CONCERNS

1. The October 25, 2003 referral and investigation could have been stronger

a. The initial referral and results of the ensuing investigation were not entered into SIS, the DYFS computerized child tracking system.

Neither the October 25, 2003, referral received via OCAC nor the results of the investigation was entered into SIS, the statewide computer system used by DYFS to track children. The SPRU Investigator made an immediate response, conducted an investigation and determined that neglect was not substantiated. According to the case record, she also completed a Findings Report. A review of the SIS documents included in the case record revealed that information about the Day/Allen family was not recorded on SIS until the December 11, 2003 referral. This practice has serious implications for the child and case manager who would be next assigned to investigate the family. Having information about previous DYFS involvement would have provided the next case manager a fuller understanding of the family situation.

b. The October 2003 Child Safety Assessment only addressed Samuel, omitting any reference to the other children in the home.

As DYFS leadership has repeatedly said, safety assessments should be a "process" for the case manager, rather than a "form" to be completed at designated timeframes. DYFS policy requires the assessment of safety of each child in the home.[7] As a part of the initial investigation, the SPRU Investigator completed a New Jersey Child Safety Assessment which only included a safety assessment of Samuel, the subject of the first referral to DYFS. Despite the fact that Ms. Day's other children were seen by the SPRU Investigator and are mentioned in the investigation notes, they are not acknowledged in the Safety Assessment. The failure to assess the other children in the household as a part of the investigation is symptomatic of a now-discredited practice in New Jersey that focused efforts on only the subject of the referral. DYFS leadership recently reiterated a directive to all field staff to observe and evaluate the condition and safety of all children within a home.

[7] DYFS Forms Manual, Form 22-21, New Jersey Child Safety Assessment

c. The SPRU investigator should have conducted a thorough investigation of the allegations contained in the October 2003 referral.

The SPRU investigator did not interview any of the other children in the household as a part of the investigation, even though Ms. Day indicated that they were in the house with Samuel at the time of the incident. Case practice standards dictate that all children in the home must be interviewed, alone if possible, as a part of the protective services investigation.[8] Additionally, the case record mentions two young nieces who were present at the time of the SPRU investigator's visit. They were not interviewed. Similarly, there is no evidence in the case record that any attempt was made to contact the neighbor or aunt to discuss purported babysitting arrangements with Ms. Day. In the end, this case was approved to be "closed with positive collaterals," but no one else was interviewed before the file was submitted for closing.

The role of the SPRU investigator is to assure the immediate safety of the child. However, follow-up collateral contacts and interviews with other children in the home by an intake worker may have helped DYFS piece together a more complete picture of the family dynamics and the mother's ability to effectively parent a special needs child. Samuel was non-verbal and therefore could not provide the investigator with any information helpful to the investigation. Ultimately, the SPRU investigator relied solely on Ms. Day's account of what happened to make a finding that neglect was not substantiated.

2. In the December 2003 referral, DYFS did not adhere to the response time frame prescribed and did not conduct a thorough investigation of the allegations.

a. DYFS did not respond to the referral within the immediate time frame prescribed.

The case manager responded within 24 hours rather than the immediate time frame assigned to the referral. There is no indication in the case record that the case manager consulted with the supervisor to adjust the time frame for the required field response.

b. DYFS did not fully address the allegations of the December 2003 referral.

During the interview, the child recanted the statement he made to the referent. However, his mother acknowledged that she "beat R.A. for serious things like getting suspended from school" in the past. Nothing in the case record indicates the Case Manager explored this statement further with Ms. Day.

Ms. Day also told the Case Manager that she had five children in her care but she only had four children of her own. The Case Manager did not ask her who the other child was or how the child came to be in her home. In fact, the fifth child was not otherwise mentioned

[8] The *District Office Case Handling Standards for Screening, Investigation a& Initial Child Welfare Assessment* states that "[during the initial filed investigation, the response worker makes personal contact and collects information from all primary witnesses and persons involved in the incident(s), including the alleged perpetrator…as soon as possible after the immediate physical safety of the child or other endangered family members is assured and any necessary medical treatment has been provided." (Page 21, subsection (3)). See also (N.J.A.C. 10:129A-2.5(a)).

in the file, listed as a household member or included on *any* Child Safety Assessment prepared throughout the history of the Day/Allen case.

The Case Manager prepared a New Jersey Child Safety Assessment on December 12, 2003, which included Ms. Day and her four children. It did not include the unknown 5th child, but for the first time in case recording, all of the Day/Allen children were assessed, consistent with DYFS' then emerging practice to see and evaluate the safety of all children in a home. Physical abuse was not substantiated and the Case Manager's recommendation was "to allow natural parents to discipline their children when necessary and as needed."

3. DYFS did not investigate the family's childcare arrangement, which apparently relied on a 13-year-old babysitter.

In October 2003, during the first investigation, the SPRU Investigator inquired about Ms. Days' child care arrangements. The case record indicates Ms. Day relayed an arrangement with a neighbor. During the investigation in December 2003, the case record indicates Ms. Day stated that either that neighbor or the children's aunt cared for the children while she was at work. There is no documented evidence that the Case Manager verified the day care arrangement in either investigation. We were not able to verify whether the purported adult babysitters had an agreement with Ms. Day to care for the children at night because the DYFS case record includes no contact information for either the neighbor or the aunt.

The unverified child care plans as noted in the case record are also contrary to information provided by counsel for Ms. Day. Ms. Day's attorney indicated that she at times had to leave her children at home in the care of a 13-year-old babysitter overnight while she worked. He further indicated that on the night Samuel died, Ms. Day had made arrangements to have her 13-year-old niece watch the children, but the plan went awry and the 13-year-old had sent her 10-year-old sister instead.[9] Both girls had been previously mentioned to DYFS by Ms. Day, but as with the two adult babysitters identified to DYFS, there is no evidence in the case record any were contacted by DYFS prior to Samuel's death.

4. A lack of support services for this family looms large.

The case record notes that Ms. Day did not request services from the DYFS. Such a notation should not be construed to mean that services were offered and declined. Indeed, the case record is silent regarding any specific service offered and refused by Ms. Day. It is common practice that the details of such a conversation are documented in the contact sheets as well as on the Case Plan In-Home. The record is likely silent on this count because child care services for developmentally disabled children, particularly overnight services, were not readily accessible to at-risk families.

The most profound failure here was systemic. The child care, early intervention and homemaker assistance services that this single mother may have needed as she tried to raise four children, including a child with autism, on her own, while working an overnight shift to

[9] As reported in the Trenton Times newspaper on February 27 & April 29, 2004, Ms. Day's attorney, James Sacks-Wilner made these comments.

generate income for the family, simply do not exist in New Jersey to meet the need. The child welfare reform plan's commitments to make significant investments in prevention initiatives can lead to genuine child welfare reform if they are targeted to strengthen families like Alicia Day's, based on an assessment community-by-community of the risk factors that place children and families at risk.

ARIANNA ELLIS – DATE of DEATH: March 5, 2004

Arianna Ellis died on March 5, 2004, one month and one day after her birth. An autopsy conducted on March 6, 2004, ruled the death a homicide. The cause of death was blunt force trauma resulting in two skull fractures and a ruptured stomach. Blood was found in the infant's spinal fluid. Her 21-year-old father allegedly admitted to harming Arianna and is currently incarcerated. Criminal charges have been filed against him.

DYFS was involved with Arianna from the time of her birth. The biological mother had a long history with DYFS, and her two sons by another father were in DYFS' custody, with no plans for reunification with either parent. DYFS believed that allowing Arianna to leave the hospital with the biological mother would pose a serious risk to the infant's health and safety. Consequently, DYFS' Office of Child Abuse Control (OCAC) was contacted and the child was not permitted to leave the hospital.

A relative was identified by DYFS as an appropriate relative caregiver and the infant was placed in her household. The relative was receiving a relative care stipend to care for the infant. Although the father was not living with the relative at the time of placement, he has admitted to moving in shortly thereafter. At the time of death, the father was residing with the relative and serving as the child's care provider during work day hours.

I. DOCUMENTS AND INFORMATION USED TO CONDUCT THIS REVIEW

i. CCAPTA notice dated March 8, 2004
ii. Case Chronology
iii. DYFS case record
iv. Relevant DYFS personnel files and caseload information
v. Autopsy Report
vi. Police Reports
vii. Transcripts of prosecutor's interviews

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

DYFS' involvement with the biological mother's family dates back to the mother's early childhood, in 1985. The mother was born into a family struggling with substance abuse issues, and both of her parents had histories of incarceration. She was removed due to abuse in the home as a young child. In the years that ensued, she lived in a multitude of different foster placements. As she reached adolescence, case records indicate that she became increasingly erratic. In addition to behavioral concerns, IQ tests revealed scores consistent with borderline mental retardation. The mother became pregnant at the age of fifteen, and again at 17, delivering two healthy sons, J.W. who was born September 30, 1999, and R.W. who was born on June 20, 2001. The father of these two boys is not Arianna Ellis' father.

From 2000 until 2002, there were several DYFS interventions regarding reports of abuse and neglect. Neglect was substantiated with respect to both of the mother's sons in 2002, and the boys entered DYFS care and custody on August 13, 2002. Reunification has subsequently been ruled out for both parents, as neither has consistently complied with their case plans. The permanency goal for the two boys is identified as fost-adopt.

Due to her DYFS history, a social hold was placed on the mother's third child, Arianna Ellis, at the hospital pursuant to DYFS instruction on February 4, 2004. A relative was identified as a kinship placement and there is no DYFS history with the father's family.

The case record indicates that two MVRs were conducted following placement. A scheduled MVR occurred on February 18, 2004. The relative was present in the home at the time of this visit. The accompanying contact sheet indicates that the infant appeared well taken care of, her needs were being met, and that the home remained safe and appropriate. An unscheduled MVR occurred on March 3, 2004. This visit was prompted by a report from the mother that the father was living in the home.

At the time of this unscheduled visit, the relative was not in the home, and the father was present and caring for the infant. He admitted to residing in the home at this time. The corresponding contact sheet reports that the infant appeared well taken care of, and no concerns were indicated as to the welfare of the child or the father's ability to care for Arianna appropriately. The DYFS contact sheet indicates that the father was told that his relative would no longer be eligible for relative caregiver funds as he was now a member of the household. The father was also apparently told at this time to ask his relative to call the caseworker to follow-up.

III. OTHER RELEVANT INFORMATION

A. Personnel Information

Personnel records indicate that the caseworker at the time of death (Caseworker 1) was appointed to the position of Family Service Specialist Trainee on September 22, 2003. The Performance Assessment Review covering the period from that date to August 13, 2004 consistently scores her performance as "commendable" and in a few categories she receives the highest ranking of "exceptional." There is nothing in the personnel file that raises concerns about her competency or performance.

Personnel files for the preceding caseworker (Caseworker 2) indicate that she was appointed to the position of Family Service Specialist Trainee on July 30, 2001. Performance Assessment Reviews spanning the period of October 27, 2003 to August 31, 2004 score her in the "exceptional" range overall. All indications are that this caseworker was highly competent in her position.

B. Caseload Information

Caseworker 1 had a caseload of five families totaling eight children in February of 2004. Her caseload grew to seven families and twelve children in March of 2004.

IV. FINDINGS

DYFS case practice in virtually all respects was model, no doubt made possible by manageable caseloads of the assigned staff. DYFS' primary concern in this case had been the parenting ability of the biological mother. Based on the Division's history with the mother, and the fact that her two other children were in the care and custody of the Division with the permanency goal of fost-adopt, there were significant safety concerns should the mother leave the hospital with the infant. Accordingly, the caseworker took steps to ensure that a social hold was placed on the infant at the time of birth, and then explored both the maternal and paternal sides of the family to identify a willing and suitable relative care provider. Once that family member was identified, the caseworker followed the established protocol by conducting required background checks and completing a home inspection. All were completed with satisfactory results. As the care provider was employed, the caseworker inquired about plans for child care during working hours. The caregiver provided the name of a sitter, and that individual was found suitable.

Documentary information in the case file also reflects that appropriate action was taken with respect to visitation. Due to the mother's past involvement with the Division, and the caseworker's familiarity with the mother's capabilities, arrangements were made for supervised visitation. Case records indicate that several visits occurred and that each was completed with proper supervision.

Appropriate background checks were conducted by DYFS on the father producing satisfactory results. As the father had no criminal history, and no prior involvement with the Division, he was approved for unsupervised visitation.

KEDAR NORRIS – DATE of DEATH: March 29, 2004

On March 29, 2004 five year old Kedar Norris' (D.O.B. January 25, 1998) birth mother took him to his pediatrician, allegedly because he had been vomiting. Kedar was reportedly unresponsive when he arrived at the doctor's office and consequently was transported to a local hospital where he was pronounced dead. An autopsy revealed that Kedar died from blunt force trauma and a perforated intestine. The source of the injury remains under investigation.

At the time of Kedar's death he was living with his biological mother; her paramour; Kedar's brother, K.N., age 3; and half-brother, J.B., age 18 months. Kedar's biological father visited with him at his school, but at the time of Kedar's death, the biological father had not seen Kedar's sibling K.N. since he was 10 months old. The biological parents reportedly were not on amicable terms and as a result had little communication.

The Monmouth County Prosecutor's Office has not charged anyone in connection with Kedar's death but the case is presently still open for investigation.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The Office of the Child Advocate (OCA) collected information from various sources to complete an in-depth review of DYFS' involvement with the Norris family prior to Kedar's untimely death. Those documents included:

i. CCAPTA Notice dated March 30, 2004
ii. Case Chronology prepared by DYFS Staff (undated and preparer's name omitted)
iii. Copy of DYFS Case Record (from November 25, 2002 to March 31, 2004)
iv. Personnel records of DYFS Case Manager 1
v. Personnel records of DYFS Case Manager 2
vi. Caseload information re: DYFS Case Manager 1 (February & March 2004)
vii. Caseload information re: DYFS Case Manager 2 (February & March 2004)
viii. Medical Records regarding Kedar Norris and siblings K.N. and J.B
ix. Interviews with employee of local child care program in which Kedar Norris was enrolled
x. Interviews with biological father and paternal grandparents.
xi. Discussion with the Monmouth County Prosecutor's Office

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

Three referrals were received by the Southern Monmouth District Office of DYFS regarding the subject family.

Initial Referral - November 25, 2002

The initial referral was received on November 25, 2002 based on Kedar's report that the mother's paramour squeezed Kedar's penis with his fingers and nails the previous night. Kedar also reported that the mother's paramour beat him for failing to follow directions and not falling

asleep. Kedar further indicated that the mother's paramour knew he was hurting him and that his biological mother was aware of the incident.

The referral was assigned an immediate response time. The case record reflects that DYFS Case Manager 1 responded on November 25, 2002, within the designated response time. According to her Referral Response Report, dated November 25, 2002, Kedar told Case Manager 1 that the mother's paramour grabbed his penis and hit him on the buttocks with a belt in the past. He also said the mother's paramour sometimes hit him with a paddle. On this date, Kedar was examined simultaneously by the school nurse and Case Manager 1, who reported that there were no physical signs that Kedar had been hit or that his penis had been scratched.

On the same date, Case Manager 1 interviewed the biological mother, her paramour, as well as Kedar's brother, K.N. and half-brother, J.B. at the family home. The Referral Response Report does not indicate whether the children were interviewed alone or in the presence of the biological mother and/or her paramour. During this visit, the biological mother stated that her paramour was not allowed to discipline two of her three children, Kedar and K.N. as they were from a previous relationship. She also reportedly stated that her paramour would never touch any of her children in an inappropriate manner. The mother's paramour stated that Kedar was probably referring to an incident in which he was play wrestling with Kedar and accidentally pinched his penis. The family denied all of the allegations of physical abuse and neglect.

Case Manager 1 sent requests for information to Kedar's pediatrician and the local police department. She also completed a New Jersey Child Safety Assessment and determined that all of the children were safe. Physical abuse and neglect of Kedar by the mother's paramour were unsubstantiated.

On November 26, 2002, the case record indicates Case Manager 1 spoke with a pediatric care representative who noted that K.N. had missed two immunizations but that the pediatrician had no concerns about Kedar. However, by November 26, 2002, Kedar had been to the pediatrician's office at least twice within the past five months to treat injuries due to events described as accidents. On June 20, 2002, Kedar visited the pediatrician due to an alleged fall at school that had caused a bruise and swelling on his left outer thigh, hematoma of the legs and ringworm on his scalp. On September 10, 2002 Kedar was admitted to the hospital with a concussion as the result of an accident at home in which he was running around the kitchen and hit his head. It does not appear that Case Manager 1 requested, nor did the pediatrician provide, information regarding the child's recent visits to the pediatrician's office.

n employee of the local child care program in which Kedar was enrolled ("child care staff person") reported to the Office of the Child Advocate that the school was also aware Kedar had suffered an accident at home, which forced him to miss nearly one month of school in September 2002. The child care staff person added that during two separate telephone conversations with the biological mother during the time that Kedar was out of school, she gave two conflicting explanations for Kedar's accident. One explanation reportedly offered was that Kedar had an accident where he bumped his head against a refrigerator and was treated at the hospital for a concussion. The biological mother later reported that Kedar's brother, K.N., pushed him off of his bed, causing the injury.

The child care staff person also stated to the Office of the Child Advocate that she had mentioned Kedar's long absence from school and his mother's conflicting accounts for the absence to DYFS. However, there is no contemporaneous record of this disclosure in the DYFS case files. According to the case record, DYFS first learned of the incident after Kedar's death, nearly two years after child care staff person purported she disclosed the information.

In short, despite the fact that both Kedar's pediatrician and teacher were aware of a serious accident suffered by the child within the past two months, there is no mention of the event, or the suspicious circumstances surrounding the event, in the DYFS case record until after Kedar's death.

On November 26, 2002, the child care staff person received a fax from the local Police Department which indicated that background checks for both the biological mother and her paramour revealed no criminal conduct. On December 2, 2002, DYFS Case Manager 1 and Supervisor 1 conferenced Kedar's case for closure. The DYFS Findings Report[10] states that physical abuse and neglect were unsubstantiated and that the case would be closed at intake. The DYFS case record reflects that on the next day, DYFS made additional contact with Kedar's pediatrician to determine whether a mark on the back of Kedar's ankle was a birthmark. The pediatrician's office could not verify that the mark was a birthmark because they reported Kedar had only been a patient for a year and a half. Case Manager 1 did not follow up with the family regarding this information and the DYFS case was closed. In her Referral Response report, Case Manager 1 notes, "[s]hould another referral come into the Division concerning sexual touching, child should have a forensic interview by a sexual abuse expert or the prosecutor's office."

Second Referral - May 20, 2003

The second referral was received on May 20, 2003. During a visit with Kedar, his biological father alleged that Kedar told him that the mother's paramour squeezed his penis with his fingers until Kedar cried and that during the same incident the paramour put a sock in his mouth with tape over it because he was crying. Kedar also told his biological father that he tried to tell his mother, but that she reportedly responded that her paramour was the man of the house.

The case was coded by a DYFS Screener for an immediate response and assigned to a different case manager, Case Manager 2. On the date of the referral, Case Manager 2 met with the biological parents and Kedar at the local police department. Case Manager 1 and a detective interviewed the biological father, who reiterated the above allegations as told to him by Kedar. They also interviewed Kedar. According to the Referral Response Report, Kedar talked about being smacked in the face but was unable to give specific details. He also mentioned being hit with a paddle on the buttocks. Kedar stated that his mother's paramour put a "brown sock" with tape over his mouth while his mother was at work. Kedar also said that his mother's paramour made his penis hurt by squeezing it. Kedar mentioned that in the past he sometimes pretended to be asleep and observed his mother's paramour perform the same type of punishment on his brother, K.N.

[10] The report prepared by Case Manager 1 to indicate whether abuse and neglect were substantiated, unsubstantiated or unfounded.

Case Manager 2 and the detective also interviewed the biological mother, who stated that her paramour watched a wrestling show on television with her sons twice a week. The biological mother's account of the incident was that one night her paramour was playing with her sons in front of the television and picked up Kedar over his head, pretending to body slam him. He grabbed Kedar on the inner thigh and accidentally pinched Kedar's penis between his fingers and Kedar's leg. Kedar yelled out and the mother's paramour put him down. The biological mother said that she and her paramour immediately checked Kedar's penis and saw that it was reddened. The next morning, Kedar said that it did not hurt and the biological mother felt that there was no need to seek medical attention. Three weeks later, Kedar told a teacher that his mother's paramour squeezed his penis until he cried.

When asked about the tape and sock, the biological mother admitted that Kedar was punished in such a manner, but alleged another family member, not living in the home, was the perpetrator. The biological mother further stated that as a result of the incident, she had an argument with that relative about disciplining Kedar in that manner and had not spoken to that person since then.

Case Manager 2 and a detective then interviewed the mother's paramour, who claimed that he had accidentally pinched Kedar's penis while wrestling but did not know anything about putting a sock or tape on the children's mouths. The mother's paramour said that he would never hurt the children. He also alleged that the biological father was constantly making allegations against him because of the biological father's previous relationship with Kedar's mother. There is no evidence, however, in the DYFS case record of a previous allegation reported by the biological father.

Case Manager 2 advised the biological mother and her paramour that they could take the children home and that she would be following up with the family at their home to make sure that the apartment was clean and orderly. A detective apparently concluded that the allegations made by Kedar were unfounded.

Case Manager 2 completed a New Jersey Child Safety Assessment in which she indicated that the children were safe. The biological mother and her paramour signed a Case Plan In-Home which stated that "[m]om agrees that boyfriend will not rough house with children to avoid accidental injuries and touching."

On June 10, 2003, the local child care program in which Kedar was enrolled called the Southern Monmouth District Office to report that the biological mother withdrew Kedar from the day care center on June 9, 2003, due to what the biological mother said was a conflict with her work schedule. On June 25, 2003, the biological father called DYFS and stated that he was very upset that Kedar had been taken out of the center and that as a result, he had no contact with Kedar. The biological father was informed that the case on the family was being closed because the allegations of abuse and neglect had not been substantiated.

On July 10, 2003, a Case Summary for Closing was signed by Case Manager 2 and Supervisor 2 stating that the allegations of abuse and neglect were unsubstantiated and the case was being closed at intake. A letter dated July 11, 2003 was sent to the biological mother and her paramour informing them that the May 20, 2003 child abuse allegation was unsubstantiated and the Division would not be providing services to the family. A letter was not sent to the biological father nor was he contacted by a DYFS representative.

Third Referral - Child Fatality - March 29, 2004

On March 29, 2004 a detective from the Monmouth County Prosecutor's Office reported to DYFS that Kedar Norris was deceased. The biological mother brought Kedar to a pediatrician because he had allegedly been vomiting. Kedar was unresponsive and was transported to a local hospital where he was pronounced dead. The autopsy revealed that Kedar died from blunt force trauma and a perforated intestine.

Subsequent to Kedar's death, DYFS obtained information documenting various accidents endured by the child. Two instances, as previously discussed, occurred before the first referral but were apparently not previously disclosed to DYFS by Kedar's health care providers. On June 20, 2002, Kedar was taken to a pediatrician as a result of an accident when Kedar allegedly fell at school and had a bruise and swelling on his left outer thigh, hematoma of the legs and ringworm on his scalp. On September 10, 2002, Kedar was admitted to the hospital with a concussion as the result of an accident at home in which he was running around the kitchen and hit his head. Recall that the local child care program in which Kedar was enrolled asserts it made DYFS aware of this incident in November 2002, and disclosed that the biological mother offered two different causes for the injury.

