OFFICE OF THE CHILD ADVOCATE
REPORT

CHILD FATALITY INVESTIGATIONS
2005

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Table of Contents

INTRODUCTION

In June 2005, the Office of the Child Advocate (OCA) issued a report of Child Fatality Investigations that included two fatalities that occurred in late 2004, Zion Nicholas and Angel Cartagena, and one fatality that occurred in early 2005, Philip O'Donnell.[1] The report focused on the involvement of the child welfare system in the lives of children who died due to suspected abuse or neglect following a recent involvement with the Division of Youth and Family Services (DYFS), which is located within the Department of Human Services (DHS).

This investigative report includes findings in connection with eight child fatalities from March 2005 through October 2005. In keeping with established practice and commitments,[2] the OCA evaluated the performance of DYFS, as well as the roles played by components of the child welfare system at-large, including schools, health care providers, and community agencies. The OCA 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 assess how DYFS responded and to understand the efforts expended by the child welfare system to identify and address the needs of families and children prior to the fatality. The examination of each of these cases places each death into the context of the overall family history with DYFS. 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 to enhance the ongoing reform.

This report includes findings with respect to the following child fatalities:

NAME	DOB	DOD	COUNTY
Russell Andrew Walker, III	09/15/04	03/12/05	Ocean
Zachary Giacobbe	05/28/05	06/27/05	Gloucester
Alana Duff	04/6/03	07/20/05	Ocean
Elijah Hanson	02/13/03	07/21/05	Ocean
Kelly Tozer	01/10/04	07/30/05	Atlantic
Jasiah Woods	07/19/04	08/1/05	Hudson
Baby Girl Harvey	08/27/05	08/27/05	Middlesex
Jeremy Celentano	08/14/05	10/18/05	Passaic

[1] Office of the Child Advocate, *Child Fatality Investigations: Zion Nicholas, Angel Cartagena, and Philip O'Donnell* (2005).

[2] The OCA committed to conduct in-depth reviews of the child welfare system's interactions with families whose children died due to suspected abuse or neglect after an involvement with DYFS pursuant to statutory authority to "[i]nvestigate, review, monitor or evaluate any State agency response to, or disposition of, an allegation of child abuse or neglect in this State." *N.J.S.A.* 52:17D-5.

Overall Observations

The OCA's findings in these cases center around several recurring themes related to provision of services; safety assessment and planning; screening and intake; case management and supervision; emerging policy and integration into case practice; and use of information technology. In the aggregate, these concerns demonstrate the systemic scope of the persistent challenges for New Jersey's child welfare system. This report indicates that New Jersey's most vulnerable children and families need meaningful systemic reform. The OCA remains committed to advocating for that reform to help keep children safe and families strong. [3]

Provision of Services

The OCA has stated in previous reports, and takes this occasion to underscore, that services required to prevent placement or to facilitate family reunification should not be delayed or denied based on the family's ability to identify a service provider or to pay for the services. Under no circumstances should a parent's inability to pay for services hinder access to services required to prevent or ameliorate the risk of future child maltreatment, or services required to rehabilitate the caregiver and enhance family stability and/or to promote reunification, ensuring permanency for the children.

While DYFS has several options for providing services to families, including but not limited to FLEX funds up to $1,500 per family, caseworkers continue to advise caregivers that DYFS does not pay for substance abuse treatment or emergency housing. In one case (Walker), DYFS advised the parent to find and provide payment for substance abuse treatment services in order to prevent placement. The family indicated that obtaining services would be delayed because they did not have the financial means to pay for the service. Delay in service provision leaves children at risk of harm. In the Walker case, the father was caring for the children while under the influence of marijuana at the time of the child's death; in the Giacobbe case, a child's clear need for behavioral health and/or developmental disability services went unfulfilled.

Affordable housing continues to be elusive for low-income families in New Jersey. Appropriate emergency housing options are insufficient to meet the need. In one case (Walker), the family (parents and two children, one of whom was terminally ill) moved between motels until finally moving in with the paternal grandmother. The second motel placement did not have a telephone or appropriate sleeping arrangements for the children. DYFS did not advocate for the family to be moved to a room that could better accommodate their needs and did not ensure that a crib was made available for the baby. In spite of Family Preservation Services' active involvement with the family, these risk factors were never remedied.