In addition to those two incidents, on May 9, 2003, shortly before the second referral, Kedar was taken to the pediatrician as a result of a car accident. From this accident, Kedar was apparently found to have no injuries. Also, on December 12, 2003, Kedar was taken to a pediatrician as a result of a bruise on his back. The pediatrician indicated that there was no information in the file regarding the cause of the injury found during the visit. On March 5, 2004, shortly before his death, Kedar again visited a pediatrician where he was treated for an injury to his right foot that reportedly occurred as a result of running in school. In total, Kedar experienced at least five accident-related visits for evaluation and treatment in the 20 months leading up to his death.

Furthermore, on November 3, 2003, Kedar's half-brother, J.B., was treated at a burn unit for burns to his left arm and neck. The biological mother's explanation for the incident was that J.B. pulled a hot cup of tea off the table and it fell on him. The burn unit determined that the incident was an accident. There is no record DYFS was aware of any of this information until after Kedar's death.

IV. OTHER RELEVANT INFORMATION OBTAINED THROUGH REVIEW OF RELATED DOCUMENTS

A. Personnel and related records regarding DYFS Case Manager 1

Case Manager 1 appears to have had a manageable caseload. During November 2002, the month of her involvement with the family, official documents provided by DYFS indicate that she managed a caseload consisting of 8 families and 17 children.

B. Personnel and related records regarding DYFS Case Manager 2

Case Manager 2 was involved with the subject family from May through July, 2003. During that time, she managed an average caseload of 22 families and 50 children. These numbers are excessive and have an adverse effect on the quality of attention a case manager is able to devote to each family.

V. OCA's FINDINGS AND CONCERNS

1. There was insufficient contact with collateral resources.

During the initial investigation, the case manager either did not solicit the child's school records documenting the injuries to Kedar, as would appear to be the case based on the DYFS record, or did not follow up when that information was disclosed as the child care program staff alleges. The local child care program had information about an incident that occurred two months prior to the referral that resulted in Kedar missing nearly a month of school due to an accident at home, in which he suffered a concussion. While not conclusive of physical abuse, the information would have been useful to the case manager in assessing the family, particularly the conflicting explanations reportedly offered by the biological mother.

2. Kedar's health care providers did not inform DYFS of concerns.

On March 5, 2004, 24 days prior to Kedar's death, he was taken to a pediatrician as a result of an alleged accident at school. According to Kedar's medical records, he received medical treatment five times in two years due to accidents. The pediatrician, however, did not contact DYFS to report this information, nor disclose the known injuries to DYFS when asked about concerns.

3. Case Manager 1's failure to adhere to Red Flag warnings included in the November 25, 2002 Referral Response Report.

The Referral Response Report, dated November 25, 2002, clearly states on page 3, paragraph 3 that "Immediate Red Flag issues or tasks: Should another referral come into the Division concerning sexual touching, child should have a forensic interview by a sexual abuse expert or the prosecutor's office." Despite this information being included in the case record, when a second referral was made on May 20, 2003, there was no forensic interview requested. A forensic interview may have elicited more comprehensive information regarding Kedar.

4. The May 2003 Case Plan In-Home inadequately addressed potential family problems.

The Case Plan In-Home developed in response to the second referral did not address Kedar's allegations of physical abuse against the biological mother's paramour. The "Expected Changes" section of the Case Plan In-Home states that "Mom agrees that boyfriend, [] will not rough house with the children to avoid accidental injuries and touching." The Case Plan ignored Kedar's allegations of the paramour's excessive punishment, despite the fact that they were being articulated by Kedar for a second time. It also failed to include a provision regarding adequate ways for the biological mother and her paramour to discipline the children. If Kedar's allegations were true, then the question of the biological mother's willingness and ability to protect all of her children comes into question. The Case Plan In-Home did not appear to be based on a thorough assessment of the family's strengths and needs.

5. DYFS overemphasized the lack of physical evidence of abuse.

According to the Case Summary for Closing dated July 10, 2003, prepared by Case Manager 1, DYFS believed that the "[c]hild seem[ed] to be influenced by his father." Additionally, the report states that there was "[n]o evidence to support allegations." The DYFS Manual entitled *District Office Case Handling Standards for Screening, Investigation & Initial Child Welfare Assessment* (March 1996) provides guidance for interviewing children who may have been abused. Specifically, the Case Handling Standards Manual states:

> *In order for any young child (and many older children) to provide true information, the child must trust the worker to protect him or her…Often children do not disclose what really happened to them for weeks, and sometimes not for years, and then the disclosure is made only in a safe setting -- the child discloses to a therapist or to a foster parent whom the child trusts.* (p. 26)

As noted in the DYFS Manual, children often reveal abuse long after the abuse has occurred. Thus, the fact that Kedar had no visible evidence of abuse on his body should not have been the determinative factor in deciding whether or not to substantiate abuse.

6. Excessive caseloads impair practice.

As previously noted, Case Manager 2 had a case load (22 families and 50 children) that far exceeded acceptable professional standards at the time she was investigating the allegations regarding the subject family. A caseload of this size negatively impacted the investigators' ability to thoroughly assess the family.

JIBRIL FULLER – DATE of DEATH: April 13, 2004

On the night of April 12, 2004, three-year-old Jibril's mother was working the 4:00 p.m. - 12:00 a.m. shift. While she was at work, Jibril and his six-year-old brother were in the care of the mother's live-in paramour. The mother arrived home from work at approximately 12:50 a.m. on April 13, 2004 and found her paramour attempting to administer CPR on Jibril. Jibril was transported by ambulance to the emergency room where he was pronounced dead due to blunt force trauma. The attending physician noted that Jibril had multiple bruises on his head, chest, arms and back. The Essex County Prosecutor charged the mother's paramour in connection with the child's death.

I. DOCUMENTS AND INFORMATION USED TO CONDUCT THE OCA REVIEW[11]

The Office of the Child Advocate (OCA) collected information from various sources to conduct an in-depth review of DYFS' involvement with the Fuller family prior to Jibril's death. Pertinent information includes:

i. CCAPTA Notice dated April 13, 2004
ii. Case History (prepared by District Office Manager - Newark District Office II)
iii. Copy of DYFS case record (January 19, 2004- April 13, 2004)
iv. Personnel Files of DYFS Case Manager
v. DYFS Case Manager Caseload Information
vi. Medical Records regarding Jibril Fuller
vii. Irvington Police Report, January 19, 2004
viii. Interview with Regional Diagnostic and Treatment Center

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

Initial Referral- January 19, 2004

The first DYFS referral on the Fuller family was made on January 19, 2004. The referent observed Jibril at a neighborhood party and noticed he had bruises on his forehead, both cheeks and a bump on his forehead. On the date of the referral, Jibril lived with his biological mother, her paramour and his six-year old brother, N. F. On January 19, 2004, a SPRU worker made an initial contact with the Fuller family at home. He observed bruises on Jibril's face and thigh. Jibril told the SPRU worker that he fell down and showed the SPRU worker the place in the kitchen where the accident occurred.

The SPRU worker then interviewed N. F., who said he once hit Jibril on his leg with a wooden drawer. N. F. also told the SPRU worker that mother's paramour hit him and Jibril, and had slapped Jibril in the face. However, when questioned by his mother in front of the SPRU worker, N. F. denied that her paramour hit Jibril. The SPRU worker did not observe any marks or bruises on N. F.'s face or upper body.

The SPRU worker then interviewed Jibril's mother about his injuries. She stated that the bruise on his thigh occurred a month before the referral and reiterated N. F.'s account of the wooden

[11] Information contained in this section includes the CCAPTA Notice and Case Chronology prepared by DYFS and received from the Department of Human Services.

drawer; and that she did not take Jibril to a doctor because he did not complain of pain. She further stated that the bruises on Jibril's face occurred two days prior to the referral while Jibril was under the care of her paramour, who told her that Jibril had fallen on his face while he was in another room.

The SPRU worker also interviewed the mother's paramour. He stated that he had never hit either of the children. When questioned about the bruises on Jibril's face, he stated that Jibril was sitting on a chair in the kitchen, fell and hit his face. He stated that he is currently unemployed and admitted to having a criminal record.

Jibril's mother agreed to go with the SPRU worker to the hospital so that Jibril could be examined. The examining physician noted: "Multiple bruising on right of face. Explanation that patient fell doesn't explain all areas of bruising from one fall. Multiple injuries, suspicious of abuse." Jibril's mother claimed that Jibril bruised easily and was consequently given a referral for blood work.

Because the examining physician diagnosed multiple injuries suspicious of abuse, the SPRU worker brought the mother and both children the local police department in order to file a report. The officer receiving the report indicated that the case would be referred to a detective who would be contacting DYFS.

The SPRU worker completed a New Jersey Child Safety Assessment and checked-off safety factor number 19 stating that the child had unexplained bruises. The SPRU supervisor advised the SPRU worker that Jibril and his brother would have to be placed with a relative unless their mother agreed to ask her paramour to move out of the home until the DYFS investigation was completed. According to the case notes in the DYFS file, the mother to have her paramour move out of the home. However, the Case Plan In-Home signed by mother and SPRU worker on January 19, 2004, states that she agrees to not allow her paramour to supervise or care for the children until the DYFS investigation is completed. The Plan does not state that the paramour was expected to move out. The case record does not explain this discrepancy, and the subsequent notes throughout the case record reflect an understanding that the mother had committed to evict her paramour.

Case Assigned for Further Investigation

On January 20, 2004, Jibril's case was assigned to a DYFS case manager at the Wynona M. Lipman Child Advocacy Center (CAC)[12]. On January 22, 2004, the DYFS case manager received a collateral information report from N. F.'s teacher indicating that he had no known emotional or behavior problems.

On February 2, 2004, the DYFS case manager went to Jibril's home for a prearranged home visit. Jibril and his mother were present but N.F. was at school. The DYFS case manager discovered that her paramour was still living in the home, although the mother represented that he had no unsupervised contact with the children. The DYFS case manager had the mother sign

[12] The CAC serves children who have experienced serious physical and sexual abuse, following an interdisciplinary approach in which the fields of law enforcement, social work, psychology and medicine work together to ensure the availability of support services for the children and their non-offending family members. Specifically, the entities involved are DYFS, Essex County Prosecutor's Office, and the Metropolitan Regional Diagnostic and Treatment Center.

a second Case Plan In-Home in which she agreed not to allow her paramour any unsupervised contact with her children. The mother gave the DYFS case manager information about a collateral source, a babysitter in East Orange. This was the last visit by DYFS to the household prior to Jibril's death on April 13, 2004.

On February 9, 2004 the DYFS case manager conferenced the case with his supervisor who expressed concerns about the paramour's continued presence in the home. The supervisor also expressed concerns about the mother's ability to properly supervise her children since she was claiming that N. F. was hurting Jibril. The supervisor advised the case manager to contact the babysitter to explore the daycare arrangements and the children's behaviors while in her care, and to send out a request for collateral information from Jibril's pediatrician.

On February 16, 2004, a SIS/perpetrator check was completed on the mother and her paramour. The results indicated that both were unknown to DYFS prior to the initial referral on January 19, 2004. Criminal background checks revealed that her paramour was charged with a non-violent, non-drug related offense; the disposition of that charge is not documented in the DYFS case record.

On February 18, 2004, the DYFS case manager met the mother and Jibril at the Metropolitan Regional Diagnostic and Treatment Center (RDTC)[13] for a follow up child physical abuse examination of Jibril. The RDTC report states that the "[p]hysical exam revealed two old oval bruises (hyperpigmented areas) on the left cheek and old oval bruises (hyperpigmented areas) on both hips. These areas were previously noted in the emergency room assessment when Jibril was examined 1/19/04. There are no acute bruises, burns, or other pattern marks."

The RDTC further reported that "[t]he cause of Jibril's bruises, which are in low suspicion areas, is unclear but unlikely due to N. F. hurting Jibril. [The mother] reports that Jibril bruises easily. A bleeding abnormality that may cause bruising is not likely but should be ruled out. Intentional injury can not be ruled out. Diagnostic Assessment: (1) Bruising in low suspicion areas- abuse can not be ruled out. Bleeding abnormalities should also be ruled out. Physical examination neither confirms nor excludes physical abuse."

According to the RDTC report, the examining physician asked the mother about her method of disciplining her children. The mother responded that she spanks them occasionally and she has hit N. F. with a belt. The examining physician discussed non-physical ways of discipline with the mother.

A third Case Plan-In Home was signed by the mother on February 18, 2004, in which she agreed that her paramour was to leave the home and have no unsupervised contact with the children until further notice from DYFS. No effort was made by DYFS to verify compliance with this case plan. The mother also agreed to keep the children safe from physical discipline by her paramour. In addition, the case manager gave the mother a referral for blood work on Jibril at Qwest Labs in order to confirm her assertion that Jibril bruised easily.

[13] The RDTC is one of four centers in New Jersey which conducts medical and psychological evaluations for the diagnosis and treatment of suspected victims of child abuse and neglect. Most of the referrals received are from DYFS. The RDTC works closely with DYFS and the Essex County Prosecutor's Office as part of Wynona's House, as noted above. The purpose of the RDTC's evaluation is to determine if there are any physical, behavioral or emotional effects of abuse and a need for medical treatment. In addition, the RDTC provides guidance to the family to assist with the child's emotional well-being and safety.

On February 19, 2004, the DYFS case manager received collateral information from the babysitter who verified that she provided child care while mother worked. The babysitter stated that she had been babysitting N. F. since he was one year old and Jibril since he was born, and that the children are often picked-up late at night on the mother's way home from work but occasionally they spent the night.

On March 8, 2004, the DYFS case manager met with the mother and both children at the RDTC for a child physical abuse evaluation of N.F. The RDTC report states that "[t]here were no physical complaints or reports of easy bruising with N. F. Physical examination did not reveal any bruises, burns or pattern marks." On March 9, 2004, the DYFS case manager again met with the mother and both children at the RDTC for a scheduled psychosocial evaluation of N.F. The therapist met with him and explored whether the mother's paramour ever hit him or Jibril. N.F. stated that neither his mother nor her paramour hit him or Jibril. However, he acknowledged that he was frequently in trouble for hitting his brother, Jibril. The therapist asked him who he lived with and he responded that he lives with his mother. The therapist then advised the mother that she needs to show both children the same amount of attention, be conscious of how she treats six-year old N.F. and gave advice on how to address the sibling conflict.

The CAC protocol requires a multi-disciplinary (medical, legal and social work professionals) collaboratively review each case to discuss information gathered during the course of the child abuse investigation to determine the most appropriate course of action. In Jibril's case no such conference ever occurred.

Second Referral-Child Fatality, April 13, 2004

On April 13, 2004, Jibril Fuller died from blunt force trauma. At the time of his death, the initial allegation of abuse remained open for investigation in the DYFS Newark District Office II.

IV. OTHER RELEVANT INFORMATION OBTAINED THROUGH REVIEW OF RELATED DOCUMENTS

Personnel and related record regarding the DYFS Case Manager

Personnel files were reviewed and were found to be unremarkable. Staff had appropriate education and, as best can be determined, had satisfactory employment history with the Division. During the time that the case manager was assigned the Fuller investigation (January 2004 through April 2004) the DYFS case manager handled an average caseload of 26 families and 35 children.

V. OCA'S FINDINGS AND CONCERNS

1. DYFS did not properly assess the initial referral regarding Jibril.

The initial referral on January 19, 2004 was coded as a family problem despite the referent clearly indicating that Jibril had bruises and marks on his face. The referent also identified a potential perpetrator. Although the initial investigation was initiated in a timely manner, the referral was inappropriately coded as a family problem instead of an abuse case.

Inappropriate coding of the case during the screening phase may potentially establish the wrong course for the investigation. Additionally, since the case was not coded as an allegation of abuse the findings of the case would not result in the perpetrator being entered in the central registry; the perpetrator could potentially gain employment in a venue that places even more children at risk of harm. In this instance, where the facts supported an allegation of abuse, the initial coding of the incident should have been upgraded from family problem to physical abuse; and an appropriate finding supported by the facts entered into the system for future reference.

During the investigation the children were interviewed separately and privately. However, N.F. recanted his statements when questioned in the presence of his mother. DYFS discounted his initial statements because he later recanted. It should be noted that children will often change their story in the presence of their caregiver for various reasons – a desire to please, fear of later reprisal for disclosing information – and this should not automatically be construed to discredit their disclosure statements.

2. DYFS did not substantiate physical abuse, despite medical conclusions.[14]

On January 19, 2004, the date of the initial referral, Jibril was examined at the emergency room. The examining physician found that the explanation provided was inconsistent with Jibril's injuries and that the injuries were suspicious of abuse.

The DYFS Manual entitled *District Office Case Handling Standards for Screening, Investigation & Initial Child Welfare Assessment* (March 1996) specifies standards for evaluating injuries and asserts that "[b]ruises are especially suspicious when [t]hey appear in or around the mouth, especially in infants or small babies….. [w]hen there are multiple bruises in the same area of the body that aren't of the same age — some look fresh, and others look faded…. [m]ultiple bruises of this sort are particularly suspicious when they appear on the back and buttocks… [t]he more bruises there are, the stronger is the probability that they are not accidental." (pgs. 27 & 28).

In the emergency room evaluation referenced above, the doctor reported multiple bruises on Jibril's face; some 3-4 days old and others 1-2 days old. Furthermore, the physician notes bruising on both hips and on buttocks, some noted as "old, more than 1-3 days" and others as "1-2 days," and on the back of the legs, 2-3 days and 2 cm in length. Jibril's bruises were of the type specifically mentioned in the DYFS Manual as being especially suspicious.

Furthermore, on page 28 the DYFS Manual states that "[i]n general, most falls or accidents produce ONE bruise on a single surface of the body, usually on a bony protuberance such as knee, a shin, an elbow. Accidental bruises are usually on the front of the body, because in a fall, most children fall forward. If a child has really fallen, there are often marks on the child's hands from trying to break the fall. Accidental bruises may occur, but are not common when they appear… [o]n the back of the legs…. [o]n the back of the buttocks… [i]n and around the mouth… [o]n the cheeks."

Jibril's multiple bruises of varying ages are inconsistent with the DYFS Manual's description of typical bruises derived from an accident. Jibril had no bruises on his hands or knees yet

[14] Based on information contained in the *Child's Medical Examination Form* (DYFS Form 11-2), Section III, paragraph 4, completed regarding Jibril and dated January 19, 2004.

had multiple bruises with varying ages in different areas of his body. In their totality, the emergency room medical report which does not support the paramour's account of what happened to Jibril, that he fell off a chair, and N. F.'s initial statement that the paramour hits Jibril, seem to establish a preponderance of evidence to substantiate physical abuse.

3. A lack of medical standardization: RDTC doctor diagnosed bruises to Jibril's face as "low suspicion areas"[15]

The assessment of the RDTC doctor that Jibril's injuries were located in a "low suspicion area" is in direct contrast to existing DYFS Policy as referenced above. Jibril had multiple bruises on his face with varying ages, multiple bruises on his both hips and bruising on his thigh and buttocks.

When interviewed by the Office of the Child Advocate, the doctor indicated that she relied on guidelines issued by the *American Professional Society on the Abuse of Children (APSAC)*[16] rather than the DYFS guidelines noted above. She further expressed that the DYFS guidelines were antiquated and not based on current medical research. At the very least, this portends a lack of medical standardization essential to the consistent diagnosis of abuse.

4. Over-reliance on the "case plan" to assure the safety of children; DYFS did not conduct any unscheduled home visits following the initial response.

According to the DYFS case record, the safety plan for the Fuller children to continue to reside in the home during the investigation required the removal of the mother's paramour from the home. Although the mother admitted to the DYFS case manager that she had violated the case plan by allowing her paramour to continue to live in the home the Division did not take further steps to assure the safety of the children. Subsequent to that date, DYFS did not make any unannounced visits to the home to determine if the mother had come into compliance with the plan to guarantee the children's safety. In fact, DYFS never even returned to the home at all. DYFS only permitted the children to remain in the home during the investigation of the initial referral because the mother agreed to have her paramour leave the home. When the mother violated the safety plan she placed her children at great risk and DYFS should have taken further action to ensure their safety.

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[15] *Metro Regional Diagnostic and Treatment Center*, Follow-up Evaluation (CORTS Clinic), page 5, paragraph 6. February 18, 2004.

[16] The American Professional Society on the Abuse of Children is a nonprofit national organization focused on meeting the needs of professionals engaged in all aspects of services for maltreated children and their families. Especially important to APSAC is the dissemination of state-of-the-art practice in all professional disciplines related to child abuse and neglect. APSAC's national, interdisciplinary guidelines task forces regularly promulgate concise, data-based guidelines on key areas of practice in the field of child maltreatment. APSAC Guidelines for Practice are submitted to a rigorous, multi-layered process of peer review, involving experts in the subject area not on the task force, the membership of APSAC, legal counsel, and APSAC's Board of Directors. All Guidelines for Practice have been approved by the APSAC Board. APSAC's Guidelines on Low Suspicion versus High Suspicion Bruises is attached as Appendix A.

5. **DYFS did not offer the mother services to assist her in caring for and protecting her children. (The Service Plan did not address the identified needs of the family).**

   The RDTC report indicates that the mother admitted spanking and hitting N.F. with a belt and had shown poor judgment by allowing her paramour to remain in her home despite representations she would not. DYFS did not offer the mother supportive services including child care and/or parenting classes. The DYFS record does not reflect any instance of case managers offering such services.

6. **A comprehensive medical evaluation for Jibril did not occur, apparently due to health insurance issues.**

   During the initial SPRU investigation on January 19, 2004, the mother claimed that Jibril had low iron and bruised easily, yet on the date of the referral, when Jibril was taken to the emergency room, no blood tests were completed. According to the DYFS Case Chronology, the SPRU Investigator gave the mother a referral to have blood work done on the date of the referral. On February 18, 2004, when Jibril went to the RDTC for a scheduled follow-up evaluation again with the mother, the blood work had not yet been done. Instead, the mother received a second referral to Qwest Labs. The mother brought Jibril and N.F. to the RDTC for medical and psychosocial evaluations of N.F. on March 8th and 9th respectively, yet no blood tests were done on Jibril either day.

   DYFS and its medical partners had at least three opportunities to obtain a blood test for Jibril to assess the credibility of the mother's claims that the child bruised easily, but it never occurred. Instead the mother was given referrals for future dates. The tests, which were planned to verify the mother's account, were essentially left to her discretion to obtain. The progress of the investigation was left in the hands of the mother.

   The RDTC represented to us that they did not conduct the blood work for Jibril because they do not accept her health insurance. Consequently, the blood work was referred to a medical facility which accepted the mother's insurance. This policy places children at risk and should be remedied by a new policy in which the medical costs of services and tests related to an abuse assessment are fully covered by DYFS at a single assessment center.

7. **An excessive caseload and the failure to conference at the CAC impaired good case practice.**

   From January 2004 through April 2004, the DYFS case manager handled an average caseload of 26 families and 35 children. That caseload is significantly higher than the caseload standards established for workers of the CAC who handle the most complex and severe cases of physical or sexual abuse. Handling such a high volume of abused children's cases makes it extremely difficult for a case manager to provide quality services to the children and families under supervision and ultimately leaves children at prolonged risk of harm. It is possible that the DYFS case manager's case load size played a role in the CAC failure to conduct the multidisciplinary case conference according to established protocol.

AJEE ANDERSON – DATE of DEATH: April 18, 2004

In the early morning hours of April 18, 2004, Newark police officers, responding to an unrelated call in the vicinity, found nine-year-old Ajee Anderson in her home unconscious. She was transported to the hospital where she was pronounced dead shortly thereafter. The cause of death was determined to be trauma to the body. An initial medical examination revealed that Ajee had bruises all over her body and that she had been sexually assaulted. At the time of the incident, Ajee lived with her mother, L.M., her sister, F.A., and her mother's paramour, M.C.

Ajee's family has an extensive history of involvement with DYFS but, at the time of Ajee's death, DYFS had terminated its involvement with this family as of October 1999 via the Plainfield District Office. The Essex County Prosecutors' Office has charged M.C. in connection with the child's death.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The Office of the Child Advocate (OCA) collected information from various sources to conduct an in-depth review of DYFS' involvement with Ajee's family prior to her death. Pertinent documents included:

i. CCAPTA Notice dated April 19, 2004
ii. Case History (dated April 21, 2004)
iii. Records obtained from an elementary school Ajee attended
iv. Copy of DYFS case record (May 13, 1992- April 19, 2004)
v. Personnel files and caseload information regarding the DYFS Case Managers

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY[17]

The DYFS case history with the family includes a total of six referrals beginning in May 1992 and ending with Ajee's death in April 2004. The first five referrals primarily involved Ajee's older brother, K.M.

Initial DYFS referral - May 13, 1992

The family's initial involvement with DYFS began on May 13, 1992, when a school nurse made allegations that K.M. had been physically abused by his mother, L.M. The DYFS case record did not include the DYFS Referral Response Report. There was, however, a description of the referral included in the Case History that was prepared by another DYFS employee following Ajee's death. According to the Case History, K.M. reportedly went to school with a welt mark on his right cheek, a black eye and bruises on both arms. When questioned by the case manager, K.M. stated that his mother hit him with a belt. Although physical abuse was substantiated, the case manager did not provide the family with any services. The DYFS case record was closed on June 10, 1992.

[17] Information in this section includes the CCAPTA Notice and Case History prepared by DYFS and received from the DHS.

Second referral - October 12, 1995

A second referral was received by DYFS' Plainfield District Office on October 12, 1995 from a school nurse alleging that K.M. had been physically abused. This time, the alleged perpetrator was Ajee's father, S.A. The referent reported that S.A. had thrown hot rice pudding at K.M. which caused a burn on his face and had thrown K.M. on the floor. The referral was coded for an immediate response and was assigned to Case Manager 1. An investigation was conducted and Case Manager 1 performed a risk assessment of all three of L.M.'s children: K.M., F.A. and Ajee. In the Findings Report, Case Manager 1 determined that S.A.'s actions were accidental and isolated.

On November 21, 1996, Case Manager 1 sent L.M. a letter indicating that the case would not be closed until Case Manager 1 was able to conduct a needs assessment of the children. Case Manager 1 scheduled an appointment to meet with L.M. on December 5, 1996. There is no indication in the DYFS case record that the meeting ever took place. Still, physical abuse was unsubstantiated. No services were provided to the family and the case remained open with DYFS. The next referral was received 14 months after the last contact with the family.

Third referral - December 17, 1996

On December 17, 1996, DYFS received a referral that alleged that the children were being neglected by L.M. The referent reported that L.M. would leave the children at home alone on a regular basis while she engaged in drug-related activities. The referent further stated that K.M. had been kept out of school during those times so he could care for Ajee and F.A. The case was assigned an immediate response time and was again assigned to Case Manager 1.

On December 17 and 18, 1996, Case Manager 1 attempted contact with the family in response to the new allegations but was unsuccessful. On December 19, 1996, Case Manager 1 apparently mailed a letter to L.M.'s home detailing Case Manager 1's attempted contacts and informing L.M. of the need for a meeting with the family. The DYFS case record contains a copy of an undated letter written by Case Manager 1 to L.M. informing her of a home visit scheduled for February 6, 1997. There is nothing in the DYFS case record to indicate that an actual home visit or attempt was made.

Case Manager 1 did not make contact with the family until May 15, 1997, when she was able to locate L.M and the children via a check of county welfare records. There is no explanation for the long time gap between contacts other than that DYFS could not find the family. On November 18, 1997, Case Manager 1 conducted a needs assessment of the family and determined that they were not in need of services. No collateral contacts were made as a part of the assessment. The DYFS case record was closed effective November 28, 1997.

Fourth referral - July 22, 1998

On July 22, 1998, K.M. reportedly told a counselor at a program he was attending that his stepfather, S.A., hit him four or five times in the leg with a broom for not helping with household chores. This referral of physical abuse was coded for an immediate response. On the same date, Case Manager 2 met with K.M. and the referent. K.M. confirmed that S.A. had hit him with a broom for not doing his assigned chores. Case Manager 2 also conducted a visual examination of K.M.'s leg, but did not observe any bruises. Case Manager 2 then made a visit to the family's home and met with L.M., F.A. and Ajee. L.M. denied the allegations of physical abuse but admitted that she had been in bed sick upstairs in the house during most of the day in question. When interviewed by Case Manager 2, F.A. stated that she sometimes got spankings on the buttocks or was sent to her room as punishment.

The following day, Case Manager 2 returned to the home and met with S.A. S.A. admitted that he had hit K.M. with a plastic stick but suggested that he did not hit him hard. He also stated that he usually did not discipline the children and admitted that his actions may have been inappropriate. During this home visit, L.M. and S.A. signed a Case Plan In-Home in which they agreed that S.A. would not use any objects to discipline the children and that L.M. would be the primary disciplinarian. The Case Plan did not make reference to any collateral information inquiries nor did it address the family's extensive DYFS history.

In the Referral Response Report dated July 23, 1998, Case Manager 2 found the physical abuse allegation to be unsubstantiated and recommended that K.M. remain in the home with no services. Case Manager 2 characterized the allegation as an isolated incident and stated that L.M. was not in need of services since it appeared that she was already linked with a program.

Fifth referral - May 18, 1999

On May 18, 1999, K.M.'s counselor again contacted DYFS to advise that K.M. had been hospitalized. According to the referent, K.M. had not been taking necessary medication because he was being left alone to care for his sisters, Ajee and F.A. There is no record of an actual 9-7 in the file. The Case History characterizes this referral as a "reopening." The referent asked that DYFS provide support services to L.M., who the referent believed was overwhelmed with the care of her children as well as with her own personal problems. The case was assigned to Case Manager 3. On May 19, 1999, Case Manager 3 visited with K.M. at the hospital. During the visit, Case Manager 3 learned that K.M. had been at the hospital for a month. Case Manager 3 also learned that L.M. had separated from S.A. and was living with her new boyfriend, M.C. There is no record in the case file of any contacts made with K.M. or his family nor were any findings or determinations made regarding the case until September 16, 1999, as noted below.

On September 13, 1999, a social worker from the hospital wrote a letter to Case Manager 3 stating that K.M. had reported being physically abused by M.C. Specifically, she reported that K.M. alleged that on August 30, 1999, M.C. repeatedly punched him in the chest and stomach area. The social worker also expressed concerns about the home, suggesting that it was a chaotic environment. Additionally, the social worker stated that L.M. and K.M. had a history of non-compliance with treatment, that K.M. had been discharged from a program he was participating in due to his and his mother's failure to attend and that L.M. removed him from the high school

affiliated with the program and place him in a local high school in Newark. There is no documentation in the DYFS case indicating that the case manager contacted K. M.'s new school.

On September 16, 1999, Case Manager 3 visited the family's home and interviewed K.M. about the August 30, 1999, incident referenced in the September 13, 1999, letter. K.M. stated that he fabricated the story. No new 9-7 referral was generated about the allegations nor was any further investigation conducted regarding the incident. On September 30, 1999, approximately two weeks after the letter, Case Manager 3 concluded that "[c]oncerns about the Mother's ability to care for the medical needs of the child [K.M.] were unsubstantiated. Mother was actively involved in the care of her son." There is no record of any contact made with the family or collateral contacts, after the September 16, 1999 home visit.

The Case History states that L.M. signed a case plan stating that she would follow up with K. M.'s medication. There is no copy or record of the case plan in the DYFS file. In addition, the Case History states that the 9-7 was coded a Family Problem and therefore did not have a finding. There is no copy or record of the 9-7. According to the CCAPTA Notice, the case was closed in September 1999.

Ajee's Death - Sixth referral reported on April 18, 2004

In the early morning hours of April 18, 2004, Newark Police Officers responding to an unrelated call in the vicinity found M.C. screaming out of his apartment window for help. When the officers arrived, they found Ajee unconscious. She was transported to the hospital where she was pronounced dead shortly thereafter due to trauma to her body.

III. OTHER RELEVANT INFORMATION OBTAINED THROUGH REVIEW OF RELATED DOCUMENTS [3]

A. Personnel and related records regarding Case Manager 1

Case Manager 1 received a Bachelor of Arts in Sociology from Trenton State College in 1990 and was hired as a Family Service Specialist III in August 1994. In October 1999, Case Manager 1 completed an Identification of Sexual Abuse Training.

In August 1997, Supervisor 1 completed a Final Performance Assessment regarding Case Manager 1. In it, Supervisor 1 expressed concerns about Case Manager 1 leaving children in situations that left them at risk without supportive services in place. Supervisor 1 noted that Case Manager 1 left several children who were under DYFS' supervision at risk and failed to make contact with them for several months at a time.

On December 8, 1997, less than one month after Case Manager 1 terminated involvement with the family, a caseload audit report was completed by Supervisor 1. The audit revealed that of Case Manager 1's case records, 54.8 percent did not contain the required contact dictation, 20.6 percent had been identified for termination but remained open, and 97 percent were without Case Plans. Additionally, Supervisor 1 noted that Case Manager 1 often failed to make home visits or gather collateral information, leaving DYFS unable to determine the risk level to the children.

On March 17, 2003, Case Manager 1 was officially reprimanded for negligence due to a lack of documentation in a case record. Due to the lack of documentation, the court could not determine if any of the court-ordered tasks, issued on December 11, 2001, had been completed. As a result of the negligence the Division was unable to provide a recommendation to the court and was out of compliance with the court order. Case Manager 1 was assigned to investigate Ajee's family on October 12, 1995. Case Manager 1's involvement with the family ended when DYFS closed the family's file on November 28, 1997. During the time between those dates, Case Manager 1 managed an average caseload of 53 children.

B. Personnel and related records regarding Case Manager 2

DYFS did not provide personnel records for Case Manager 2. DYFS reported that it no longer possesses those personnel records because Case Manager 2 transferred to another department, although it did not provide the date of the transfer. They did, however, provide data regarding Case Manager 2's caseload information. During the month of July 1998 when Case Manager 2 was assigned to provide services to the family, Case Manager 2 managed a caseload of 49 children.

C. Personnel and related records regarding Case Manager 3

Case Manager 3 was hired by DYFS in January 1995 and assigned to the Plainfield District Office. According to Case Manager 3's personnel file, Case Manager 3 filed a grievance in October 2000 challenging an unsatisfactory rating on a Performance Assessment Review (PAR). The State agreed in April 2001 that Case Manager 3's PAR score should be changed from unsatisfactory to commendable. There is no copy of the grievance or Notice of Suspension in the personnel records.

Again, in June 2003, Case Manager 3's PAR rating was changed from unsatisfactory to commendable as a result of a grievance filed by Case Manager 3. Case Manager 3 was assigned to serve the family on May 18, 1999, and involvement with the family ended on October 1, 1999 when DYFS closed the case. During that time, Case Manager 3 managed an average caseload of 70 children, well above the national standard.

D. School Records

The OCA obtained and reviewed records regarding Ajee Anderson from a public school she attended in Newark, NJ. Those records do not indicate that any school personnel noted a concern that Ajee was a victim of physical abuse.

IV. OCA'S FINDINGS AND CONCERNS

A. A thorough and timely investigation did not occur.

The DYFS Manual entitled *District Office Handling Standards for Screening, Investigation & Initial Child Welfare Assessment* (March 1996) specifies procedures for locating and making contact with the family. Relevant procedures include case manager consultation from the field

with the supervisor, follow-up with the referent and/or contact with identified collaterals for additional information. Specifically, the Case Handling Standards Manual states:

If the worker has problems finding the family or in making personal contact for some reason, the worker consults from the field with the Supervisor. The worker or the Supervisor contacts the person making the report or contacts another identified collateral for additional information. The worker documents each unsuccessful attempt to make personal contact with the family and/or any circumstances that make personal contact impossible on the DYFS 9-7 or in attachments to it. The worker documents the extra steps or strategies she or he uses to try to make personal contact when traditional techniques or approaches do not work.

The third referral on the family was received on December 17, 1996. At that time, allegations were made that K.M., F.A. and Ajee were being neglected by L.M. Specifically, the referent alleged that K.M. was being kept out of school to care for his sisters, Ajee and F.A., and that L.M. would leave the children home alone on a regular basis while she engaged in drug-related activities.

Despite several attempts, Case Manager 1 did not make contact with the family until five months later, on May 15, 1997, when the family was located through a check of county welfare records. If Case Manager 1 had conferenced the case with a supervisor, a check of welfare records and other ways to locate the family may have been suggested well before the five month lapse in time. Also, once the family was located, a needs assessment of the family was not conducted until November 18, 1997, almost a year after the referral was received and six months after Case Manager. Additionally, in the needs assessment, Case Manager 1 concluded that the family was not in need of services despite the fact that the family had been living in a motel for at least six months and had an extensive history of involvement with DYFS.

B. The failure to gather collateral information impeded good decision making.

According to the DYFS case record, three case managers investigated the family at various times. All three at different points closed the case without seeking sufficient collateral information.

On October 12, 1995, Case Manager 1 conducted an investigation of K.M.'s allegations that his stepfather, S.A., threw hot rice pudding on his face, hit him, and threw him on the floor. On page six of the Referral Response Report, dated October 12, 1995, Case Manager 1 reported that S.A.'s actions were inappropriate. Case Manager 1 conducted a risk assessment for K.M., F.A. and Ajee Anderson. In the Findings Report, Case Manager 1 determined that S.A.'s actions were accidental and isolated. Case Manager 1 did not, however, close the case. On November 21, 1996, Case Manager 1 sent L.M. a letter indicating that the case would not be closed until a needs assessment was completed and an appointment was scheduled for December 5, 1996. There is no record in the DYFS file that indicates that the appointment was ever kept.

Throughout the course of the DYFS investigation, Case Manager 1 did not attempt to contact schools, medical institutions, paternal relatives or counselors. Similarly, Case Managers 2 and 3 both closed the case without attempting to gather information from collateral sources.

C. Professional warnings should receive appropriate weighting.

On August 30 and September 13, 1999, a social worker from a different entity informed Case Manager 3 of alleged physical abuse by M.C. against K.M. There is no record that Case Manager 3 reported this allegation to a supervisor or generated a new referral. At a minimum the warning might have provided reason to keep the case open for further investigation instead of closing the case on October 1, 1999.

D. Case Manager's excessive caseloads

According to the personnel files provided by DYFS regarding caseload information of the three case managers assigned to this case at separate times since 1995, the caseloads were excessively high at the times they serviced the family. It would be very difficult for any case manager to perform effectively under the overwhelming volume of children assigned to each one of the three case managers below. The average caseload noted below was derived from the information provided by DYFS, which notably excluded all caseload statistics for 1996. The DYFS-provided information also excluded caseload information regarding the number of total families served.

From the date Case Manager 1 was assigned to the family on October 12, 1995, until the case was closed on November 28, 1997, Case Manager 1 managed an average caseload of 53 children. During the month that Case Manager 2 was assigned to the family in July 1998, Case Manager 2 was managing a caseload of 49 children. From the date Case Manager 3 was assigned to the family in May 1999 until the case was closed on October 1, 1999, Case Manager 3 managed an average caseload of 70 children.

SHARON JONES – DATE of DEATH: APRIL 22, 2004

On February 28, 2004, Sharon Jones, a twenty-month old female child was admitted to a hospital in Newark, New Jersey, after she reportedly suffered a seizure. On March 19, 2004, Sharon was transferred to different hospital in New Jersey. On April 22, 2004, Sharon Jones, then a twenty-two month old female child, died while still a patient at that hospital from injuries related to the February incident.

Sharon and her mother resided with Sharon's paternal grandparents from June 2002 until September 2003, when the mother and Sharon moved out. The mother's six-year old son, M.J., remained with his paternal grandparents, who have legal custody of him. The mother then rented a room for herself and Sharon in a home in Orange, New Jersey, where they lived until the end of January 2004. At the time of her injury, Sharon was residing with her mother, her mother's paramour, the paramour's sister, and the paramour's sister's four children in the paramour's sister's home in Newark, New Jersey. Sharon and her mother apparently moved into that home the beginning of February 2004.

In November 2004, an investigator from the Essex County Prosecutor's Office informed OCA that the Medical Examiner reported that Sharon's death had been ruled a homicide, and that the Essex County Prosecutor would be presenting its case to the Grand Jury sometime in December 2004 or January 2005.

FAMILY INFORMATION

During the investigation, Office of the Child Advocate (OCA) staff conferred with the Essex County Prosecutor's Office Investigator, and learned that Sharon's biological parents met at an occupational day program. The mother and her paramour also knew one another from the occupational day program. The mother also reported during a psychological evaluation that she met Sharon's biological father at a social services agency program in Newark, New Jersey.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The OCA collected information from various sources to complete an in-depth review of the child welfare system's involvement with this family prior to Sharon's death. Those documents included:

i. CCAPTA Notice date March 1, 2004
ii. Updated Case History prepared by a Newark District Office II manager on May 19, 2004
iii. Copy of DYFS Case Record from February 27, 2003 through February 28, 2004
iv. Personnel Records of Caseworkers 1 and 2
v. Requested Medical Examiner's Report
vi. Medical Records from two hospitals
vii. Conversation with an investigator at Essex County Prosecutor's Office
viii. Sharon's medical records from her pediatrician

ix. Interview with a parent aide from a family support services agency center in Newark

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

This family first became known to DYFS in 1998. The Newark DO II, through SIS, learned that this family became known to DYFS on February 16, 1998. The Division received another referral regarding the family on March 30, 1998. The case was later closed on September 3, 1998. On May 30, 2000, DYFS investigated an allegation of neglect; an SIS review indicates that the case was closed on May 31, 2000. On February 27, 2003, DYFS reopened the case after receiving a referral from a therapist at a counseling center in Newark, who reported the mother's allegation that her son M.J. was sexually abused by his father.

Referral/Initial Involvement with DYFS: February 16, 1998

On February 16, 1998, the mother contacted the Office of Child Abuse Control (OCAC) alleging that the paternal grandparents had alleged that she was unfit to parent and were threatening to file for custody of M.J. This call was coded as a family problem. The statement of conclusions indicated that the mother had a history of violent acting out and mental limitations, remained in need of "DYFS risk assessment" and the paternal grandparents appeared to be providing adequate care and supervision to M.J.

The OCA review of SIS revealed that this mother was known to the Division as a child with confirmed allegations of abuse or neglect. The specifics of the case activity should have been accessible on SIS at the time (February 1998), as the case was closed on March 25, 1998. The electronic information available on the case is now inactive and inaccessible due to time elapsed since case closing. The OCA is unable to determine the specifics of the investigation, whether the previous history of the mother was evaluated or disposition of the case in the absence of the case record.

Referral: March 30, 1998

On March 30, 1998, the mother contacted OCAC to report that she had been admitted to the psychiatric unit at a hospital in Newark after arguing with her child's paternal grandparents and throwing things around the home. The statement of conclusion notes that she is developmentally delayed. The call was coded a family problem with no abuse or neglect. Per SIS, the case was opened with a goal of family stabilization and closed on September 30, 1998. The OCA is unable to determine the specifics of the investigation and closing in absence of the case record.

Referral and Case Reopened:May 30, 2000

On May 30, 2000, an anonymous caller contacted DYFS to report that the [surname's] household was without electricity and the family was using candles in several rooms. [It is not clear

whether the reported "household" meant that of the paternal grandparents, or whether the mother and her children's father may have had their own residence.] In addition, the family had a dog as a pet and the caller was concerned the dog might knock over the candles. The allegation of neglect was unsubstantiated.

The OCA's review of SIS revealed that the statement of conclusion indicates that "there was no evidence of the family using candles," that there were ongoing "problems with the landlord" and the family would be trying to move. The case was closed at intake on May 31, 2000. Although unable to fully assess the investigative activity in absence of the case record, the closing of the case within 24 hours suggests that the investigation was shallow and did not include follow up with collateral sources.

Referral and Case Reopened:February 27, 2003

The mother contacted a counseling center in Newark, requesting information about parenting classes. During her conversation with a therapist, she stated that her children's father had sexually assaulted M.J., and had put his hands in Sharon's diaper. The mother alleged the incidents occurred in June 2002. M.J. was in the legal custody of his paternal grandparents and his father also resided in the home. Caseworker 1 and a colleague visited the paternal grandparents' home. They interviewed M.J., the mother, the father and the paternal grandmother. The worker also saw Sharon, who could not be interviewed due to her young age. M.J. denied ever being sexually abused by his father. The worker questioned the mother about her mental health history; she reported that she had taken medications, Risperdal and Lithium, in the past, but that her doctor stopped prescribing them.

On February 27, 2003, Caseworker 1 created an In-Home Case Plan, valid for six months. The mother agreed to take both children for a complete physical evaluation.

On February 28, 2003, M.J. was evaluated by a physician's assistant at a medical office in Newark. The medical report indicates that there was no indication that he had been sexually abused. The allegation of sexual abuse was unsubstantiated. Concerns were once again raised about the mother's mental state and ability to parent. The case was opened for "in home services" with a goal of family stabilization.

Referral: March 18, 2003

The mother contacted her worker, Caseworker 1, and reported that she saw M.J. tugging on his father's penis, that the paternal grandmother did not intervene, and that S. [another relative living in the home] hit M.J. Caseworker 1 visited the home later that day and interviewed the mother, M.J., the paternal grandmother, and the father. The mother told Caseworker 1 that M.J. had been tugging on the front of his father's pants and when she told him to stop, the father began laughing. The mother also reported that S. hit her son on one occasion and had thrown a coat at him. The mother further reported that S. had been charged with sexual assault and was on probation.

Caseworker 1 spoke with the father, the paternal grandmother, A. [a child residing in the home], and M.J. about the mother's allegation that her son tugged on his father's penis. In separate

interviews, the father and the paternal grandmother each reported that M.J. tugged on the front of the father's pants, but that the pants were baggy. The paternal grandmother did not believe that the father had acted inappropriately. When the worker questioned M.J., outside the presence of others about the incident, he denied touching his father's pants.

During the course of her interview with M.J., Caseworker 1 asked him again about his mother's allegation that his father had sexually abused him. M.J. laughed and would not answer, but the worker asked him to be honest, and he said that the event happened when he was four years old. When the worker asked him to confirm it, he laughed and said "yeah."

Caseworker 1 also asked M.J. about his mother's allegation that S. had hit him and thrown a coat at him. M.J. reported that he and S. played games, like "high five", and sometimes S. would trick him by moving his hand away, but denied ever being hit by S.

In addition, Caseworker 1 questioned the paternal grandmother about the mother's allegation that S. had been charged with sexual assault and was on probation. The paternal grandmother reported that S. was developmentally delayed and a woman he knew made the sexual assault allegations. She further reported that the prosecutor investigated the case, deemed it an isolated incident and sent S. to a program, which he continued to attend.