In three cases (Hanson, Walker, Giacobbe), the lack of medical insurance was identified as a barrier to receiving prenatal care or routine pediatric care. In fact, in one instance the caseworker required a medical evaluation of the child during the investigative phase and asked the parent to

[3] The OCA has raised some of these concerns previously. *See* Office of the Child Advocate, *Child Fatality Investigations: 2004* (2004); Office of the Child Advocate, *Child Fatality Investigations: Zion Nicholas, Angel Cartagena, and Philip O'Donnell* (2005). To the extent those issues were elevated in previous investigative reports, the concerns and recommendations discussed there are incorporated here by reference.

take the child to the doctor. The investigation was thwarted because the mother did not have medical insurance for the child and did not follow through. The State must be more assertive in linking families under investigation or supervision with medical care through NJ FamilyCare, providing coverage for medical exams needed during investigations or temporarily until another program is activated, or accessing one of the Federally Qualified Health Centers.

In several instances in this report, DYFS employees appear not to have been adequately informed of enhancements to agency policy or the array of services available. Although DYFS policy and services are evolving at an unprecedented pace in light of the Child Welfare Reform Plan, DYFS employees in these cases frequently seemed insufficiently aware of emerging agency policy. The OCA has general concerns about the manner in which new policy is disseminated to all staff ensuring integration in daily practice. DYFS must assure that staff in the field is aware of, and accesses, supports and services to facilitate family stabilization including emergency funds (FLEX funds, PRS emergency fund), agency contract providers, and community services.

Screening and Intake

There are some concerns with centralized screening policy and protocols, intake procedures, and investigations/assessments in three of the cases (Duff, Hanson, Woods), but this report does not conclude the problems are typical because these investigations do not include random sampling and analysis of field work. The OCA has previously expressed concerns regarding proper coding, handling of, and timeframe for calls at screening and the need for comprehensive training of screeners and their supervisors. During the course of these investigations, the OCA learned that screening staff perceive there to be in place disturbing protocols for rating employee performance at screening based on a quota system (quantity of calls referred for investigation each month) rather than the quality of the information gathered through appropriately engaging the caller and properly assessing the information gathered (Duff). DHS firmly denies the existence of a quota system. At best, this demonstrates confusion among some screening employees regarding the expectations of them when handling calls to the hotline. Better training and guidance are in order.

The OCA previously elevated related concerns regarding the State Central Registry, noting that emerging agency policy governing practice lacked sufficient guidance in some key areas and that screeners were not uniformly eliciting sufficient information about the nature of the allegations and general family dynamics when the information is known to the referent.[4] Screeners' consideration of meeting quotas suggests a potential correlation between moving through the call quickly to meet the established monthly quota and the failure to elicit all relevant information to thoroughly assess and code the concerns of the referent.

[4] Office of the Child Advocate, *Child Fatality Investigations: Zion Nicholas, Angel Cartagena, and Philip O'Donnell* (2005).

Case Planning and Safety

Assessment of safety, risk, and individual and family strengths and needs is the foundation for intervention that leads to improved outcomes for children and families. Establishing rapport with the caregivers, engaging the family in the assessment and planning process, and maintaining a relationship with the family are essential. Throughout the cases investigated in this report, the OCA routinely found that the case planning process did not appear to involve the family. Case plans were developed without input or discussion with the family. In one instance, the case manager discussed a case plan with the mother and paternal grandmother only, despite that services for the father were central to the plan and he was asleep in the next room. The mother and paternal grandmother signed the plan but ultimately the father did not comply. Caseworkers were unable to engage noncompliant clients who had total disregard for case plans. Although the lack of compliance was clearly documented month after month in the contact sheets, there was no evidence of a case conference with the supervisor to strategize for a more effective intervention with the family. Noncompliance was not addressed even when services had been court-ordered for the family.

Safety assessments and protection plans were similarly impotent. In two cases (Walker, Hanson) family members who were aware of the previously abusive or neglectful parenting behavior were asked to provide supervision of the alleged perpetrator's contact with the children. Even when the plans were violated, DYFS did not establish an alternate plan. Such plans, reliant upon supervision by someone who was previously aware and failed to intervene on the child's behalf, are of little value and do not ameliorate the safety threat for the child.

Caseload Management

The Child Welfare Reform Plan acknowledges that management of caseload size is a cornerstone of the ongoing reform effort. Even as average caseloads at DYFS have declined significantly, some of these cases reveal that throughout 2005 there were employees still burdened with the task of managing unreasonable caseloads (Walker, Duff). The OCA recognizes that there are many contributors to caseload management including, but not limited to, ensuring adequate staffing at the local level and providing sufficient supervision and support to accomplish daily tasks. The OCA found that in one instance the case manager was carrying an ongoing caseload in addition to two child welfare assessments and two child protective services investigations. The competing interests of managing cases in the intake phase with managing cases under supervision is difficult to negotiate at best; at worst, cases in either category are set aside and case management becomes a series of exercises in crisis intervention. Here, again, the role of the supervisor is critical to establish clear priorities and to move cases to more appropriate units whenever feasible. Supervision in most of these cases was an issue as most cases bore little evidence of supervisory oversight such as conference notes, signatures on contact sheets, or other case documentation.