During her visit to the home, Caseworker 1 observed the mother's interactions with M.J., and noted that at one point, the mother yelled at M.J. to "tell the truth about what his father did to him or he was going to go to foster care." The paternal grandmother intervened, told the mother to stop and sent M.J. inside to change his clothes.

The worker, in the Referral Response Report, dated March 18, 2003, noted that the mother's parenting ability and mental health are in question, and Sharon and M.J. were scheduled for medical evaluations on 3/19/03. She recommended that the family be referred for services and monitored for continued services. She also indicated that she would conduct a background check on S. and all adults in the home who were 18 and older. The worker also prepared a Case Plan In-Home. She noted that the paternal grandparents meet Sharon and M.J.'s basic needs, the mother needed a psychiatric evaluation, criminal history background checks needed to be completed on all adults in the household, and parent aide services needed to be implemented for the mother. DYFS was to help the mother obtain childcare for Sharon. In addition, the paternal grandmother agreed to notify DYFS if the mother left the home with the child [not indicated whether the caseworker is referring solely to M.J., Sharon, or both] and does not return. SIS reflects that DYFS paid for services to be provided to the family.

Case Transfer: April 9, 2003

The case file contains a standard memo form from a Regional Diagnostic Clinician at the Newark hospital, to Caseworker 1. The clinician's preliminary recommendations were for the mother to have a psychiatric evaluation and "maintain ongoing DYFS involvement regarding custody of 10 month old child [Sharon]". The form noted that a full psychological evaluation with final recommendations would be forthcoming.

Caseworker 1 prepared a Case Summary for Closing/Transfer. In Section 3, the worker wrote that the medical exam evaluators suggested that the mother have a psychiatric evaluation; in

Section 4, the worker noted that daycare services for Sharon should be explored with the mother, and in Section 5 [issues that require the immediate attention of the new case manager], the worker wrote:

- The mother complete her psychological evaluation and recommended follow up services, deemed necessary by Dr. B.;
- Sharon Jones not remain in the physical custody of her mother Jones due to her mother's mental instability, as per the medical exam recommendation; and
- Exploring daycare services for Sharon with mother, so that she may participate in continued psychological/psychiatric services.

Caseworker 1 sent a letter addressed to the paternal grandparents and the mother, notifying them that the case was being transferred to the Generic Unit and that the mother had a psychological evaluation scheduled with Dr. B. on May 6, 2003.

April 15, 2003: DYFS submitted referral for parent-aide to FIS/YAP:

The parent-aide referral was prepared by Caseworker 1 on April 10, 2003 and faxed to the FIS/YAP agency in Newark, on April 15, 2003. DYFS requested a parent-aide for 8 hours a week. The DYFS file does not indicate whether services were ever implemented, although the District Office manager approved the SAR.

May 6, 2003: Psychological Evaluation with Dr. B.

There is no record that the mother attended her appointment with Dr. B. The file does not contain a copy of a psychological report.

June 6, 2003: Case Assigned to New Worker

Supervisor 2 reassigned this family's case to Caseworker 2 on June 6, 2003. In the cover sheet, Supervisor 2 advised Caseworker 2 to:

- Read record and assess for services;
- Obtain psychological evaluation completed by Dr. B.;
- Check status of family involvement with Family Intervention Services;
- Check status of medical exam evaluations; and
- Complete MVR and SDM (safety assessment).

SIS indicates that the case was not officially transferred until June 23, 2003.

June 20, 2003: MVR

Caseworker 2 visited the paternal grandparents' household and met with the father, the mother, M.J., and Sharon. The mother reported that she was receiving mental health services from a Newark hospital and that she had been prescribed Risperdal, but then the doctors took her off the medications.

August 12, 2003: MVR

Caseworker 2 visited the paternal grandparents' household and met with "all parties". During the visit, the mother indicated that she was frustrated with the paternal grandparents, who would not allow her to discipline M.J. The caseworker told her that they had legal custody and that the mother would need to return to Family Court in order to amend the custody agreement. The caseworker also told the mother that she might want to consider getting her own place to live if she was dissatisfied living with the paternal grandparents.

September 16, 2003: MVR

Caseworker 2 received a call from the mother that she and Sharon had left the paternal grandparents' home and had rented a room in a home in Orange. The caseworker visited with the mother, Sharon, and the home's owner, P.C. The caseworker conducted a Child Safety Assessment and deemed that Sharon was safe. In the case note, the worker noted, "Sharon appeared to be in good physical health at this time." The caseworker prepared a Case Plan In-Home, dated September 16, 2003 to ongoing. MVRs were to be conducted both every 4 weeks and every 6 months. The mother agreed to provide for all of Sharon's basic necessities and provide appropriate supervision when M.J. visited her. In addition, the mother agreed to attend parenting classes, if needed, to make herself available for the parent-aide, and to submit to a psychological evaluation. P.C. agreed to oversee the mother and Sharon while they were in her home. The caseworker submitted a background check of P.C. to SIS. An October 16, 2003 notation on the form indicated that no record of P.C. was found.

October 7, 2003: MVR at paternal grandparents' household

Caseworker 2 conducted an MVR at the paternal grandparents' home. She met with M.J., the paternal grandmother, and the father. She spoke with M.J., who informed her that he had weekend visits with his mother and saw his sister during that time. The caseworker told M.J. that she would refer him for either a psychiatric or psychological evaluation. The paternal grandmother informed the caseworker that the mother had left the grandmother's home in August 2003. The paternal grandmother said that M.J. was permitted to visit with his mother at her (his mother's) home.

The caseworker completed a Safety Assessment for M.J. and deemed him safe.

October 8, 2003 through October 14, 2003: DAG Conference and Caseworker obtained M.J.'s Psychosocial

On October 8, 2003, the Regional Diagnostic Center faxed M.J.'s April 9, 2003 Psychosocial Evaluation to Caseworker 2. The evaluator made a number of recommendations regarding the mother and M.J., including continued therapy for the mother and father; additional psychological and psychiatric evaluations be conducted, including assessments for parenting skills; continued monitoring of the mother's interaction and supervision of her children. In the evaluation's narrative, the clinician wrote, "If [the mother] is asked to leave the home of the paternal family,

DYFS should intervene to assess whether she is able to independently care for her infant daughter, Sharon Jones."

The case notes reflect that there was a conference with the Deputy Attorney General on October 8, 2003, but do not indicate the substance of the conference.

On October 10, 2003, the caseworker referred the mother to a family support services agency in Newark for a parent-aide for services to: increase the mother's social and interpersonal skills; assist her in parent/child management skills; assist her in home management functions; provide direction, guidance, and support with the aim of improving her self-esteem, increase her awareness of community resources and encourage their use; assist her in becoming more self-sufficient, and increase her awareness of social/recreational activities. She also referred her for psychiatric and psychological evaluations and therapy at Family Connections.

In addition, the caseworker contacted a hospital in Newark to confirm the mother's assertion that she was being seen there for out-patient services. An employee informed the caseworker that the mother had been an in-patient for one week in June 2002, but she was not in the system as an out-patient client.

The worker also referred the father to a facility for psychiatric and psychological evaluations. There are no psychological or psychiatric evaluations for the father in the case file.

November 5, 2003: MVR

Caseworker 2 visited with the mother and Sharon and brought along the parent aide so that services could begin. The mother informed the caseworker that she had filed for custody of M.J. The caseworker noted that Sharon appeared to be in good physical health, was walking, and appeared more independent. The caseworker told the mother that her psychological and psychiatric evaluations and therapy were scheduled for December 1, 2003.

December 1, 2003: Psychological Evaluation for the Mother

The mother received a psychological evaluation on December 1, 2003. The evaluator completed the report on December 2, 2003 and faxed it to the caseworker on December 4, 2003. The evaluator spoke with the parent-aide and the DYFS caseworker to garner their perceptions of the mother. The parent-aide reported she began providing services to the mother on November 11, 2003, had been in the home three times a week for two to three hours per visit and observed the interactions between the mother and Sharon to be appropriate. She noted the mother's strength was patience and her weaknesses were defensiveness and a mistrust of others.

The evaluator recommended that the mother participate in individual counseling; participate in parenting skills training, maintain appropriate stable housing; participate in a psychiatric evaluation; and participate in frequent and supervised visitation with her son.

December 14, 2003: Psychiatric Evaluation for the Mother

The mother had her psychiatric evaluation on December 14, 2003. The psychiatrist obtained collateral information from the mother's grandmother, the paternal grandmother, the December

1, 2003 psychological evaluation, and DYFS reports. In the Medical and Surgical History Section, the mother reported no history of seizures, head trauma, or loss of consciousness.

The psychiatrist recommended that the mother continue with her parenting skills training, receive psychiatric treatment and follow-up regarding her poor self control and, with individual therapy and psychiatric treatment, she should be able to reunite with her son. The psychiatrist's report was faxed to Caseworker 2 on March 2, 2004, four days after Sharon was admitted to a hospital, and almost 3 months after the date of the evaluation.

December 29, 2003: Office Visit

The mother, her parent-aide, and Sharon visited the caseworker at the DYFS office. The mother informed the caseworker that she had a court date on January 2, 2004 for a permanent custody hearing for M.J. The caseworker noted Sharon appeared to be in good physical health. The mother provided the caseworker with an updated copy of Sharon's immunization record. The case record does not contain notification from the court of the hearing or requesting DYFS input for decision-making.

January 29, 2004: Parent-Aide Monthly Report

On January 29, 2004, the parent-aide faxed her monthly report to Caseworker 2. The report stated that the mother planned on moving because she and Sharon had been without heat and hot water since December 29, 2003. There is no indication that Caseworker 2 responded to the parent-aide's report. (The last documented MVR to the household was in November 2003).

A member of the OCA staff met with the parent aide on November 9, 2004. The parent aide recalls speaking with the DYFS caseworker during that time and remembers notifying the caseworker that the mother had moved and gave her the mother's new address. The parent aide also reported that she told the mother to contact the caseworker.

February 28, 2004: 9-7 Referral

A hospital in Newark contacted OCAC to report that the mother called 911 and stated that Sharon had stopped breathing. EMT responded to the call and brought Sharon to the hospital. She arrived in full respiratory arrest and had no heartbeat. There was a bruise under Sharon's left eye. Sharon was placed on a ventilator.

According to the mother, at about 10 p.m. on February 27, 2004, she went into the bathroom in the home she shared with Sharon, the mother's paramour, the paramour's sister, and the sister's four children. Sharon remained in the living room with the paramour, who suddenly called out for the mother, yelling "the baby, the baby." The mother rushed back to the living room and saw Sharon convulsing. The mother and the paramour tried to lower Sharon's temperature, called 911 and were advised to begin mouth to mouth resuscitation. Sharon started breathing again, they called 911 a second time, and the ambulance arrived. The mother reported that a toddler had pushed Sharon down earlier in the day, resulting in the bruise under Sharon's left eye.

The paramour reported that the mother went to the bathroom and Sharon was on the floor while he made her a drink. He looked back at Sharon, saw that she was convulsing and yelled for the

mother. The family called 911 and began mouth to mouth resuscitation; the EMT arrived shortly after and Sharon was transported to a hospital.

Hospital medical staff expressed concern that Sharon's convulsions began at 10 p.m., but almost four hours passed before Sharon was brought to the hospital at 2:45 a.m. on February 28, 2004. However, the paramour's sister, E., reported that she went out at 12:15 a.m. and Sharon was fine at that time. When she returned at 2:30 a.m., the ambulance was outside the house. She reported that the mother and Sharon had lived in her home for about a month and she had not observed any abuse or neglect.

E.'s son, A., reported that he woke up when his uncle yelled A.'s name. A. left his room and saw Sharon convulsing. A. said it was sometime after 2 a.m. when it happened.

Sharon remained at the hospital until March 19, 2004, when she was transferred to a different hospital.

Child Fatality- April 22, 2004

Sharon remained hospitalized until she died in on April 22, 2004.

In November 2004, an investigator from the Essex County Prosecutor's Office informed the OCA that the Medical Examiner ruled Sharon's death a homicide and that the Prosecutor's Office will present Sharon's case to the Grand Jury. The investigator was unable to provide a firm date, as he still needed to complete and submit his final report, but felt that his office would most likely present the case sometime in December 2004 or January 2005.

III. OTHER RELEVANT INFORMATION OBTAINED THROUGH REVIEW OF RELATED DOCUMENTS

1. Sharon Jones' Pediatric Records

Sharon's primary care physician was Dr. R., and she was seen regularly at his office. In addition, Sharon was treated by emergency room physicians on two occasions, July 3, 2002 and September 11, 2003. A review of the records indicated that the doctor's visits were generally well-baby checkups for vaccinations and the doctor may have been treating Sharon for allergies. In addition, the doctor conducted a physical exam at the February 2003 appointment, after the mother alleged that the children's father had sexually abused M.J. and Sharon.

2. Interview with the Parent-Aide

The parent aide reported that the mother was worried about Sharon's development and thought that Sharon might be delayed in meeting developmental milestones. The parent-aide believes this conversation may have occurred in January 2004. The parent-aide also reported that the mother had been concerned because she had observed Sharon banging her head against a wall. The parent-aide, based on statements made by the mother to her, believed that the mother

informed Sharon's doctor about her concerns. The parent-aide's recollection was that the mother reported the doctor was not worried about the milestones. The parent-aide did not know if the mother had informed the doctor that Sharon was hitting her head against the wall.

The parent-aide began working with the mother in November 2003 and continued as the parent-aide until Sharon was transported to the hospital on February 28, 2004. The parent-aide reported that she worked with the mother on Mondays, Wednesdays, and Fridays for two hours at each visit. Much of the time she accompanied the mother to appointments to the Social Security Administration regarding the mother's Supplemental Security Income, as well as visits to a program in Orange. She also accompanied the mother to a court date regarding custody of M.J. and to other miscellaneous appointments.

The parent-aide reported that Sharon was a happy, healthy child. She reported that Sharon would fuss when the parent-aide arrived at the home because Sharon knew that they would be going outside to take care of errands and Sharon enjoyed being outside. The parent-aide's last home visit occurred on February 25, 2004. She had an opportunity to observe the mother interact with Sharon and, on a few occasions, she observed the paramour's interactions with Sharon. She did not note any problems. Additionally, the parent-aide noted that the mother did not trust many people and she felt it was significant that the mother allowed the paramour to interact with Sharon.

IV. OCA'S FINDINGS AND CONCERNS

1. Case Manager does not respond to Parent Aide's January 29, 2004 Monthly Report

On January 29, 2004, the parent-aide faxed her monthly report to Caseworker 2. In the report, the parent-aide noted that the mother and Sharon were moving from the rooming house because they had been without heat and hot water since December 29, 2003. Concern is noted that the service provider was aware of the family's circumstances but she did not make an immediate call to the case manager to assist the family; rather, the worker was not notified until she issued her report a full month later. Sharon, and M.J. when he visited, were at risk in the home with no heat or hot water. There are no case notes or other indications that the case manager read the report, that she was aware of the mother's anticipated move, or that she knew where the mother and Sharon were living until February 2004. There is no record that a 9-7 was generated in response to the parent-aide's report.

2. The most recent Case Plan In-Home, dated September 16, 2003 to "ongoing," states that MVRs will occur both every 4 weeks and every 6 months.

DYFS' Field Operations CaseWork Policy and Procedures Manual, §703.2, states that the District Office Manager must approve MVRs if they are to occur on a six month basis, but there is no documentation in the file to indicate DO Manager approval. The most recent MVR occurred on November 5, 2003. There were no MVRs in December 2003, January 2004 or February 2004. Given the ongoing circumstances of the family and the intensive involvement of the parent-aide, a quarterly MVR may be justifiable if there was regular communication between

the parent-aide and the case manager. A monthly MVR would have been preferable. Approval of a semi-annual MVR would demonstrate a lapse of professional judgment in this case.

The case record documenting two different MVR schedules is a concern because the case manager is likely confused about the level of supervision the family requires; potentially leaving the children at elevated risk of harm.

3. Caseworker 2's caseload grew by 39 families and 65 children between June 2003 and February 2004

A review of Caseworker 2's caseload shows that in June 2003, when she was assigned this family's case, she had a caseload of 23 families and 40 children. On July 24, 2003, Caseworker 2's supervisor submitted an Inter-Office Communication to a Supervising Family Services Specialist I, recommending that Caseworker 2 be removed from the intake rotation immediately. In making her recommendation, the supervisor noted that Caseworker 2 had inherited 24 cases, 17 of which needed to be investigated, and that she had received 16 new families since being re-assigned to Intake on June 2, 2003. The supervisor carbon copied her communication to the District Office Manager. In July 2003, Caseworker 2 was responsible for 45 families with 80 children.

The personnel record obtained by the Office of the Child Advocate does not include a response communication from either the Supervising Family Services Specialist I or the District Office Manager.

In August 2003, Caseworker 2's caseload dropped to 41 families and 68 children. Her supervisor issued a memo to her on September 4, 2003 advising her that her statistics for July and August were overdue. In September 2003, her caseload again increased to 51 families and 88 children. Her caseload continued to increase each month, through February 2004, when Sharon died.

In February 2004, Caseworker 2 was responsible for 62 families and 105 children. On February 20, 2004, her supervisor sent a memo to her that she was scheduled for 10 days of protection planning. Her scheduled dates were from February 23, 2004 through March 5, 2004. Sharon's incident occurred on February 28, 2004.

A review of Sharon Jones' DYFS case file showed that Caseworker 2 failed to conduct any MVRs after November 5, 2003. Additionally, Caseworker 2 did not respond to the parent-aide's January 2004 monthly report.

The caseload carried by Caseworker 2 was excessive throughout her involvement with this family. The level of concern is elevated in consideration of each case representing an ongoing investigation at the intake level. In spite of the issue being raised to the highest managerial level in the district office, no action was taken to relieve the situation. That Caseworker 2 continued to be assigned new cases in spite of the supervisor's request that she be removed from intake rotation is troubling. The OCA is aware of strategies in the Child Welfare Reform Plan targeted to address this issue. Strategies for assuring manageable caseloads should include benchmarks and measures of management accountability to actively address burgeoning caseloads.

4. The record does not clarify the legal relationship between A., a child who resided in this home, and the paternal grandparents.

On February 27, 2003, Caseworker 1 conducted a field visit to the paternal grandparents' home, in response to the 9-7. During the course of the visit, the caseworker spoke with A., which is reflected in the Referral Response Report's narrative. However, A. is not listed as one of the persons with whom the caseworker had "field contact" on the first page of the report. No additional information about A., other than his first name, is contained in the report. There are several other mentions of A. in the record (during March 2003 office visit by the paternal grandfather, he reported that "[A.] is not a blood relative, but was taken by the [paternal grandparents] because his mother was running the streets and did not want him. [A.] had a DYFS case before"; and in an April 9, 2003 Psychosocial Evaluation of M.J. the evaluator noted the presence of A., 14 years old).

However, in the February 28, 2004 Safety Assessment, conducted by SPRU, at the home of the paternal grandparents, M.J. is the only child listed. The form's instructions require that all children living in the home at the time of the Safety Assessment be listed on the form. If a child is not present at the time of the assessment, the child's whereabouts must be noted. The Safety Assessment failed to name A. as a child residing in the home.

As the DYFS record contains little information about A., other than passing references to his age and ambiguous relationship to the paternal grandparents, it raises concerns about this child's identity, the legal relationship between him and the paternal grandparents, and his whereabouts at this time.

5. Failure to follow through on recommended mental health services for the parents

Throughout the DYFS involvement with this family, the mental health and stability of each parent, and their respective ability to parent independently were in question. The Division was in possession of reports from psychologists and psychiatrists that indicated that the mother would need continued support. Although recommended, the case record does not include documentation of completed mental health evaluation on the father. In addition, the mother indicated that she met her paramour at the occupational day program, which is an indicator that he may have special needs as well. There is no indication that the mother received the ongoing counseling and supports that were last recommended for her in December 2003 by a psychologist and a psychiatrist. It is noteworthy that the case manager did not receive the report from the December 2003 psychiatric evaluation until after the incident that resulted in Sharon's death in March 2004.

If the hospital's version of the facts is true, that convulsions began 4 hours before the first call for help for Sharon, then the ability of each parent/caregiver to fulfill their role becomes critical. It appears that, for whatever reason, the mother did not use sound judgment in determining the need for medical assistance. It is unclear if earlier medical intervention would have led to a different outcome.

ILIANA WIENER – DATE of DEATH: June 11, 2004

On June 11, 2004, Iliana Wiener, a two-year-old girl, was asphyxiated while hiding in a closet with her five-year-old brother and her mother's paramour. The three were hiding because the paramour wanted to avoid detection by the children's grandparents. While in the closet, the paramour was reportedly holding Iliana around the chest and covering her mouth so that she would not make noise. When the three emerged from the closet, Iliana was not breathing. Efforts to resuscitate her failed and she died after being transported by emergency medical personnel to the hospital. The autopsy report states that the cause of death is asphyxiation from constriction.

I. INFORMATION USED TO CONDUCT THE OCA REVIEW

i. CCAPTA notice
ii. DYFS case record
iii. Case manager personnel records and caseload data
iv. Autopsy Report

At the time of her death, Iliana's parents were divorced and the children spent half of each week with their mother and half of their week with their father. Prior to Iliana's death, the parents often fought over custody of the children and accused one another of parental abuse and neglect. Between April 6, 1999, and the time of Iliana's death, DYFS received four referrals regarding the Wiener children. Each time DYFS received these referrals, workers were immediately dispatched to investigate the allegations; none of the allegations were ever substantiated.

II. REVIEW OF DYFS' INVOLVEMENT WITH FAMILY

Four referrals were received by the Northern Monmouth District Office regarding the Wiener Family.

A. Initial Referral - April 6, 1999

The first referral concerning the Wiener children was made on April 6, 1999. The referent called DYFS to complain that the mother was taking her son to work and that he was spending the day in a crib or playpen, that she had been arrested for controlled drug use and that the mother and her sister were under psychiatric care. The case was appropriately assigned a 72 hour response time.

The case record indicates that between April 8, 1999 and June 9, 1999, DYFS Case Manager 1[18] made several attempts to contact the family. Specifically, on April 12, 1999 and April 15, 1999, the worker visited the identified residence where the referent indicated the mother was residing with the children. When no one answered the door she left her card. On April 22, 1999, the worker sent a certified letter to the address. On May 19, 1999, the worker received a telephone

[18]Caseload for Case Manager 1: April 1999 – 25 families/41 children; May 1999 – 21 families/40 children; June 1999 – 20 families/38 children. Caseload numbers reflect that the case manager was successful in moving cases through the intake process.

call from the mother's stepmother who denied providing child care for the child. She went on to explain that the parents had reunited and she provided the worker with a number where she could contact the mother. When the worker addressed the drug allegation with the stepmother she became very upset and stated that it was irrelevant because the family no longer resided with her.

Initial efforts to establish contact with the parents at the number given were unsuccessful. The case manager was able to establish phone contact with the mother on June 19, 1999, and met with the family at their home on June 26, 1999. DYFS recorded that the father allegedly admitted that he contrived the allegations because he was angry with his wife.

The case manager obtained favorable medical collateral information on the child and that there was no record of the father having been arrested, or of the police being called to the home. The allegation of neglect was not substantiated and the case was closed at intake.

B. Second Referral - August 1, 2002

On August 1, 2002, DYFS received an allegation that the mother spanks her son and had hit him in the mouth the week prior. The referent also indicated that the child's maternal grandfather hits him. The referent was also concerned that the child had pulled down his own pants and climbed on top of the referent. The referral was appropriately assigned a 24 hour response time. The investigation was assigned to DYFS Case Manager 2.[19]

On August 2, 2002, the case manager addressed the allegations with the mother who was once again living with her son in the home of her father and stepmother. The mother stated that she was not surprised by the allegations because she and the father were fighting over custody of their son and their baby, Iliana. The mother told the case manager that she had left the father permanently and they were in the midst of a bitter divorce. Her plans were to continue to reside with her parents until she could be on her own.

The case manager appropriately interviewed her son separately and privately. The worker explored the sexual abuse allegation with the son; he was clear that he had not been sexually abused. In the interview of the maternal grandfather and his wife, they told the case manager that the mother had problems in her relationship with the father, but that she wants her priority to be her children. Regarding the sexual abuse allegation, the grandfather and stepmother told the worker that the child might have inadvertently been exposed to something of a sexual nature on television, but never for an extended period of time.

The worker concluded the investigation by contacting the children's pediatrician who expressed no concerns about the children. The safety assessment completed on August 5, 2002 concluded that the children were safe with no identified risk factors. The allegations were not substantiated. The supervisor approved the case for closing on August 6, 2002 pending the medical collateral which was obtained on August 8, 2002. The notification of findings and case closing was not forwarded to the family until February 10, 2003. There is no documented activity on the case

[19] Case Manager 2 was a Family Service Specialist I with a "specialty" in sexual abuse. Her employee training history included in her personnel file indicates that she had attended a one day, 5 hour training session related to sexual abuse. There is no other documented training in this area, although the possibility of additional training that was not recorded is duly noted.

during the intervening time period. SIS indicates the case was actually closed on January 29, 2003.

C. Third Referral - July 22, 2003

On July 22, 2003, DYFS' Office of Child Abuse Control received an anonymous call stating that the father's house was filthy, the toilets were backed up with feces, and there was open trash, bugs and garbage bags all over the house. The caller also alleged that the father was a diabetic and leaves his needles around the home. The parents had joint custody of the children; the father had them from Sunday through Wednesday. The SPRU Investigator was able to establish immediate contact with the father and children. The investigator completed a safety assessment and determined the children to be safe and the home free of hazards. The investigator referred the case to the intake unit to follow up with the paternal aunt and the pediatrician as collateral contacts, and assure that the father followed through on cleaning the kitchen. Neglect was not substantiated.

DYFS Case Manager 3[20] conducted a follow up visit to the father's home. The date of the contact is not indicated on the documentation. The home was noted to be clean and appropriate at the time of the home visit. The record does not reflect any follow up activity with the aunt or the mother. The father was notified of the investigative findings and case closing through correspondence dated August 15, 2003. The worker obtained medical collateral information from the child's pediatrician on August 19, 2003.

D. Fourth Referral - November 3, 2003

On November 3, 2003, the referent notified DYFS that the mother slapped her son on November 2nd, just two weeks after the court reinstated unsupervised visits between the mother and the children. The referent indicated that the child was taken to the police station to document what appeared to be finger marks on his left arm. The parents had joint custody at the time.

Case Manager 3[21] received the referral with a 72-hour response and responded immediately. The child indicated that when he wanted to call his father, his mother became upset and slapped him on the back of his forearm. The child was interviewed at school in the presence of his teacher. During the course of the interview it became clear that he knew intimate details about his parents' divorce proceedings and was clearly being negatively impacted by the ongoing dissension between his parents. The case manager did not document discussion with the child that explored whether his mother's actions hurt or caused him injury, or if Iliana was ever hit by their mother. Likewise, although the case manager learned a lot about the child from a documented interview with his teacher, she did not document if the teacher had ever noted signs that he was being abused or neglected on other occasions.

On November 6, 2003, Case Manager 3 met with the mother; she denied hitting her son and attributed the allegations to a vendetta that her husband has against her. On November 13, 2003,

[20] Case Manager 3 caseload: 55 families and 91 children in July 2003, and 61 families and 104 children in August 2003.
[21] Case Manager 3 caseload was 61 families and 109 children in October 2003, and 43 families and 79 children in November 2003.

Case Manager 3 conducted a safety assessment of the home and found the home environment to be appropriate. The worker found that the mother interacted appropriately with her children, provided structure and that the children were safe in her care. On the same day, the worker went to the Freehold Township Police Department to look at the pictures taken of the alleged injury. The pictures showed no visible sign of bruising or injury. When the DYFS worker asked the assigned detective whether he saw marks or bruises on the child's arm when he was brought to the station, he said he saw what appeared to be two small faint red marks, perhaps from an insect. When the worker asked why the police had not notified DYFS about the incident at the time, he said "because it was not serious."

On November 18, 2003, the worker requested immunization and attendance records from the school. The records showed that he had missed a total of 14 days of school; twelve of those days he was with his father, one day he was out due to a documented illness and one day he was out for a Jewish holiday. Case Manager 3 also conducted extensive collateral interviews with the therapists and a relative. The mother's therapist stated that she was doing very well. The child's therapist expressed concern about what he was going through as a result of the custody battle, but said that "she has no concerns about the children's well being or safety." The relative stated that on the day of the alleged incident she saw no bruises or marks on the child and that the father was still very angry with the mother due to the divorce. She indicated that she told the father "if the child had marks on him, you [father] put them there."

Based on her investigation, Case Manager 3 concluded that the allegation was unsubstantiated. The mother was notified of the investigative findings and case closure through correspondence dated December 3, 2003. The worker recommended the father have a parenting assessment. It is not clear whether the assessment occurred or if there was further intervention or services offered by the Division to address child welfare concerns.

E. Child Fatality - June 11, 2004

On June 11, 2004, the Freehold Township Police Department reported to DYFS that Iliana Wiener had died. Prior to the death, Iliana and her brother were in their mother's home under the supervision of their mother's paramour.

Following the death, the DYFS worker learned that when the children's maternal grandparents approached the home, the paramour took the children into the closet to hide. They stayed in the closet approximately 10 minutes. The paramour reportedly believed that the maternal grandparents hated him and, as a result, he would hide in the closet whenever they came to the home. This was the first time that they had stopped by while he was alone with the children. According to the Freehold Township Police Department, the paramour indicated that while the three were in the closet he crouched down and held Iliana around the chest and covered her mouth. The surviving sibling verified that account. When they emerged from the closet, Iliana was not breathing; the paramour started mouth to mouth resuscitation and called 911. According to the hotline report, Iliana had a pulse when EMS arrived at the home, but she was not breathing. The child was transported to the hospital and was pronounced dead at 7:48 p.m. The Monmouth County Medical Examiner issued an autopsy report and an addendum that indicates the cause of death was "traumatic asphyxia due to chest compression" and the manner of death was determined to be "homicide."[22] The Monmouth County Prosecutor's Office has charged the

[22] Final Report of the Office of the Medical Examiner of the County of Monmouth, October 2, 2004.

paramour with aggravated assault and endangering the welfare of a minor. The paramour was released on bail and ordered to have no contact with the surviving sibling or the mother's home.

In investigating the death, the DYFS case manager learned the mother allegedly worked from 11 p.m. to 7 a.m. at a nursing home; she would assure that her paramour had the children out of the home by 7:30 a.m. so that she could sleep. There is no clearly documented child care plan while the mother worked over night. Based on the initial investigation of the death, on June 13, 2004, the DYFS worker determined that the surviving sibling needed a medical exam, that the mother's parenting skills and mental health status needed to be assessed, and that the home and relatives needed to be evaluated.

III. PERSONNEL INFORMATION

A review of the personnel file of Case Manager 3 revealed that she had appropriate education and experience to carry out the duties of a case manager. The following table presents caseload information for Case Manager 3:

Month/Year	# Families	# Children
May 2003	47	73
June 2003	52	85
July 2003	55	91
August 2003	61	104
September 2003	59	107
October 2003	61	109
November 2003	43	79
December 2003	38	68
January 2004	35	60

One of the Case Managers noted in her file that she had no supervisor from December 2002 through February 2003. She was assigned a supervisor in February 2003 but none of her cases submitted for conference or closing were moved until she was reassigned to another supervisor in June 2003.

Personnel information regarding Case Manager 2 and Case Manager 1 were also reviewed. Each had appropriate education and, as best can be determined, had satisfactory employment history with the Division.

IV. FINDINGS AND CONCERNS

1. Role of the Supervisor

An area of concern highlighted by this case is the need for consistent and diligent supervision. One of the DYFS Case Managers clearly articulated the impact of being unsupported, or under-supported, by effective supervision. Supervision is one of the keys to assuring adherence to existing agency policy at the ground level of the organization and improving case practice decision making. In formulating the Child Welfare Reform Plan strengthening the role of the supervisor was identified a key element of the reform efforts.

2. Child Welfare Concerns

By the third referral on this family it becomes evident that the ongoing battle over custody of the children was central to the allegations, and that the parties were using the child protection system, in part, as a weapon in their private custody dispute. This undoubtedly colored the agency's treatment of the family.

The 5-year-old child was being subjected to trips to the police station, interviews about the family, etc. where he was placed in the middle of the feud between the parents. During the November 2003 investigation, the child clearly articulated the emotional impact of the family dynamics. The mother revealed the intensity of her psychiatric history and ongoing mental health needs. The intake investigator rightly identified the need to obtain an assessment of the father to determine his ability to parent. However, although the concerns were noted, the case was apparently closed at intake.

Similarly, the issue of substance abuse by the step-grandmother was not resolved during the initial investigation because she was no longer in a position to care for him when the family reunited. However, while investigating the second referral of August 1, 2002, DYFS learned that the mother and children were living with her father and stepmother. At this time, it certainly would have been prudent for DYFS to determine whether the stepmother was using drugs and caring for the children, given that she was in such close proximity to them.

3. Specialized Case Loads

Developing specialties in the DYFS district office to address more challenging areas of case practice is not without merit. The OCA is concerned that in this case the purported sexual abuse specialist had only one documented training in the area of specialty. The Division must ensure that staff who are designated as "specialists" in a given area are provided with ongoing training and professional development opportunities to support their work in that area. If the Division seeks to have the expertise of staff formally recognized it will also be important to assure that accurate records of training attendance is maintained and establish continuing education standards to stay abreast of developments in the defined area.

As DYFS embarks upon an ambitious reform effort to create new specialists in the child welfare system, namely those who serve adolescents and support resource families, the keys to their success will be adequate training and supervision.

CHRISTIAN STOKES – DATE of DEATH: July 4, 2004

On July 4, 2004, Christian Stokes, a three-year old male child (D.O.B. -- 6/7/00), died from complications of injuries he received nearly four years earlier. On September 5, 2000 Christian's biological father was supervising the child and his two older brothers, M.S. (D.O.B. 11/17/97) and A.S. (D.O.B. 3/1/99). Police reports indicate on this date a baby wipe became lodged in Christian's throat causing chronic static encephalopathy. Since the incident occurred, Christian remained hospitalized and dependent on a ventilator. DYFS substantiated neglect against the biological father.

At the time of the incident, the family had been the subject of two prior investigations with the Ocean County District Office of the Division of Youth and Family Services. In the first incident neglect was unsubstantiated with child welfare concerns against the biological mother, and in the second incident, lack of supervision was substantiated against the biological father.

I. DOCUMENTS/OTHER INFORMATION USED TO CONDUCT THE OCA REVIEW

The Office of the Child Advocate (OCA) collected information from various sources to conduct an in-depth review of DYFS' involvement with the family prior to Christian's untimely death. Pertinent documents included:

i. CCAPTA Notice dated July 6, 2004
ii. Copy of DYFS case record (February 2, 2000 – July 4, 2004)
iii. Copy of DYFS personnel records for DYFS Case Manager
iv. DYFS SIS database

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY[23]

Three referrals were received by the Ocean County District Office regarding the subject family. One referral was received by the Southern Monmouth District Office regarding the subject family.

November 23, 1998

DYFS initially became involved with this family when a referral was received alleging domestic violence incidents and alcohol abuse on November 23, 1998. There is no further documentation regarding this incident in any case record. SIS reflects that the referent alleged that the biological father moved out of the home following the domestic violence incident and the biological mother "partie[d] constantly" since then. The allegation further indicates that the biological mother sleeps half the day and the baby (M.S., one year old)) was not being cared for. The caller reported that the biological mother does not have a drivers' license and drives with the baby in the car while under the influence of alcohol; specifically, that she is drunk when she picks the baby up from the maternal grandparents. Details of investigative activity are unknown. However, the SIS statement of findings indicates that neglect was unsubstantiated with child

[23] Information in this section includes the CCAPTA Notice and case records received from the Department of Human Services.

welfare concerns. The domestic violence is noted as a "verbal argument" with "minor physical pushing." The biological mother filed a restraining order. The allegations regarding drinking and driving were denied. Finally, the conclusion indicates that the biological mother was on welfare (AFDC) and child M.S. was behind on his immunizations. The case was closed at intake on February 10, 1999. It should be noted that the biological mother was pregnant at the time of the investigation and gave birth to child A.S. on March 1, 1999.

February 2, 2000

On February 2, 2000, while the biological father was caring for the children and the biological mother was at work, A.S. splashed bleach into his eye. The biological mother returned from work and was tending to A.S.'s eye when the biological father attempted to steal money from the biological mother's purse. The biological parents began to argue and the biological father pushed the biological mother to the ground and left the home. On February 2, 2000, the biological father was arrested and charged with theft, robbery and simple assault. He was released from jail on February 6, 2000. The bleach incident was referred to DYFS four days later on February 6, 2000. In addition, allegations of neglect/lack of supervision were substantiated against the biological father.

According to the case record, on February 6, 2000, the biological parents signed a case plan which indicated that the biological father would not be the primary caretaker of the children pending the outcome of DYFS' investigation. According to DYFS Case Manager 2's notes, arrangements had been made for the biological father and children M.S. and A.S. to be supervised by a maternal aunt, while the biological mother was at work. The biological father contacted DYFS because he was unsure of the aunt's address. He assured DYFS Case Manager 2 that he would not be alone with his children. There is no further indication in the case record as to whether or not the biological father was left alone with his children unsupervised. The case records indicate that DYFS Supervisor 2 gave DYFS Case Manager 2 permission for the biological father to be left alone with the children; however, the date is unknown. As part of the case plan, the biological father agreed to undergo a substance abuse evaluation.

On February 7, 2000 a substance abuse evaluation of the biological father was completed. Out-patient substance abuse treatment was recommended based on the evaluation. On March 15, 2000, DYFS case records indicated that the biological father was terminated from treatment due to non-compliance with the treatment plan.

According to the case record, DYFS Case Manager 2 made three unsuccessful attempts to locate the family on April 25, 2000, May 3, 2000 and May 16, 2000 via telephone.

DYFS records include a handwritten note dated May 17, 2000 from DYFS Office Manager 2. In addition to a recap of the incident, the note questions why DYFS would allow the biological father to be left alone with the children when he assaulted the biological mother and was deemed to be at high risk for intoxication based on his substance abuse evaluation. In a case note, DYFS Office Manager 2 requests updated police reports, contact with the biological father's probation officer, and an in-person visit to the home. The note finally insists that personal contact is needed in order to engage the biological parents in a treatment plan.

The family was located on May 17, 2000. The biological mother and the children were residing in the home of the maternal grandmother. The maternal grandmother stated that the biological father had moved out of state. At this time, DYFS Case Manager 2 learned that the biological mother was pregnant. On May 19, 2000, DYFS Case Manager 2 contacted the biological mother's treating physician and confirmed that she was receiving pre-natal care. Additionally, DYFS Case Manager 2 did a background check on the maternal grandmother. The case record does not indicate if a collateral check was done with child A.S.'s treating physician.

On the "Referral Response Report: Documentation of Response" for the September 5, 2000 incident, DYFS records indicate that the case regarding the February 2, 2000 bleach incident was closed on May 14, 2000.

September 5, 2000

On September 5, 2000, DYFS received a referral that Christian Stokes (3 months old) was at the hospital with a baby wipe stuck in his throat. According to the referral, the biological father was home with Christian and his brothers, A. S. (19 months) and M.S. (2 years, 10 months). The biological father said he was preparing a bath for A.S. and M.S., when M.S. walked into the bathroom indicating that there was something wrong. The biological father said he attempted to remove the wipe and was unsuccessful. The biological father brought Christian to a neighbor's house to call 911 because the family did not have a phone.

The case record indicates on September 7, 2000, a DYFS medical consultant observed Christian. Areas of bruising were observed on Christian's left ear, as well as bruising on the chest and marks on Christian's left leg and on the sole of his right foot. On the same day, DYFS was made aware that a chest x-ray revealed several rib fractures on the child's right side. It was medically determined that the fractures were not attributable to the incident of September 5, 2000.

On September 8, 2000, an e-mail was sent from DYFS Office Manager 1 to DYFS Office Manager 2 and DYFS Case Manager 1 indicating that x-rays were positive for rib fractures of ribs 7, 6, 5, 4, 3, and possibly 8. The e-mail states that the fractures were consistent with abuse and were approximately 3-4 weeks old. In closing, the e-mail indicates that the radiologist would prepare a report for DYFS stating that the injuries are in fact consistent with abuse.

The suspicious nature of the rib injuries and aspiration of the baby wipe were further documented in written medical reports. On October 21, 2000, a "portable skeletal survey" was conducted. The survey report notes that the old healing rib fractures are suspicious for previous incidents of abuse. On November 8, 2000, written correspondence between medical professionals states that the incident of September 5, 2000 in combination with the fractured ribs, could only lead to the conclusion that Christian's injuries were the "direct result of physical abuse." A medical report submitted to the Ocean District Office on January 16, 2001, states a medical conclusion that multiple rib fractures in an infant are "clear evidence of inflicted, abusive injury." It is further noted that the aspiration event, even without the presence of rib fractures, would be very suspicious for abuse. "With evidence of prior abuse in the form of rib fractures, the aspiration of the baby wipe is even more likely to have been an intentional act."

The DYFS investigation was concluded with the origin of the rib fractures undetermined. The siblings were placed with the maternal grandmother (relative care) on September 6, 2000. DYFS gained custody of A.S., M.S. and Christian Stokes on September 12, 2000.

Christian remained hospitalized in critical, but stable condition. There is no indication that Christian had any preexisting special needs prior to September 5, 2000.

To date it is unclear how a baby wipe came to be lodged down Christian's throat. The biological father claimed that Christian's brother, M.S., who at the time was 2 years and 10 months old, forced the baby wipe down Christian's throat. However, in a neurodevelopmental consultation report it was noted as highly unlikely that M.S. would "forcefully conceal" the baby wipe in Christian's throat. According to the report, M.S. would have needed intent to injure Christian with such a maneuver. The medical belief was that M. S., at 2 years and 10 months, did not have the ability to form such an intent. The report deemed it highly unlikely that M.S. could have inserted a baby wipe into Christian's throat and forced it down so deeply that it could not be seen and suggested that the prosecutor's office continue their investigation seeking a more likely suspect.[24]

January 14, 2002

The family was scheduled to meet with the DYFS Case Manager 2 and Supervisor 2 in the office on January 14, 2002. The maternal grandfather indicated he had neither seen nor heard from his wife and the children since the previous night. The police were notified as the Division had legal custody of the children. The maternal grandmother, mother and children were located on February 25, 2002. DYFS concluded the biological mother continued to be a "noncompliant drug addict" and the children were at risk in her care. Neglect was substantiated and the children were placed in an unrelated DYFS foster home.

July 4, 2004

On July 4, 2004, Christian Stokes was brought to the Emergency Department of a local hospital with difficulty ventilating. Christian died from respiratory complications stemming from being ventilator dependent.[25] Christian was ventilator dependent due to the September 5, 2000 incident, in which a baby wipe had become lodged in his throat.

According to the CCAPTA notice dated July 6, 2004, and a letter written by the biological father on May 14, 2004, the biological father is incarcerated on unrelated charges. Additionally, the biological mother is missing.

As of June 21, 2004, A.S. and M.S. reside with their paternal grandparents. The paternal grandparents are in the process of gaining Kinship Legal Guardianship of A.S. and M. S.

[24] According to the Ocean County Prosecutor's office on October 28, 2004, the prosecutor will not further investigate the circumstances surrounding Christian's death.

[25] According to documents provided by DuPont Hospital for Children, Christian Stokes died because of cardiopulmonary arrest from overwhelming sepsis.

III. FINDINGS AND CONCERNS

1. Quality Assurance and Accountability Issues

- **Case Closing With Unresolved Child Welfare Concerns**

The case was closed at intake on February 10, 1999. The biological mother was pregnant at the time of the investigation and gave birth to A.S. on March 1, 1999. The statement of findings indicates that neglect was unsubstantiated with child welfare concerns, an elusive finding that DYFS intends to abandon as part of its reform plan. The domestic violence incident was minimized as a "verbal argument" with "minor physical pushing." There was also concern raised regarding routine well-baby care for M.S. There is no indication in the case record that any of these issues were addressed or resolved prior to case closing.

- **Managing Noncompliance and Maintaining Consistent Personal Contact with Families**

The case manager noted that the father was noncompliant with substance abuse services. The record also indicates efforts to maintain contact with the family via telephone. Again, given the nature of the concerns with the family and the age of the children, the case manager should have assured regular, face to face contact with the mother, father and children. The family was apparently not in missing status because the case manager was able to see them the next day when instructed to do so by the District Office Manager.

Each of these issues is addressed in measures to be implemented through the Child Welfare Reform Plan. The Plan includes new screening and investigative protocols for allegations of child abuse and neglect. In addition, it establishes expectation for families with ongoing child welfare issues to be serviced in the community to assure the safety and well-being of the children through community collaboratives. In the interim, the Division must assure that known child welfare concerns are addressed prior to case closings.

2. Domestic Violence, Substance Abuse, Paramour Caregivers, Unexplained Injuries and the Risk of Harm

From the initial encounter (September 1998) with this family, domestic violence and substance abuse were identified as issues. In the earliest referral the extent of the domestic violence was minimized by the case manager and alcohol abuse was denied by the mother. Neither issue was addressed in any meaningful way. The next referral (February 2000) again surfaces issues of domestic violence and alcohol abuse; and, one of the children sustained an injury due to substantiated neglect/lack of supervision. Seven months later (September 2000) Christian is the victim of what ultimately became an incident of fatal abuse/neglect. The children were at home under the sole supervision of their father in each of the last two instances. This case should have been handled under the high risk protocols due to the age of the children, allegations of substance abuse and domestic violence in spite of the family denying or minimizing the severity of these issues.

The Division has determined, and national data supports, that at least 50 percent of families under supervision are impacted by substance abuse or domestic violence. In response to

several of the fatalities described in this report, DHS has already revised policy to address the risk associated with paramours and giving direction for staff in related decision-making. In like manner, DYFS should review policy related to identifying, measuring and responding to risk related to domestic violence and substance abuse in families when they are present individually and in tandem with one another.