Water Safety

Water safety gained prominence for those concerned with child safety during the summer of 2005. Three of the children (Duff, Tozer, Hanson) in this report drowned in the family swimming pool while inadequately supervised. According to statistics published by Safe Kids Worldwide, drowning is the leading cause of accidental injury-related death among children ages one to four years, there are approximately 300 residential swimming pool drownings each year, and more than half of these drownings occur in the child's home pool.[5] Eight children, all under the age of sixteen, drowned in New Jersey between June 20, 2005, and July 24, 2005. Of those eight children, four died in backyard pools and the two youngest victims were two years old.[6]

Domestic Violence

Domestic violence unreported to DYFS was an underlying issue in two of the cases (Duff, Hanson). In each case, local law enforcement was called to the respective residences to address domestic violence complaints. Understandably, in many instances law enforcement may not make a referral to DYFS for fear of further impugning the victim. Although not directly related to the fatal incident, these lapses in referral each represent missed opportunities to reach out to the families and engage them in preventative services and support the non-offending parent's efforts to create a safe home environment for the children.

When domestic violence is one of the presenting problems with the family, some DYFS employees appear to need additional guidance on how to intervene to assure the safety of all parties (non-abusive caregiver and children). For example, in the Hanson case, the mother was able to acknowledge domestic violence and request help in the absence of her abuser. However, in his presence, she joined him in denying the existence of a problem. Returning to the abuser for nurturance and support once removed to safety is another fairly common dynamic in domestic violence situations. The case manager and supervisor were unsuccessful in recognizing the family dynamics; efforts to intervene with the family were futile and never effectively ameliorated the associated risks for the mother and children.

Information Technology

During these investigations the OCA learned that supervisors and senior managers, remaining without useful information management and decision support systems, continue to rely upon manual systems of accountability for case assignment, decision-making, and oversight. For example, the case assignment and tracking systems in the Ocean County District Office were inefficient and lacked consistency. Interviews with the caseworker and local office supervisor revealed concerns about the assignment system in place for new investigations and child welfare assessments. These concerns apply to both the process by which assignments are made and the manner in which caseworkers are notified of new assignments.

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[5] www.safekids.org (visited November 16, 2005).

[6] Ralph R. Ortega and Suleman Din, *State suffers 7 drownings in 5 days*, Newark Star Ledger, July 25, 2005. New Jersey's Child Fatality and Near Fatality Review Board is the primary resource for the review of aggregate trend data regarding child fatalities.

According to a supervisor in that office, the process of assigning every incoming report or referral for investigation or assessment is an arduous task requiring access to DYFS' database, "NJ SPIRIT," as well as the manual review and maintenance of multiple independent log books to check for caseload information and daily attendance of caseworkers prior to assigning the case to a caseworker for investigation or assessment. Staff reported ongoing difficulty with the case management database that has often resulted in cases being temporarily misplaced in the system, requiring advanced searches of the database and creating major impediments in caseworkers' abilities to update the system and complete necessary documentation. Similar concerns were raised regarding supervisors' ability to track outstanding investigations and assessments after they have been assigned.

RUSSELL WALKER III – DATE OF DEATH: March 12, 2005

On March 12, 2005, police officers responded to a 911 call at the Walker family residence. When the police arrived, Russell Walker III was found unresponsive. The paramedics performed CPR and brought the child to the hospital. Russell III was pronounced dead at 2:36 p.m. by an emergency department physician.

Russell's father, Russell Walker II, admitted that he had smoked marijuana while caring for his son. The medical examiner concluded that the cause of death was acute airway obstruction by emesis and aspiration and that the death was accidental. Toxicology tests showed that Russell III had trace amounts of marijuana in his system. Russell Walker II has been charged with fourth-degree child neglect and possession of marijuana.

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 Walker family prior to Russell III's untimely death, including:

i. CCAPTA Notice dated March 14, 2005.
ii. DYFS Case Chronology
iii. Copy of DYFS Case Record
iv. Medical Records regarding Russell Walker III
v. Police records regarding Russell Walker II
vi. Investigation report from Ocean County Prosecutor's Office
vii. Miscellaneous Records regarding Walker family
viii. Personnel records of DYFS Caseworkers
ix. Personnel records of DYFS Supervisors
x. Caseload information re: DYFS Caseworker #2 (January 2004-July 2005)
xi. Interview with DYFS Caseworker #2

II. REVIEW OF DYFS INVOLVEMENT WITH THE FAMILY

Between November and December of 2003, DYFS received five referrals regarding the Walker family alleging abuse or neglect. None of the referrals were substantiated.