J. A. – DATE of DEATH: July 5, 2004

At the end of the school year in June 2004, 17-year-old J.A., a teen-ager in the legal custody of DYFS with a long history of behavioral health issues, was left without any behavioral health supports for the summer months and committed suicide on July 5, 2004. The teen's mother had committed suicide in 1997 and was discovered by the child, devastating the youth psychologically. DYFS, the ACE Program[26] and the CART (the county-based mental health consortium) each assumed another agency or agencies were responsible to address the youth's ongoing needs in the summer of 2004, but none did. The CART office indicated that DYFS had represented the family was "connected to school- based services," therefore, they did not continue to try to engage the family. A DYFS file note indicates that the DYFS Case Manager believed that the "CART was supposed to set up aftercare services," but notes that the "CART is out of money." Further along in this same note, the DYFS Case Manager writes, "Need family counseling – if CART can't provide, refer to Value Options," referring to the centralized administrator of the State's behavioral health program. J.A.'s DYFS Case Manager reported to OCA that he decided not to refer the youth in the summer of 2004 to the state's emerging behavioral health system for children because J.A. was not interested in services. Administrators from that behavioral health system expressed to OCA that the referral should not have been discretionary.

On July 5, 2004, at approximately 2:00 P.M., J.A. was found hanging by his shoelaces in his closet. The death was ruled a suicide. While J. A.'s death occurred at his own hand and does not fit within the classic definition of abuse or neglect by a caregiver, we believe that the lack of coordination and communication among child-serving agencies comprised a form of systemic neglect, justifying this investigation and report. It is not certain that utilizing one or more specific interventions, or providing one or more additional services, would have prevented this tragedy from happening, but J.A.'s death points to the urgent need for better planning and coordination among child-serving agencies, particularly for children with serious mental health needs.

I. DOCUMENTS AND INFORMATION USED IN THE REVIEW

We collected information from many sources to complete an in-depth review of the child welfare system's involvement with J.A.'s family prior to his death. These documents and interviews included:

i. Copy of the DYFS Case Record
ii. Copy of Juvenile Detention Center and Shelter Record
iii. Interviews with:
    Staff from the County CART
    Staff from J.A.'s school system
    Staff from the Group Home
    Drug & Alcohol Counseling staff from U.M.D.N.J.

[26] The ACE Program is described as an alternative educational program for students that require more attention in the classroom. Class sizes are smaller, classes are shorter and students can receive optional individual and group therapy. No family therapy is offered.

II. REVIEW OF THE CHILD WELFARE SYSTEM'S INVOLVEMENT WITH THE FAMILY

This family initially became known to DYFS in September 1984 due to allegations of neglect associated with an older child. The allegations indicated that the child was left alone on the street. The police found the mother to be incoherent and were not comfortable releasing the child to her care. DYFS substantiated that the child "was not properly supervised and was uninjured" and confirmed that her mother was responsible. A subsequent referral to DYFS was received in August 1985 indicating that the same child was admitted to a local hospital with second degree burns. Her mother indicated that she accidentally spilled coffee while in the car. This time, abuse/neglect was not substantiated. The case remained open for supervision of the family by DYFS until 1987.

Nearly a decade later, Mrs. A. committed suicide. The Division was not involved with the family at the time of the mother's death.

April 30, 1999

In April 1999, DYFS became aware of allegations that Mr. A, J.A.'s father, was alcoholic. An individual who frequented the home alleged that Mr. A. was physically abusive when he was under the influence of alcohol and that the children were not safe. The findings of the investigation are unclear; however, Mr. A. was directed to receive alcohol/substance abuse evaluations.

September 5, 2000

One of J.A.'s siblings made suicidal threats on August 28, 2000 and was taken to a local hospital. A referent contacted DYFS and indicated the child needed psychotherapy, but her father was failing to follow through on the services. The referent also related concerns about continued alcohol abuse in the home. The Statement of Findings/Conclusion indicates that appointments were made for alcohol evaluation for Mr. A. DYFS expressed concerns for the children as "they express emotional and behavioral problems and father is not following through with their mental health needs."

This same sibling was again the subject of two referrals to DYFS on February 1st and 2nd, 2001. Following a reported conflict with Mr. A., the child was placed her with a friend by DYFS. The child subsequently ran away from that placement, but DYFS obtained custody and placed the child with a maternal aunt.

In 2001 J.A. was arrested for a minor burglary. He was placed on probation and ordered to attend substance abuse treatment and abide by a curfew. DYFS was responsible for arranging substance abuse treatment. J.A. was referred to the Youth Advocate Program for services on May 11, 2001, but in August, 2001, J.A. was found to be out of compliance with the conditions of his probation and DYFS obtained legal custody. He remained, however, in his father's physical custody. J.A. was again ordered by the court to attend individual counseling and psychiatric treatment.

January 2002

In January 2002, J.A. was placed in a juvenile detention center due to a violation of probation. He was released to the county Youth Shelter on January 22, 2002, pending a court ordered DYFS out-of-home placement. On February 24, 2002, J.A. returned to detention to await placement because he attempted to run away from the shelter. On March 13, 2002, J.A. was placed for in-patient substance abuse treatment. On September 17, 2002, J.A. was discharged and placed in the a Group Home. He was not able to return home, allegedly because of his father's non-compliance with substance abuse treatment and concerns regarding his ability to adequately supervise his son.

J.A. was at first a loner at the group home but over time became increasingly comfortable. According to his discharge summary from the Group Home, J.A. did very well in their program, making great progress in many areas. The most significant emotional issue J.A. confronted according to all records reviewed was the death of his mother and his tumultuous relationship with his father.

The group home discharge summary reads, "Although J.A. has accomplished the personal objectives that were established throughout his placement, we remain concerned with respect to issues that remain unsettled regarding his father's ability to provide adequate supervision." The discharge summary appears that it was obtained and reviewed by DYFS.

The summary continues reporting that J.A. will start the "Ace Program at school which will provide counseling and mentoring." The staff describe the Ace Program as providing assistance with academics "and any issues that may develop." The Group Home determined that the ACE Program would provide adequate aftercare for J.A. The discharge summary does not reflect any additional support services for the family.

Upon discharge from the Group Home, on August 15, 2003, J.A. moved home with his father and uncle. J.A. was assigned a new DYFS Case Manager that month. The new Case Manager was assigned a monthly MVR schedule with the family. A review of the contact sheets reveals that these meetings occurred approximately every 1 ½ months. The Case Manger appeared to meet with J.A. at school and home. The meetings were private enough to allow J.A. to speak openly with the Case Manager. The Case Manager reported a great deal of difficulty maintaining contact with Mr. A., who often did not return his phone calls.

J.A. started the ACE Program at his high school in September, 2003. The ACE Program is described as an alternative educational program for students who could benefit from more attention in the classroom. Class sizes are smaller, classes are shorter and students can receive optional individual and group therapy. No family therapy is offered.

In March, 2004, J.A. started a part-time job at a local supermarket. In April, May and June, 2004 J.A. met with his DYFS Case Manager and reported that things were going well for him. He thought that he would be receiving A's and B's in school and that things were going smoothly at home. Additionally, he hoped to start training to be a cashier at Stop & Shop.

The ACE Program reported that J.A. was doing so well during the school year that they did not think that he required any further services during the summer. The students are briefed during

the course of the year regarding phone numbers to call in case of crisis, which J.A. did not use. The CART had reached out to J.A.'s family on several occasions but the family allegedly never returned the contact. She further noted that DYFS informed her that "the family is very connected to school based services." Based upon this information, the CART believed that the child was linked with adequate mental health services for the summertime. For its part, DYFS did not refer J.A. to the children's behavioral health system because J.A. reportedly expressed his disinterest in services.

In retrospect, professional staff of the high school observed that J.A.'s "situation deteriorated as soon as the school ended" due to the lack of structure and support that he had been receiving during the school year. In fact, J.A. was not receiving any support services when school was dismissed for the summer. Family members concurred that as the summer wore on, J.A. became more depressed and his behavior more erratic.

According to the local police, after J.A.'s body was discovered on July 5, 2004, Mr. A. was too "upset and too intoxicated to speak to her" that day. The police indicated that Mr. A. had been "at a friend's house, down the street, drinking" when J.A.'s body was discovered by another family member.

III. OCA's FINDINGS AND CONCERNS

It is not clear that utilizing one or more specific interventions, or providing one or more additional services would have prevented this tragedy from happening. The case history, however, does indicate the need for better coordination among child welfare agencies in the arena of adolescent behavioral health services.

1. Inability to establish and document continued sobriety of parents in Alcoholics Anonymous or other 12 step programs potentially leaves children at risk

The OCA was unable to determine if all issues associated with the father's alleged alcoholism had been addressed and resolved. The father was purported to be clean and sober, and regularly attending AA meetings. While in some instances, DYFS is able to have parents agree to have a sponsor at the meeting verify their attendance and continued sobriety, this practice is inconsistent and cannot be enforced. In this case, no AA/NA meeting attendance documents were found in the file. Reliance upon attendance at an anonymous support group leaves DYFS without any means of verifying the parents' continued commitment and sobriety. The DYFS Case Manager indicated during an interview that he believed that Mr. A. was clean and sober because J.A. indicated this to him during their monthly meetings. Sole reliance upon a child for this type of information is, at best, suboptimal, and in this case appears in conflict with the police report describing Mr. A. as drinking alcohol before his son's death was discovered. What remains unclear is whether or not this was a recent and coincidental relapse.

2. J.A. Did Not Receive Adequate Counseling and Supports

Discharge planning for J.A. from his group home to the community was centered on reintegration and stability in the educational environment. The discharge plan did not create linkages for the family to appropriate services to address J.A.'s individual and family issues, perhaps because those services were in short supply in the county. The discharge summary

clearly elevates concerns regarding the father's ability to adequately support and supervise J.A., but no agency followed up on this identified need for services.

The ACE Program is focused on the student's functioning in the school environment and relied upon the student to self-identify the need for additional support. Individual counseling is optional and group work was designed around select themes such as substance abuse or anger management. While these types of groups are important, J.A. may have benefited from a more formalized group therapy environment, such as the one in which he participated in the Group Home. The ACE Program staff were dedicated and invested in the academic success of their students. J.A. needed help in additional areas of his life, i.e. trauma associated with the death of his mother, his relationship with his father and ongoing substance abuse.

The aforementioned description of the ACE Program runs contrary to the DYFS Case Manager's understanding of the program. DYFS believed that this program was oriented towards working with students on the serious types of mental and behavioral health issues that confronted J.A. and his family, and thought J.A. had more than one counselor in the program and had the opportunity to address all of his issues in individual and group counseling. Once again, the ACE Program staff indicated that individual counseling was optional and they did not offer any family therapy.

None of these agencies (DYFS, CART, ACE or the juvenile detention center) ever contacted the children's behavioral health system to link J.A. with supportive services and care. The fragmentation of this system looms large in these events. Had a referral been made to the children's behavioral health system, services could have been offered to J.A.'s family to address the numerous issues affecting them. A key component of reform in the wake of this tragedy, then, is to make referral to DCBHS by DYFS caseworkers non-discretionary in pre-defined instances. A comprehensive service plan, developed and implemented by the Division of Child Behavioral Health Services, may have provided this family needed wraparound support and relieved some of the apparent stress on J.A.

3. Elevated Obligation to Children in the Legal Custody of the State

In August, 2001, when J.A. was found to be out of compliance with the conditions of his probation, the court ordered him into the legal custody of DYFS. The Division permitted him to remain in the physical custody of his father. J.A. was left in a home environment where caregivers had known and documented substance abuse problems. In addition, DYFS had already documented the father's pattern of failure to follow through on services for another sibling with no clear indication or reason to expect that he would function differently with respect to J.A.

In-patient substance abuse treatment was recommended for J.A. on November 1, 2001, but treatment was not available him until March 2002. The record does not indicate the reason for the 5 month delay in providing this service, though the scarcity of available addiction resources at that time almost certainly played a role.

JEFFREY JOHNSON – DATE of DEATH: JULY 24, 2004

On August 24, 2004, Jeffrey Johnson, a five month old male child, died of respiratory failure due to broncho-pulmonary dysplasia while a patient at a local hospital. Jeffrey was admitted to a local hospital on July 5, 2004 after being removed in poor condition via DODD. DYFS maintains that it first learned of Jeffrey's birth during its July 5, 2004 response to a referral of domestic violence between Jeffrey's biological parents. Jeffrey's mother allegedly concealed her pregnancy, thereby preventing the Division from providing oversight.

The family has an extensive history of involvement with DYFS. At the time of Jeffrey's death, there were open cases on siblings C.J. and Ch. J. through the Perth Amboy District Office.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The Office of the Child Advocate (OCA) collected information from various sources to complete an in-depth review of DYFS' involvement with the Johnson family prior to Jeffrey's untimely death. Those documents included:

i. CCAPTA Notice dated July 27, 2004.
ii. Case Chronology prepared by Perth Amboy District Staff on July 25, 2004
iii. Copy of DYFS Case Record
iv. Personnel records of Case Worker 1
v. Personnel records of Case Worker 2
vi. Personnel records of Case Worker 3
vii. Personnel records of Casework Supervisor 1
viii. Personnel records of Casework Supervisor 2
ix. Medical and social service records regarding Jeffrey Johnson and the biological mother from the treating hospital.
x. Primary care physician records, June – July 2004
xi. DYFS Nurse reports: Medically Fragile Report and Final Report.
xii. Report of Medical Examiner
xiii. Meeting with the Monmouth County Prosecutor's Office
xiv. Interviews – Hospital staff person; male relative; DYFS nurse; Casework Supervisor 1.

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

A discrepancy exists between the DYFS Chronology, which documents eight referrals (plus one allegation) regarding the family between October 1999 and July 2004 and a July 4, 2004 DYFS Report which states "There have been 17 referrals on this family between 10/14/99 and 1/18/04." The OCA's review, based on various sources, documents 19 referrals, beginning October 14, 1999 and ending on July 5, 2004.

First Referral/Initial Involvement with DYFS: October 14, 1999

On October 14, 1999, a referral was made stating Jeffrey's half-sister, A.G., was living with her aunt since July 5, 1999. The aunt received custody on August 27, 1999 through a court order due to the biological mother's drug addiction, neglect, and emotional abandonment. The referent

was concerned by A.G.'s sexualized behaviors and verbalized awareness of sexual intercourse. Findings indicated that A.G. returned to her biological mother. A.G. appeared well cared for and happy to be with her mother. The biological mother provided a urine drug screen and it was negative. No further concerns were noted and the case was closed at intake.

Second Referral: May 1, 2000

On May 1, 2000, a referral was made alleging that the biological mother is neglectful. Caller had not seen A.G. in a year, but another relative saw A.G. at a local supermarket and child looked malnourished. Findings indicated that child was not malnourished, according to school nurse and doctor. Allegations were also cited that the biological mother used alcohol and crack, although upon investigation these allegations were unfounded. Caller also stated that the mother is pregnant. VNA had no concerns regarding mother's prenatal care or any suspicion of alcohol or drug use. Abuse was unfounded.

Third Referral: May 8, 2000

On May 8, 2000, a referral was made alleging that the biological mother and A.G. "were locked out of their home by the stepfather (Jeffrey's biological father). (The biological mother and A.G.) slept outside on the street. (The biological mother) is pregnant, a battered woman, and abuses alcohol (beer/liquor). Findings indicate that parents deny allegations. (The biological mother) tested negative for drugs, and (they) do not wish to receive services. Neglect was not substantiated."

Fourth Referral: September 28, 2000

On September 28, 2000, a referral was made subsequent to the police responding to a "911 call and finding (the biological mother) and two adult friends intoxicated." Upon investigation, it was determined that the biological mother was providing care for her children while under the influence of alcohol. Finding of neglect, as the biological mother's "diminished functioning placed (her) children at risk."

Fifth Referral: September 30, 2000

On September 30, 2000, a referral was made "stating that (the biological mother) went out drinking and left C.J. with a friend." The referent was also concerned by the presence of a male relative in the home. Findings for neglect were not substantiated. The biological mother was not found to be intoxicated. The parents denied that the male relative in question had been in the home or had access to the children. One urine screen came back positive for illicit drugs.

Sixth Referral: November 5, 2000

On November 5, 2000, a referral was made alleging that, on November 4, 2000, the biological father had requested that a male relative provide care for C.J. for "a few hours," although the biological father failed to return. The biological mother arrived on the morning of November 5, 2000 and appeared intoxicated. The police were called and the biological mother left without C.J. prior to the police arriving. The male relative took the child because both the biological parents' whereabouts were unknown to him. The biological mother was stated to have denied

being intoxicated, with the biological father reportedly stating that he left C.J. with a male relative because he wanted to leave his home and avoid an argument with the biological mother. C.J. and the biological mother were stated to have relocated to the residence of one of her relatives. Abuse or neglect not substantiated.

Seventh Referral: November 27, 2000

On November 27, 2000, a referral was made to OCAC alleging that the biological mother was intoxicated while providing care for C.J. Both she and the biological father were reported to reside with one of his family members who abuses drugs. Upon investigation, neglect was not substantiated relative to these allegations or the allegation that the biological mother had failed to obtain medical attention for C.J. for a skin condition. It was also cited that the biological mother had complied with DYFS' recommendation to attend therapy as well as submitted to regular urine screenings, testing negative for substances.

Eighth Referral: February 3, 2001

On February 3, 2001, a referral was made alleging that the biological parents were evicted from their residence two weeks prior. The biological father moved in with a family member. The biological mother previously resided with a friend who has a history of substance abuse. Concerns were expressed that C.J. "has a gash under her neck and it is unknown how child received it." Findings indicated that neglect was not substantiated as (the biological mother) did not appear under the influence of drugs/alcohol. Children appeared well cared for and (the biological mother) reported that C.J. was under a doctor's care for the skin condition.

Ninth Referral: June 2, 2001

On June 2, 2001, a referral was made through SPRU alleging that the biological father and the biological mother were "residing in a garage with no beds." The biological father was also cited to abuse drugs and alcohol. C.J. was observed to have an untreated skin condition. Neglect was not substantiated, as the biological mother denied residing in a garage, again stating that she and her children lived with one of her relatives and stayed with one of the biological father's family members during weekend visits.

Tenth Referral: July 2, 2001

On July 2, 2001, a referral was made to DYFS stating the biological mother drinks all day and has strangers caring for C.J.. She reportedly was under a tree with C.J. while it was thundering, lightening, and raining. Child did not have on a shirt. (The biological mother) goes from house to house. A.G. resides with a relative and is left alone everyday from 6 to 7 p.m. Findings indicate neglect was substantiated. The biological mother was under the influence of alcohol, appeared unconscious, and was not adequately supervising (C.J.). Home was unsuitable, dirty, and (the biological mother) did not have adequate baby items for (C.J.). (The biological mother) was also arrested for disorderly conduct. C.J. was removed from the biological mother's care.

Eleventh Referral: November 8, 2001

Although C.J. was removed from the biological mother's care and placed in foster care on July 2, 2001, there is information to indicate that a referral was received by DYFS on November 8, 2001, alleging that the biological mother was observed drinking in a bar on the weekend while C.J. was in her care. Upon investigation, the biological mother denied the allegation.

Twelfth Referral: January 16, 2002

DYFS advised that a police officer came upon an abandoned vehicle and contacted the owner of the vehicle. The vehicle's owner indicated that the biological father was supposed to do repair work on the vehicle. The Officer and her Sergeant found the biological parents drunk in a known drug trailer on the same street as the abandoned vehicle.

Thirteenth Referral: June 27, 2002

On June 27, 2002, an allegation was received relative to an incident of alcohol abuse and domestic violence in the home between the biological parents. The investigation triggered by this referral revealed that the biological mother had given birth to a daughter, Ch. J., on May 30, 2002. As per the Out-of Home Permanency Assessment, it was also cited that "police reports revealed domestic violence issues this past February 2002 which also revealed arrests of the biological father for D.V., DWI, and driving a vehicle with false plates, expired license, failure to inspect, displaying false inspection…" These allegations did not prompt removal of Ch. J. from the biological mother's care.

Fourteenth Referral: July 31, 2002

On July 31, 2002, a referral was received indicating police involvement following a domestic violence incident between the biological parents, resulting in a removal and placement of Ch. J. in foster care. Reportedly, during this incident, the biological parents "were screaming at each other and the biological mother was bleeding and had blood all over her. The biological mother was intoxicated and the biological father was arrested…"

Fifteenth Referral: August 25, 2003

Caller reported that on August 27, 2003, A.G. and her cousin were hit by a car, causing both to sustain concussions. Both were ready for discharge on August 28, 2003. The hospital was concerned about the biological mother because she was delayed in coming to the hospital, was indignant with the staff, and was not available to the child and staff.

Sixteenth Referral: January 11, 2004

On Friday evening, child (Ch. J.) was transported by her DYFS worker for a weekend visit with the biological mother. Ch. J. began to get sick. Caller phoned the biological mother and was told that Ch. J. is "smoking up all night and would not eat." Biological mother told Caller she was going to give Ch. J. Tylenol. EMT lives down the road and may take Ch. J.. Child was reported to be fragile and suffer from asthma.

Seventeenth Referral: January 18, 2004
Biological mother had visitation with child and was supposed to return that night. Mother was concerned about driving in icy, snowy weather. Biological mother was unable to call child's foster mother and sought permission to keep her child until the following morning.

Eighteenth Referral: June 17, 2004

During the child's return placement with her biological mother today, the mother asked the worker if there was a physical for C.J. The biological mother asked if the doctor said anything about C. J.'s vagina and was "trying to do this to Ch. J.." When the mother was asked why nothing was said earlier, she stated that she believed the physical would have detected something. The mother later stated that she believed the child had been touched inappropriately by the foster father, which the child denied to her worker. The child was brought for a physical evaluation on June 18, 2004, and nothing was found to indicate abuse. The matter was referred for follow-up.

Nineteenth Referral: July 5, 2004

On July 5, 2004, Detectives from the Middletown Police Department twice responded to the residence of one of Jeffrey Johnson's relatives. During the first response, Detectives responded to the relative's home, where they spoke with the relative outside and left the premises unaware of any allegations of child abuse concerning the Johnson children. The second response was triggered by a report of suspected domestic violence and child abuse. An incidence of domestic violence reportedly took place on the evening of July 4, 2004 perpetrated by the biological father against the biological mother, after which she fled with the children to a relative's house. The referent was concerned by his observation of extensive physical bruising on the biological mother's body, Ch. J. to have a large red scratch by her eye, and Jeffrey to be in distress. These concerns were reported to the Middletown Police, who responded to the relative's home where they found the biological mother, Jeffrey, C.J., and Ch. J.. Jeffrey was thought to be the victim of medical neglect due to the fact that his apnea monitor was switched off and his oxygen tube had melted to his face and was not properly inserted into his nostrils.

C.J. and Ch. J. were in DYFS' care prior to July 5, 2004, having only been returned to the biological mother from the custody of their foster parents three weeks' prior. The girls were examined at a local hospital and returned to their foster mother's care. Jeffrey was unknown to DYFS prior to July 5, 2004 and was removed to a local hospital for failure to thrive.

Child Fatality – July 24, 2004

Jeffrey was admitted to the hospital on July 5, 2004 and remained there until his death on July 24, 2004. The cause of death is listed as respiratory failure to broncho-pulmonary dysplasia. He was considered medically fragile since birth, having been born prematurely at 28 weeks without prenatal care. He was delivered on March 8, 2004 weighing one pound and was transferred to the Neonatal Intensive Care Unit, where he remained until June 2, 2004. A discharge report from that day indicates that hospital Social Services cleared Jeffrey for discharge home.

OTHER RELEVANT INFORMATION OBTAINED THROUGH INTERVIEWS AND REVIEW OF RELATED DOCUMENTS

A. Interview with Casework Supervisor 1, Perth Amboy District Office

Casework Supervisor 1 oversees between five and seven caseworkers, each of whom carries approximately 30 cases. She works with the caseworkers to develop case plans, conduct conferences, make assessments, and track children in placement. Casework Supervisor 1's specific involvement with the subject family spans from September 2002 to the present. Her recollection of caseworkers responsible for the family deviates from information obtained independently by the OCA from SIS. According to Casework Supervisor 1, Case Manager 1 was replaced as a case manager by Case Manager 2 because Case Manager 1 did not make accurate assessments of the family. Case Manager 2 was promoted and reportedly replaced by Case Manager 3. Similarly, Case Manager 3 was promoted and reportedly replaced by Case Manager 4. According to Casework Supervisor 1, Case Manager 4's promotion resulted in Case Manager 5 becoming the family caseworker. According to Casework Supervisor 1, Case Manager 5 remains the caseworker for the family to date.

According to Casework Supervisor 1, Jeffrey remained a very ill child during his hospitalization and was never medically stable for discharge. She seemed unaware that the child's medical chart at the hospital made clear he was in fact cleared for discharge and was awaiting a foster home while bordering in the hospital. According to Casework Supervisor 1, a DYFS nurse visited Jeffrey in the hospital and concluded he was "very ill" and might eventually need a specialized foster home for medically fragile children, known as SHSP (Special Home Service Provider) home. As a result, Casework Supervisor 1 said Case Manager 5 made a referral to the Foster Care Unit, a centralized unit run out of Newark, which identifies SHSP homes in that area of the state. According to Casework Supervisor 1, the DYFS nurse served as the link between the hospital and the DYFS district office. Casework Supervisor 1's prior case experience created an expectation that the hospital would affirmatively contact her once Jeffrey became medically cleared for discharge, which she said did not occur. Casework Supervisor 1 did not visit Jeffrey in the hospital, nor did Case Manager 5. She was unaware of whether the hospital contacted the Foster Care Unit directly to alert them to his readiness for discharge.

B. Interview with DYFS Nurse

The DYFS nurse was assigned to the Johnson case via a referral from DYFS Casework Supervisor 1 and Case Manager 5. The DYFS nurse reports that she had a less-than-average case load during the three week period in which she worked with Jeffrey Johnson (her present caseload is ten children in foster care). She visited Jeffrey in the hospital on three occasions in July. Each visit lasted thirty minutes. During her visits, the DYFS nurse spoke to the nurses treating Jeffrey, personally observed him and completed an assessment of his condition. The DYFS nurse also had access to Jeffrey's medical charts during her visits. In addition, the DYFS nurse met with a hospital social worker. The DYFS nurse also met with staff of the hospital's Child Protection Center (CPC) during her initial assessment, and staff was present when the DYFS nurse examined Jeffrey. The CPC staff indicated to the DYFS nurse that Jeffrey was feeding better and gaining weight but remained fussy.

Based on her assessment, the DYFS nurse completed a medically fragile report on Jeffrey (See Section II, Subsection I herein). The DYFS nurse's understanding of the DYFS plan for Jeffrey was that the Case Manager was either looking for a (SHSP) home or to reunite him with a distant family member. The DYFS nurse was not involved in the placement process for Jeffrey. According to the DYFS nurse, she gave her assessment and report to Casework Supervisor 1 and discussed what she thought was the kind of care Jeffrey would need, her assessment of the complexity of the case, and her belief that Jeffrey was not close to being discharged. It was the DYFS nurse's observation that Jeffrey appeared very ill when she saw him in the hospital on July 9, 2004. She observed an improvement in Jeffrey's condition on July 16, 2004, but noted that his health declined by her third visit on July 23, 2004.

According to the DYFS nurse, when Jeffrey appeared near discharge, she would have taken a more active role in his placement but it would never be her role to evaluate a SHSP home for Jeffrey. According to the DYFS nurse, despite her involvement, it remains the Case Manager's responsibility to evaluate SHSP homes for placement.

C. Personnel and related records regarding Case Managers

Personnel files were reviewed for all staff known to be involved in service delivery to this family. Review of the records was unremarkable. Staff had appropriate education and, as best can be determined, had satisfactory employment history with the Division. The most recent case manager for the family was Case Manager 5.

D. SIS Data

Review of SIS data indicates high caseworker turnover and questionable caseworker vacancies throughout the case history. The SIS caseworker chronology is as follows:

5/1/00: Case opened. No worker or supervisor listed.
5/20/00: Case closed.
6/7/00: Case opened. Caseworker assigned.
3/7/01: Case closed.
8/21/01: New caseworker assigned.
8/22/01: Transfer to new caseworker.
10/9/01: New caseworker assigned.
10/15/01: Caseworker listed as "Unknown."
10/15/01: New caseworker assigned.
10/15/01: New caseworker assigned.
11/19/01: New caseworker assigned.
11/26/01: Caseworker listed as "Unknown."
3/19/02: New caseworker assigned.
5/23/02: New caseworker assigned.
11/22/02: New caseworker assigned.
9/8/03: Same caseworker as 11/22/02.
1/7/04: Caseworker Unknown*
3/11/04: Caseworker Unknown**
7/14/04: Caseworker listed as "Vacant"***

* This is a critical time because it was during the biological mother's pregnancy with Jeffrey. DYFS asserts it had no knowledge of the pregnancy, but may have if there was consistent case management.

** This, too, is a critical time because it was during the biological mother's pregnancy with Jeffrey. DYFS claims it had no knowledge of the pregnancy but may have if there was consistent case management.

***This is a critical time period in the case because Jeffrey was on a social hold from July 5, 2004 until the date of his death on July 24, 2004, pending DYFS' identification of a SHSP home (per Medical notes).

E. Birth Records

Birth records indicate on March 8, 2004, the biological mother presented at a local hospital in active labor at 28 weeks gestation without prenatal care. Approximately one hour prior to arriving at the hospital, the biological mother experienced vaginal bleeding and contractions. Baby Jeffrey was delivered rapidly and weighed 2 pounds 4 ounces at birth. He was placed in a warmer, put on a ventilator, and stabilized until a transport team from another local hospital arrived approximately two hours post-delivery and relocated him to the neonatal intensive care unit there.

F. Primary Care Physician Records

The biological mother did not receive prenatal care prior to Jeffrey's birth on March 8, 2004. She had her first prenatal visit scheduled for March 26, 2004, which was cancelled.

On June 15, 2004, Jeffrey was seen for a routine child health exam. He received EPSDT services (3-5 months). His next appointment was scheduled for 7/20/04 (no-show because admitted to the hospital on 7/5/04). Additional follow-up was scheduled with a variety of health care providers.

G. Apnea Records

Apnea results for Jeffrey from June 16th to July 5th, 2004 indicate he was on an apnea monitor while in his mother's care. The plan for Jeffrey was to continue monitoring, oxygen, and albuterol and follow-up with various health care providers. Apnea records state "Jeffrey is currently hospitalized at [] due to domestic violence at home. He remains in DYFS custody at [] pending placement in a foster home."

H. Hospital Records 7/5/04 – 7/24/04

On July 5, 2004, Jeffrey was admitted to a local hospital via a removal by DYFS due to domestic violence in his home and failure to thrive. Upon admission, he was observed to be grey in color and suffering from some degree of respiratory distress while in the ER, which was noted to have been medically resolved by the time he was moved out of the ER on the same day. A diaper rash was also noted. Notable entries include the following:

- 7/5/04: Physician Progress Record describes Jeffrey as "stable three month preemie for social hold."
- 7/6/04: Physician Progress Record includes a social work entry which states "Family has an open case with Perth Amboy DYFS. Contacted caseworker to notify her of baby's admission. At this time, baby's discharge plan is undetermined. Social worker will collaborate with DYFS on safe and appropriate discharge plan for baby." Additional notes state "Jeffrey will be here until placement decided;" and "no further respiratory distress noted since admission."
- 7/7/04: Physician Progress Record notes slight improvement in diaper rash. Jeffrey described as "four month old ex preemie with multiple medical problems, now awaiting input from social worker regarding DYFS placement."
- 7/8/04: Physician Progress Record shows "patient is stable." "DYFS assumed custody and will likely have placement in foster home by the end of the week." "Patient continuing to improve on weight and PO intake."
- 7/9/04: Physician Progress Record shows "patient feeding well overnight" and "weight improving." "Generally resting comfortably" with stable respiration, "good air entry with no wheezing." "Awaiting DYFS placement in foster home. Follow-up with Social Worker." "Diaper rash improving."
- 7/10/04: Physician Progress Record basically same as 7/9/04. Additional note that "patient is clinically stable without signs of respiratory distress." Follow-up with Social Worker.
- 7/11/04: Physician Progress Record indicates patient continues to gain weight and needs medications adjusted for weight gain.
- 7/11/04: Physician Progress Record states patient is feeding well and is clinically stable. Awaiting placement by DYFS in foster care.
- 7/12/04: Physician Progress Record notes patient's increased nutrient needs. Call made for a pediatric developmental consult to assess developmental delays and possible placement in Early Intervention program.
- 7/13/04: Physician Progress Record states patient continues to take good po intake, resting comfortably without changes in medical condition. Awake and alert. Awaiting placement by DYFS in foster home. Follow-up with Social Worker about placement and follow up with developmental consult. "DYFS Hold – No placement yet found."
- 7/14/04: Physician Progress Record notes patient remains stable. "DYFS continuing their search for SHSP foster home for baby."
- 7/15/04: Physician Progress Record indicates patient was seen by developmental specialist and will start PT and ITP program. Follow-up with Social Worker regarding placement.
- 7/16/04: Physician Progress Record states patient "here awaiting placement in foster home by DYFS." Follow up with Social Worker.
- 7/17/04: Physician Progress Record notes "admitted as a social hold with DYFS as guardian. Patient not breathing as well as usual despite clear breath sounds. May be upper respiratory infection (URI)." "Monitor progress closely."
- 7/18/04: Physician Progress Record shows patient wheezing diffusely, likely transmitted UR congestion."

- 7/19/04: Physician Progress Record notes patient "here for social hold awaiting placement in foster home by DYFS." "Had some viral illness over the weekend which appears to be resolving. "Continue meds, monitor closely."
- 7/20/04: Physician Progress Record notes "some episodes of respiratory distress which resolved. But infant appears to have more nasal congestion, cough, and tachytonea over the past two days." "Now with (illegible) infection, probably viral." Chest x-ray ordered.
- 7/21/04: Physician Progress Record indicates Jeffrey had "episodes of cough and desats and was transferred to the PICU overnight for close monitoring and intubation if necessary."
- 7/22/04: Physician Progress Record states "Jeffrey now in PICU on vent. Will continue to review; eventual plan for discharge through DYFS placement."
- 7/24/04: Physician Progress Record notes "Jeffrey had progressive difficulty with ventilation. Despite Albuterol, nebs, suctioning, ETT change, Jeffrey developed a very stiff chest which required bagging via ETT. Patient then developed brachycardia, chest compressions were started and epi was given. The patient continued to deteriorate and progressed to asystole. CPR was administered for 34 minutes. There was a brief return of pulse at 20 minutes. There was approximately 90-120 seconds of spontaneous circulation. Then patient became asystolic again." "Patient was pronounced at 6:45 p.m."

I. Medically Fragile Report

The DYFS nurse prepared a Child Health Nurse Consultation Report on July 9, 2004 based on the following: (1) a telephone conversation and visit with a CPC staff person; (2) a hospital social worker; (3) the child's medical records; and (4) interviews with the staff nurses caring for the child**.** The DYFS nurse determined that Jeffrey met the criteria to be designated Medically Fragile. She recommended the following:

> If the child is placed in foster care, a skilled home (like a SHSP) is recommended in order to be able to meet this child's complex medical needs after discharge from the hospital. An additional option that is recommended is a skilled children's facility like Children's Specialized Hospital. If a biological caretaker is identified, the previously recommended knowledge and skills are recommended. In addition to those skills, it should be stressed that this child should not be placed in daycare and there should be a maximum of two children in the home as he, at this point, requires extreme care. Also, since Jeffrey is currently hospitalized [], additional medical evaluations and interventions are continually being done to fully determine the extent of current and future needs.

J. Medical examiner's report

Cause of death found to be respiratory failure due to broncho-pulmonary dysplasia due to premature birth associated with respiratory distress syndrome. Failure to thrive due to multiple medical conditions related to premature birth. No prenatal care. Rapid delivery at hospital at 28 weeks gestational age.

K. Police reports

The DYFS file contained thirteen police reports related to domestic violence involving the biological parents and/or their intoxication, spanning from 1998 through 2004.

IV. OCA'S FINDINGS AND CONCERNS

1. **Jeffrey Johnson was a boarder baby, medically cleared for discharge but kept in the hospital on a social hold for 19 days, during which time he developed a secondary infection that led to his death. Major discrepancies exist between the hospital records, DYFS records, and the DYFS nurse's versions of the medical condition and case plan for Jeffrey Johnson.**

   Hospital records spanning July 5, 2004 through July 24, 2004 and telephone conversations with hospital staff indicate that Jeffrey, Jr. remained at the hospital until his death on a social hold while DYFS identified a SHSP home. Records support that he gained weight and was clinically stable/medically ready for discharge almost immediately after admission, but nonetheless remained in the hospital until July 20th. On that date he became gravely ill leading to his demise, possibly as a result of the environmental hazards present in a hospital setting. See Section III: Other Relevant Information Obtained Through Review of Related Documents, Hospital Information.

   DYFS Casework Supervisor 1 asserts that DYFS never received communication from the hospital that he was medically cleared for discharge, which communication would have triggered identification of a foster home placement. Casework Supervisor 1 claims her staff made a referral to the Foster Care Unit about Jeffrey's potential need for a SHSP home but there is no documentation concerning this in the DYFS file. There is similarly no documentation that a DYFS caseworker ever visited Jeffrey in the hospital during his July 2004 admission. Furthermore, a hospital staff person asserts that a caseworker never visited Jeffrey and that the DYFS nurse was the only DYFS contact who visited the hospital.

   Per a report of the DYFS nurse, Jeffrey was designated Medically Fragile on July 9, 2004. According to the DYFS nurse, a DYFS Regional Home Liaison would normally work with the DYFS nurse to locate a home for a child once he was deemed Medically Fragile. Per the DYFS nurse, a Regional Home Liaison was not involved with Jeffrey because tests and paperwork remained to be completed by the hospital and the DYFS caseworker was looking for a family member to care for Jeffrey, in which case a Regional Home Liaison would not become involved.

   These disparate versions of case management for Jeffrey Johnson raise serious concerns. In light of the disparities, the OCA is left to conclude that improvements are needed to fortify the working relationship between the child welfare and hospital systems. At the very least, the Johnson case evidences either a lapse in communication between the hospital and DYFS to convey Jeffrey's readiness for discharge or a failure on the part of DYFS to identify a SHSP home or relative placement in a timely fashion. Irrespective of

the causation, Jeffrey languished in a hospital environment where he was exposed to the health risks that a hospital presents to an infant.

2. **DYFS staffing concerns. High turnover of caseworker oversight of case as well as caseworker vacancies left Jeffrey Johnson and his siblings vulnerable to administrative neglect.**

   See Section Three, Subsection D: Other Relevant Information Obtained Through Review of Related Documents, Hospital Records.

3. **A DYFS caseworker and a CARRI worker each failed to take action upon finding an unidentified newborn infant in the Johnson home during June 2004. Furthermore, documentation of contacts is brief and does not include pertinent information regarding the interviews and observations during MVRs.**

   Following Jeffrey's discharge home from the hospital on 6/2/04, several unannounced MVRs during overnight visits between the biological mother and her daughters C.J. and Ch. J. took place on 6/7/04, 6/10/04, and 6/11/04. The 6/11/04 contact sheet noted a baby in a bassinet. The biological mother stated that she was babysitting her cousin's child. There is no further description of the child. There is no other note in the record of the presence of a baby during the worker's contact. A subsequent report from CARRI indicated that the contact was in the yard as the biological mother had a barbeque. The CARRI worker asked about going into the home but the biological mother did not want to go inside. The biological mother made reference to a baby sleeping in the home. The worker asked if she was going to check on the baby and the biological mother's eldest daughter, A.G., went into the home. A.G. returned, stating the baby was sleeping. There is no other note in the record of the identity and/or condition of the baby. Despite these encounters, DYFS alleges not to have known about the birth of Jeffrey Johnson until a DODD removal took place on July 5th as a result of domestic violence in the home.

4. **No documentation of collateral contact with family members about whether the biological father was involved with the biological mother.**

   The biological parents' relatives knew about on-going domestic violence between Jeffrey Johnson's parents and also knew of the baby's birth. During the 7/5/04 DYFS investigation, a relative told the SPRU worker that the biological father beating the biological mother caused the premature birth of Jeffrey.

5. **Length of time it took DYFS to identify domestic violence and substance abuse issues and to take the necessary steps to protect the children.**

   The case history evidences a long period of DYFS involvement. A history of domestic violence is similarly documented by various Monmouth County police reports. See Section II: DYFS' Involvement with Family and Section III: Other Relevant Information Obtained Through Review of Related Documents, Subsection K.

6. Lack of prenatal care does not trigger DYFS notification/intervention.

Policy is lacking to require hospital staff to refer expectant mothers who present in labor without prenatal care to DYFS as medical neglect cases. In this case, DYFS intervention at delivery would have revealed an extensive history with the Division and would have likely prevented Jeffrey from being discharged to the biological mother's care. At a minimum, the absence of prenatal care should be identified as a trigger for a referral to DYFS for a child welfare assessment to determine if the family has the capacity to provide appropriate care for the newborn.

7. Incorporating unverified claims into the DYFS case file without independent investigation or substantiation.

The OCA investigation revealed two examples of DYFS incorporating unverified information into the case record without independent investigation and substantiation. A male relative is alleged to have physically assaulted the biological father as part of the July 5th domestic violence incident between the biological parents, detailed herein. SPRU Response Report, Stated Problem Section, states in part "[Male relative] beat up [the biological father] last night in retaliation for [the biological father] assaulting [the biological mother]. One male relative, went to another male relative's home this morning to discuss the incident. One male relative felt threatened and called the police. The OCA interviewed one of the male relatives involved, who vehemently denied having assaulted the biological father. Despite the relative's assertion, the lack of a police report documenting an assault, and a lack of evidence that an assault took place, DYFS staff incorporated the alleged assault into the case record as fact. The fact that the male relative accused of perpetrating the assault was denied custody of his nieces subsequent to the alleged assault raises the possibility that the denial was based, at least in part, upon the inclusion of hearsay information.

A second example that may have influenced case practice appears in the DYFS case record regarding a July 5th domestic violence incident. DYFS records indicate that the hospital nurse who received Jeffrey from the ambulance "stated that it is serious neglect when the apnea monitor is not on. It was reported that [the biological mother] never showed up for her follow-up care appointments with Jeffrey." This statement is contrary to independently obtained medical documentation that proves that the biological mother indeed complied with Jeffrey's course of medical care as set forth at discharge from the hospital on June 6, 2004. Records indicate that Jeffrey was seen regarding his apnea monitor on June 16th and was scheduled for his next follow-up visit in mid-July. Jeffrey was also seen by his primary care pediatrician on July 15, 2004 and was scheduled for his next follow-up visit in mid-July.

JMEIR WHITE – DATE of DEATH: August 22, 2004

On August 22, 2004, at approximately 4:15 p.m., Tahija Handberry of Asbury Park, New Jersey, called 911 to request emergency first aid attention for her non-responsive, 14-month-old son, Jmeir White. The child was deceased and rigor mortis had begun to set in when the emergency responders arrived. The exact cause of Jmeir's death is chronic malnutrition-homicide. The autopsy revealed evidence of trauma, including a small laceration on the left side of his forehead, facial abrasions and scars, and two areas of focal hemorrhage-the right scapular region and the left lumbar region.

At the time of his death, Jmeir weighed only 10.4 pounds, a thirty percent (30%) weight loss from his last recorded weight of 15 pounds in March. A pediatrician specializing in child abuse described the child as "severely malnourished" at the time of his "highly suspicious" death. The Monmouth County Prosecutor's Office has charged Jmeir's parents in connection with the death.

The Division of Youth and Family Services (DYFS) history includes a single referral on the family, which occurred on June 23, 2004. An intake worker from the Southern Monmouth District Office visited the family that day, viewed all of the children, and closed the case on July 16, 2004.

I. DOCUMENTS AND OTHER INFORMATION USED TO CONDUCT THE OCA REVIEW

The OCA collected information from various sources to complete an in-depth review of the child welfare system's involvement with the Handberry/White family prior to Jmeir's death. That information includes:

i. CCAPTA Notice dated August 23, 2004;
ii. Case Chronology prepared by DYFS, dated August 24, 2004;
iii. Copy of DYFS Case record;
iv. Personnel records relevant DYFS employees;
v. Primary care physician and hospital records for Jmeir White;
vi. Findings from pediatrician consultant;
vii. Report of Medical Examiner;
viii. Statement provided to the Monmouth County Prosecutor's Office by Tahija Handberry, dated August 23, 2004, (in DYFS file);
ix. Interviews with the DYFS Case Manager and Supervisor;
x. Interviews with the visiting nurse and supervisor;
xi. Interview with Jmeir's pediatrician;

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

June 23, 2004

On June 23, 2004, the Southern Monmouth District Office of DYFS received a call alleging that X.W., then nearly two weeks old, suffered from anemia and had missed two required injections of Epogen to treat her condition. The referent reported that a visiting nurse was charged to

provide three weekly shots but had been unable to reach Ms. Handberry and, as a result, X.W. was at risk, particularly since the baby had lost 4 ounces since her birth and that a delay in treatment would cause the baby to lose her appetite and additional weight. The referral was coded for an immediate response.

The DYFS Case Manager made contact with the family at their residence at approximately 2:00p.m. on June 23, 2004. Ms. Handberry explained she had experienced difficulty contacting the visiting nurse because a block on her phone prevented calls from reaching the nurse's cell phone, which the DYFS Case Manager confirmed. Ms. Handberry called a local hospital with which the nurse was affiliated and made contact with the nurse. They spoke briefly and scheduled an Epogen treatment for the baby at 3:00 p.m.

During the visit, Ms. Handberry apparently mentioned that she had other children. Consistent with DYFS policy and procedures, the DYFS Case Manager asked to see the children. With Ms. Handberry, the DYFS Case Manager went upstairs, where he saw X.W. sleeping in an infant carrier atop Ms. Handberry's bed. He then entered an adjacent bedroom and viewed Jmeir napping in a children's bed. Two-year-old T.W. was playing quietly with a doll on the floor in the same room. Throughout the visit, Jmeir did not rouse. The DYFS Case Manager observed both children up close and concluded that both T.W. and Jmeir appeared to be thin and small. He did not observe any scars or bruises on any of the children. According to the DYFS case record prepared by the Case Manager, "both children did appear to be fairly small for their weight," which the Case Manager explained to OCA meant that T.W. was short and thin for her age and Jmeir was thin for his age.

Ms. Handberry reportedly told the DYFS Case Manager that both children had been anemic at birth, which caused their condition. She indicated that neither child was currently anemic. Our review of the children's medical records reveals that both T.W. and Jmeir suffered from anemia at birth.

There is no discussion of the children's father, Wesly White, in the DYFS case records documenting the first referral. The DYFS Case Manager, in his interview with OCA, indicated that Ms. Handberry had indicated at the time that Mr. White did not live with her. The record is silent whether the DYFS Case Manager discussed general parenting issues with Ms. Handberry, such as how she was coping with giving birth, with her severe eye impairment or with parenting three children under age three alone, including a sick infant. The DYFS Case Worker did learn Ms. Handberry and X.W. had been released from a local hospital earlier in the month after the child was born, but there was no referral at that time to DYFS or plan put in place to offer supportive services.

The DYFS Case Manager advised OCA that the household appeared generally neat and clean, and the refrigerator held a "medium" amount of food, including children's food and milk. The DYFS Case Manager confirmed that Ms. Handberry maintained a supply of Epogen to treat X.W. in an emergency.

The DYFS Case Manager informed Ms. Handberry, and recorded in the case record, that he would need to obtain medical records for all the children, and a police check for the family before the case would be closed.

The DYFS Case Manager sent a standard form to the Asbury Park Police asking if they had any records on X.W., which was returned by the Asbury Park Police as "no record" on July 2, 2004. In fact, Asbury Park Police had been called to the home twice in 2004, once for a noise complaint related to a child's crying, and another time because someone in the house apparently dialed 911 but then hung up. Police records show both times officers talked to Ms. Handberry, but DYFS was unaware of these facts because its "Request for Information" form does not ask police about a given address or contact with adults. The DYFS police check form simply asks whether the police had any records on one-month-old X.W., which they did not.

In the afternoon of June 23, 2004, the DYFS Case Manager spoke with the visiting nurse by phone, and she confirmed the Epogen injection to X.W. had occurred. In a Summary of Findings Report in the DYFS file, the DYFS Case Manager recounted that the nurse told him "there were no other concerns for [X.W.'s] health and there are no other concerns for the other children." According to the DYFS Case Manager, the nurse relayed she had similarly treated T.W. in 2001 for anemia and she described anemic children as experiencing stunted growth and may be underweight. The DYFS Case Manager therefore came to surmise anemia was the cause of the children's thin condition. Finally, the nurse indicated to the DYFS Case Manager that the Epogen treatments required three weekly shots for at least six weeks, and that a visiting nurse from her organization would continue treating X.W. until the end of the period. She reportedly added that anemia acts as an appetite suppressant and without Epogen treatments, the baby's appetite could be affected.

The nurse, however, did not provide a medical reference to DYFS for Jmeir or T.W. She relayed to OCA that she had not seen T.W. since 2001, and did not see her while treating X.W. in 2004. The nurse was adamant to OCA that she had never seen Jmeir, and her only patient was X.W. She held that DYFS never asked her about either T.W. or Jmeir, that she was completely unfamiliar with Jmeir's medical condition and that she did not provide medical information about him whatsoever. In fact, four nurses affiliated with the hospital made 17 visits to the household from June 16, 2004 to July 28, 2004. None of them ever saw Jmeir. When one of the four nurses inquired as to the whereabouts of other children, Ms. Handberry reportedly told her they were out of the house.

The DYFS Case Manager confirmed to OCA that he did not raise Jmeir's name "specifically" in his conversation with the nurse and that the nurse did not, in fact, provide a medical reference for the child. The DYFS Case Manager told OCA that he and the nurse talked about childhood anemia more generally and that he assumed Jmeir may have been suffering from the after-effects of that condition based on Ms. Handberry's account.

The DYFS Case Manager completed a form new to DYFS, the Structured Decision-Making Risk Assessment, on June 28, 2004. In it, he identified three affirmative risk factors for the children: the nature of the referral (neglect); the age of the children (under two); and their condition as "medically fragile/failure to thrive." The form derived a risk level for the children as "moderate." A service plan to address the diagnosed risk was not developed.

The DYFS Case Manager completed a Safety Assessment, concluding the children were "safe." Neglect was unsubstantiated and the case was prepared for closing.

The DYFS Case Manager requested that the nurse send X.W.'s medical records by fax and DYFS received them on August 3, 2004. The DYFS Case Manager reported to OCA that he had sent a request for the other children's medical records to a local hospital by regular mail because it refused to accept fax requests from DYFS. No medical records for any of the children were received before the case was closed. Medical records for T.W. and Jmeir were never obtained by DYFS until after Jmeir's death. The DYFS Case Manager did not ask if Jmeir was being seen by a pediatrician, and did not request any medical records from Jmeir's local pediatrician because he was unaware that one existed.

The DYFS Case Manager conferred with his Supervisor who approved closing the case on July 16, 2004, without obtaining medical records for any of the children in the home. DYFS did not follow up with the visiting nurse(s) or the hospital after the date of the first referral to determine whether Ms. Handberry was compliant with X.W.'s treatment plan, or to ascertain the condition of the children. The DYFS Case Manager explained to OCA that in recommending case closure, he relied on (1) the neat condition of the home; (2) the absence of a prior DYFS history with the family; (3) the absence of prior documented police involvement with the family; and (4) his conversation with the nurse. The Case Summary For Closing/Transfer indicates in Section Three (3) that "there are no other concerns for the physical health of the children."

The DYFS Field Operations Casework Policy and Procedures Manual states at section 419.3 that "serious medical conditions are referred for consultation if…the available medical documentation appears inadequate or incomplete." The policy goes on to permit consultation by the supervisor with a DYFS nurse consultant. Section 207.2a of the Manual requires that medical consultation with a DYFS Pediatric Physician Consultant be "sought whenever…the severity of the child's condition is unclear…[or] the there are any questions about the child's medical status and the treatment received." However, neither the DYFS Case Manager nor Supervisor consulted with a UMDNJ nurse consultant assigned to their Southern Monmouth District Office, nor with a pediatric child abuse consultant assigned to the office. According to the DYFS Case Manager, the UMDNJ nurse and the doctor were unavailable for routine consultation on intake cases, and devoted most of their time to field work, including assessments of children in out of home placement. The Case Manager's union representative stated the ratio of doctors to children in a given region made meaningful consultation by caseworkers with the doctor impractical in virtually all cases.

During her interview with the OCA, the UMDNJ nurse said that she was available for consultation with caseworkers in person or by cell phone when necessary. For his part, the DYFS Supervisor indicated that he was not aware the children had a serious medical condition, even though the Risk Assessment on June 28, 2004 had identified three affirmative risk factors for the children, including noting their condition as "medically fragile/failure to thrive." These clashing perspectives from persons employed within the same DYFS District Office, make plain that a system for coordinated identification and evaluation of medical risk for children is still not in place.

The DYFS Supervisor acknowledged that medical collaterals were required for all the children before the case was closed, but he said the Case Manager informed him that he had obtained verbal collateral information from a local hospital for the children. There is no documentation of this in the file, and the local hospital has no record of any conversation with DYFS regarding children other than X.W.

Second Referral: Child Fatality, August 22, 2004

Both T.W. and X.W. were removed by DYFS from the household after their brother died, and T.W. was small, thin and had unexplained bruises that were by their location very suspicious for inflicted injury.

III. OTHER RELEVANT INFORMATION OBTAINED THROUGH REVIEW OF RELATED DOCUMENTS

A. Experience and Training

The DYFS Case Manager was hired as a Family Service Specialist Trainee on October 4, 2003. In February 2004, he received an overall satisfactory performance review as a trainee.

The Case Manager advised the OCA that he participated in the standard training regimen for DYFS trainees, featuring a combination of locally-controlled on-the-job training and centrally administered classroom lectures and simulations. He stated that each DYFS District Office determines how it will handle the "on-the-job" portion of the training cycle. Some District Offices, for example, assign trainees to a consolidated training unit, while others assign them to working units. New employees receive 17 days of centralized training before being assigned their first case, and they complete another 18 days of centralized training within the first year of employment.

The DYFS Case Manager indicated that he did participate in a centralized training on high-suspicion and low-suspicion injuries; child physical development; cognitive development and the use of growth charts. He stated that "it was not in-depth" and he did not remember whether he received any handouts.

B. Jmeir's health care records

Records of Jmeir's visits to a local pediatric practice reveal that Jmeir had gained no weight between December 16, 2003, and March 11, 2004, when he weighed 15 pounds, his last recorded pre-fatality weight. During that time, his weight dropped from the twenty-fifth percentile (25%) on the child development growth chart in December to the second percentile (2%) in March. This explains why the DYFS Case Manager observed that the child appeared very thin during the June 2004 visit. Jmeir's weight loss represents an overall decline in body weight of thirty-one percent (31%) between March and August. The local pediatrician's records reveal, however, that Jmeir continued to grow in length. On August 4, 2003, Jmeir was 20 inches in length; he was 24 inches in December of that year; 25 inches in February, 2004, and 27 inches in March, 2004.

Jmeir's pediatrician explained to OCA that she did not order tests for Jmeir because the child was already being tested for dwarfism at a local hospital by March 2004. We issued a subpoena to the hospital identified by the pediatrician for any and all records on Jmeir. The records produced by the hospital end in August 2003 and reveal no subsequent testing for dwarfism. The records indicate, however, that Jmeir was born anemic, and that the hospital had not been successful in establishing a schedule of Epogen injections for the

child. The hospital records indicate that Ms. Handberry said she did not have health insurance to cover the injections. The hospital made several efforts in July and August to schedule an appointment with Ms. Handberry for Jmeir's care, and assist her completing the health plan enrollment forms, but Ms. Handberry missed an appointment scheduled for August 7, 2003, and the hospital apparently ended its efforts to reach her. There is no documentation of a referral by the hospital to DYFS with respect to Jmeir's lack of Epogen injections or overall care, nor any record of communication between the hospital and Jmeir's pediatrician following the missed August appointment.

C. Pediatric Consultant's Report on Jmeir:

A pediatrician specializing in child abuse and neglect observed in September 2004, "The appearance of [Jmeir's] body is of a child who is chronically malnourished rather than weight loss on an acute and recent basis. The cheeks are sunken, the neck narrow with lack of fatty tissue. The ribs are prominent and the chest scaphoid with an absence of fatty tissue. The skin is dry and wrinkled with loss of skin turgor and a lack of subcutaneous fat with marked wrinkling of the skin over the buttocks and thighs and upper arms. A child with acute weight loss will lose water weight but not show the marked loss of fat and muscle exhibited by Jmeir. The muscles are described as small and atrophied….It is inconceivable to this reviewer that any caretaker could fail to recognize the loss of fat, the severe wrinkling of the skin, the marasmic appearance of this child. Nor could this child have had enough energy for normal activity, normal interaction, or normal development. It is highly unlikely that this child could cruise and interact enough with his environment to produce the large amount of old and recent trauma to the face, back and fingers."

IV. OCA'S FINDINGS AND CONCERNS

A. The child protection system continues to suffer from a lack of coordination with respect to medical information for children at risk of abuse and neglect.

The medical examination reveals a child chronically malnourished, whose atrophied muscles, wrinkled skin and lack of fatty tissue presented as telltale symptoms of malnourishment. Indeed, the DYFS caseworker assigned to the June referral was concerned about Jmeir's medical condition and noted the need for medical checks on the child and his siblings before the case would be closed. Yet DYFS did not obtain nor review any medical information about Jmeir prior to closing the case. The only medical professional contacted by DYFS, the visiting nurse, did not know of, nor provide, any information to DYFS with respect to Jmeir. Our findings are:

1. The nurse assigned to the Southern Monmouth District Office was not consulted in the case because, according to the case worker, she was frequently busy with field work with medically fragile children in out-of-home placements.
2. The Structured Decision-Making Risk Assessment measured the fragile medical condition of the children and characterized the overall risk to the children as moderate, but the case was closed without medical collaterals or a safety plan to address the moderate level of risk. This case suggests the tool in

this instance served merely as a mandated form rather than as a process of discernment for the caseworker and supervisor.

3. No child development growth charts were used by DYFS to gauge the condition of the children. The charts are not routinely used in case practice even when the medical frailty of children is identified in the Risk Assessment.
4. The caseworker described his medical and child development training as "not in depth" and he maintained no handouts or written tools from this training.
5. DYFS did not seek, obtain or review Jmeir's pediatric medical records despite the observation the child was underweight and a medical check was necessary. The caseworker said it was often very difficult to get medical records from the local hospital and that the coordination between his office and the hospital was poor.
6. Even if DYFS had obtained collateral medical evidence for Jmeir, there is still not a routine process in place for that evidence to be evaluated by a DYFS-retained medical expert. When X.W.'s medical forms arrived in the DYFS office after the case had been closed, they were merely filed.
7. The caseworker accepted Ms. Handberry's explanation for Jmeir's condition – anemia – without any corroborative medical evidence.
8. Despite the identification of medical concerns with respect to the children, no one from DYFS made contact with the visiting nurse(s) between the date of the first referral and the date of the case closing to ascertain whether the family was compliant with X.W.'s treatment plan, or the condition of the children.
9. A caseworker with modest training, most of it developed and administered locally with only partial statewide standardization, was left to assess the medical condition of a child at demonstrated risk.
10. The standardized police check form used by DYFS in this instance asked only whether there was a police record on an infant child, not whether the police had any prior involvement with the family or the address. DYFS is placed at a great disadvantage by asking the question too narrowly, and then relying on inadequate information in response.

B. Jmeir's health care looms large.

Jmeir's last recorded weight between December 16, 2003, and March 11, 2004, stayed constant at 15 pounds. His weight dropped from the twenty-fifth percentile (25%) on the child development growth chart in December 2003 to the second percentile (2%) in March. Despite this evidence, the boy's pediatrician noted no concerns regarding Jmeir's health in March 2004, and apparently made no referral for additional medical consultation or referral to DYFS for investigation. The pediatrician further offered that Jmeir had continued to grow (overall 7 inches from August 2003 to March 2004), and opined a three-month gap in weight gain (December 2003 to March 2004) for a young child was not unprecedented in this doctor's practice and therefore not worrisome. We consulted a pediatrician with extensive experience in forensic child abuse and neglect diagnoses and treatment who disagreed with Jmeir's pediatrician's assessment.

The clash in perspectives may be symptomatic of ongoing miscommunication between the hospital and the pediatrician. For example, the doctor's records include no references to Jmeir's anemia or a need for ongoing Epogen treatments, though the hospital records

include a Pediatric Consultation Report apparently requested by Jmeir's pediatrician, dated June 15, 2003, which diagnoses anemia and includes a carbon copy notation to the pediatrician. A separate hospital record includes a notation that Jmeir needed Epogen treatment, but that record was not copied to the pediatrician.

RECOMMENDATIONS

As previously indicated, the DHS has already taken steps to address many of the concerns that have been elevated in this report. Based on the review of the cases, and fully acknowledging both the relevant aspects of the child welfare reform plan and recently implemented DYFS agency policy and initiatives, we made the following recommendations:

1. **OCA found agency policy that governed case practice at the time of DYFS intervention with these families to lack sufficient guidance in some keys areas. OCA recommends that the DHS/DYFS ensure that DYFS policy requires or includes:**

    a. Verification of child care arrangements identified by the primary care giver.
    b. Identification of all residents of the home and those who frequent the home, their relationships within or to the family, and the extent to which each individual is involved in providing care for the children.
    c. Clear protocols regarding locating missing families, maintaining consistent personal contact, and working with evasive families, including but not limited to communication with the Division of Family Development, as indicated.
    d. Guidance regarding weighing evidence from various sources.
    e. Effective policies related to identifying, measuring and responding to risk related to domestic violence and substance abuse in families when they are present individually and in tandem with one another.

2. **Because of the imperative need to monitor and manage case load size for case managers, and the absolutely critical role of the first line supervisor in DYFS, particularly with regard to ongoing communication between the case manager and the supervisor, DHS/DYFS should:**

    a. The OCA recommends that DHS/DYFS immediately implement the elements of the child welfare reform plan targeted at professional development and support of the supervisor.
    b. Further develop the capacity to track supervisory conferences with case managers to assure guided and supported decision-making, contemporaneous documentation of case activity and consistent adherence to agency policy.

3. **The DHS should ascertain the need for specialized child care and early intervention programs for parents caring for children with developmental disabilities, and develop a strategy to fulfill the need as identified.**

4. **The Training Academy required by the child welfare reform plan must assure that case managers of "specialized case loads" receive intensive training in the area of specialty, and are required to participate in continuing education opportunities to remain abreast of new developments in the field, specifically those designated to specialize in sexual abuse, serving adolescents and supporting resource families. The training academy should become operational in the next 60 days.**

5. **The Plan's renewed commitment to Continuous Quality Improvement and systems of accountability should include or enhance the following:**

a. Training staff that how best to use SDM as a process and standard of case practice;
b. A requirement that all child protective services and child welfare issues are appropriately resolved prior to termination;
c. Random audits of investigations and findings decisions to determine the extent to which investigations are thorough and complete and decisions are supported by the underlying evidence.
d. A requirement that all case closings for supervisors with less than 2 years supervisory experience are reviewed by staff with more than 5 years of supervisory experience.
e. Review and assess appropriateness of decision making at critical junctures in case practice, including but not limited to, establishing supervision, services to be offered and termination.
f. Review and assess the use of collaterals – making appropriate contacts, asking appropriate questions and effective application of information/advice. DYFS Assistant Commissioner Ed Cotton's decision to abandon the long-held practice among DYFS staff to submit standardized forms to police, schools and health care providers to learn about a child or family, and to instead require DYFS staff to speak directly with collateral sources, is a very strong reform that should be supported. It portends a radical improvement in case practice if staff receive adequate training.

6. DYFS must provide guidance for case managers regarding intervention in cases where infants are co-sleeping with their caregiver(s). While the cases where co-sleeping was an issue are not included within this report, the OCA would be remiss if we failed to elevate this issue again. (This issue has been raised by the Child Fatality and Near Fatality Review Board and the New Jersey Task Force on Child Abuse and Neglect.)

The subject of co-sleeping has been a point of ongoing controversy over the past several years. Supporters of the practice of bed sharing include stronger bonding between the infant and caregiver as one of its advantages or benefits. On the other hand, a 1999 report from the Consumer Product Safety Commission based on national data identified 515 cases of accidental infant deaths that occurred in a shared adult bed over an 8-year period between 1990 and 1997, with approximately 65 deaths per year. The study determined that the actual causes of death, verified upon review of the scene and autopsy, included, but were not limited to, accidental asphyxiation by an adult and getting trapped between the mattress and headboard or other furniture. The practice of co-sleeping is not without its risks due to the potential for the caregiver to roll over and asphyxiate the infant.

The OCA is concerned about the practice of co-sleeping absent education of new parents about the attendant risks. The OCA recommends that DHS' Office of Child Abuse Prevention and the Department of Health and Senior Services work collaboratively on a safer sleep campaign. Such a campaign should include, but not be limited to, materials for DYFS workers, health clinics, and others who routinely come in contact with new mothers to review and leave with parents about safer sleep for their newborn.

7. Create cohesive policy and provide leadership to establish linkages and cooperation between the medical community (including providers, hospital systems, contracted nurse services, and related medical service providers) and DYFS.

a. There is an overarching need for centralized medical accountability and the development of protocols for the role of health care providers as child welfare agents. At present, confusion exists as to the roles of various actors, including the DYFS Case Manager, Supervisor, District Office Nurse and community providers. The OCA recommends that the newly-appointed DYFS Medical Director will articulate protocols and standards in this regard. Those protocols should set forth the process that DYFS and all medical providers will follow when treating a DYFS-involved child. Protocols should also delineate the parties' responsibilities upon admission/entry into care/start of services, the parties' respective roles in the child's treatment plan (both medical and social planning), and the parties' roles in the discharge process.

b. Equally important is the establishment and enforcement of stringent documentation requirements to chronicle interactions between actors. DYFS should create standard forms for inclusion in a child's medical file and DYFS file that capture developments in a child's condition as well as developments in child's case plan.

8. Clarify the role of the DYFS Nurse and educate the health care and child welfare communities as to this role. Standardize the role of DYFS nurses statewide to minimize variations in the level and quality of care a child receives.

a. The DYFS nurse should supplement, not supplant, the role of the DYFS case manager. DYFS policy should unequivocally convey that case managers maintain primary responsibility for a child's case, even if a DYFS nurse is involved. The case manager and the DYFS nurse should communicate weekly. In addition, the case manager should continue to visit with the child and communicate regularly with the child's medical providers, even if the child is hospitalized, and irrespective of the child's age (i.e. an infant).

9. Improve the Special Home Service Provider (SHSP) program.

a. A series of efforts are needed to improve the SHSP program, which serves a vital role in protecting New Jersey's most vulnerable, medically fragile children. At the outset, the State must aggressively recruit additional SHSP homes, both from existing foster homes and new applications. Certain DYFS district office personnel are under the impression that their responsibility for case management decreases once a referral is made to the centralized Foster Care Unit that oversees the SHSP program. The mandatory training program should educate case managers regarding the roles of the respective actors and that they retain overall responsibility for ensuring that the centralized Foster Care Unit timely finds a SHPS home.

10. **Create policy that establishes lack of prenatal care as a trigger for DYFS notification/intervention.**

    a. Implement a program to instruct hospitals to refer every case in which expectant mothers present without prenatal care to DYFS. On receipt of such a referral, DYFS policy should require DYFS to conduct a child welfare assessment to determine if the family has the capacity to provide appropriate care for the newborn, and to identify what services could be offered to strengthen the family and protect the infant.

11. **When implementing the medical provider training described in the child welfare reform plan, DHS/DYFS should also partner with the American Academy of Pediatrics, medical schools, and other professional organizations to ensure that trainings meet the needs of practitioners and protect children.**

12. **Standardize the guidelines utilized by health professionals and DYFS personnel in assessing abuse and neglect. Train health care providers and DYFS personnel on the standardized guidelines.**

    a. At present, there is a lack of standardization of child abuse and neglect guidelines utilized by health care professionals and DYFS personnel. Medical practitioners may rely on guidelines issued by the *American Professional Society on the Abuse of Children (APSAC)*[27] rather than the standards for evaluating injuries set forth in a DYFS Manual entitled *District Office Case Handling Standards for Screening, Investigation & Initial Child Welfare Assessment* (March 1996). Medical standardization is essential to the consistent diagnosis of abuse.

13. **DYFS case practice standards should prohibit case closure where unresolved child welfare concerns exist.**

    a. Irrespective of whether abuse or neglect is substantiated, a child's case should not be closed where child welfare concerns are noted. Personnel must be trained to address and document their actions, beyond intake, to resolve all child welfare concerns prior to closing a case.

[27] The American Professional Society on the Abuse of Children is a nonprofit national organization focused on meeting the needs of professionals engaged in all aspects of services for maltreated children and their families. Especially important to APSAC is the dissemination of state-of-the-art practice in all professional disciplines related to child abuse and neglect. APSAC's national, interdisciplinary guidelines task forces regularly promulgate concise, data-based guidelines on key areas of practice in the field of child maltreatment. APSAC Guidelines for Practice are submitted to a rigorous, multi-layered process of peer review, involving experts in the subject area not on the task force, the membership of APSAC, legal counsel, and APSAC's Board of Directors. All Guidelines for Practice have been approved by the APSAC Board.

14. Medical conclusions should meaningfully and consistently inform decision-making.

a. Deference should be given to an examining physician's finding that an explanation provided about an injury is inconsistent with the child's injuries, especially where the observed injuries are suspicious of abuse.

15. DYFS should create and enforce policy to ensure that lack of health insurance never impedes access to services established to treat and protect children.

a. At a minimum, the medical costs of services and tests related to an abuse assessment should be fully covered by DYFS at a single assessment center. More comprehensively, all services and tests put in place to protect children from abuse and neglect should be covered by the State so as not to leave children vulnerable.