Initial Referral – November 10, 2003

On November 10, 2003, a referent called DYFS and reported that one of Russell III's siblings, J.W., did not speak for hours and seemed to be afraid of her father. The referent also relayed that another sibling, J.D., had no use of his left arm and was not stable on his feet. Finally, the referent stated that Russell Walker II, his mother, and Jackie Jaca, J.D.'s mother, routinely blew marijuana smoke in the children's faces to get them to fall asleep.

DYFS coded the allegations for an immediate response and assigned the case to Caseworker #1. According to his contact sheets, Caseworker #1 made an unannounced visit to the home that

same day and met with Mr. Walker, his mother, and both siblings. The caseworker reported that the children "seemed to be very clean, appropriate and well cared for" and that the house "seemed clean and appropriate." Caseworker #1 also noted in his contact notes that the house had plenty of food and all of the utilities were in working order. He further noted that the left side of J.D.'s face was "drooping a little bit," but that the child was using both arms and walking age-appropriately. Caseworker #1 inquired about the child's medical condition and whether he was under the care of a pediatrician. He was told that "nothing was wrong" with the child and that the child's mother, Jackie Jaca, could provide the name and contact information for the pediatrician. The caseworker was also told, however, that J.W. did not have a pediatrician because she did not have any medical coverage at that time. Mr. Walker and his mother denied the allegations of drug use, but the caseworker nonetheless requested that all the adults report to the Ocean District Office the following day for a drug screen. He also instructed the family to take the children to see a pediatrician as soon as possible and to provide him with the name and contact information of the physician or physicians they saw.

On November 12, 2003, Mr. Walker, his mother, and Ms. Jaca visited Caseworker #1 in his office in order to submit to urine drug screening. During the visit, Ms. Jaca provided the telephone number for J.D.'s pediatrician and signed a release for medical records. The caseworker noted that all the adults were very appropriate during the office visit and none seemed to be under the influence of any type of substance. Mr. Walker provided J.W.'s immunization record and assured the caseworker that she would see a pediatrician in the near future.

On December 10, 2003, Caseworker #1 called J.D.'s pediatrician and was informed that he had not been there since January 21, 2003, and that his immunizations were not current. That same day, the caseworker received the results of the drug screens. They indicated that Mr. Walker's mother and Ms. Jaca tested negative for all controlled substances but that Mr. Walker tested positive for marijuana. The caseworker contacted Mr. Walker to inform him of the results and requested that all the adults submit another sample. At that time, Mr. Walker denied any drug use. The caseworker also informed Mr. Walker that a protection plan and substance abuse evaluation were necessary.

Second Referral – December 11, 2003

On December 11, 2003, DYFS documented in a referral response report that Mr. Walker had tested positive for Cannabinoids (THC). The referral was coded as a family problem involving parental substance abuse and a child's medical issues. At that time, J.D. was hospitalized with a malignant brain tumor.

On December 12, 2003, the caseworker made a home visit. Mr. Walker's mother was at home with J.W., and Mr. Walker and Ms. Jaca were at the hospital with J.D. while he was having an operation to remove his brain tumor. Caseworker #1 spoke with Mr. Walker's mother about the children's medical care and about Mr. Walker's positive drug test. At that time, Mr. Walker's mother stated that she had never seen her son smoke marijuana. She further stated that he had never smoked in the house or around the children as far as she knew. The caseworker drafted a case plan for the period between December 11, 2003, and June 11, 2004, that required Mr.

Walker's mother and Ms. Jaca to supervise all contact between Mr. Walker and the children; that all three adults to submit to another urine screen by the next day; that Mr. Walker consent to a substance abuse evaluation and agree to follow all recommendations arising out of that evaluation; and that the family seek medical care for the children. After the case plan was faxed to the hospital for Mr. Walker's and Ms. Jaca's review, all three adults agreed to comply.

Subsequently, the hospital wrote a letter indicating that the tumor was not the result of abuse or neglect. As a result, the investigation ultimately concluded that the allegations were not substantiated.

Third Referral – December 13, 2003

The Office of Child Abuse Control (OCAC) hotline received a referral on December 13, 2003, at 8:35 a.m. The referent alleged that J.D. had died on the operating table on December 12, 2003; that she was concerned about Mr. Walker's history of abusing the children; that she had witnessed inappropriate interaction between Mr. Walker and the children; and that J.D. had not seen a doctor in four months.

A Special Response Unit (SPRU) worker responded to the Walker home at 1:40 p.m. on December 13, 2003. Because Mr. Walker, Ms. Jaca, and J.W. were at the hospital visiting J.D., who had not, in fact, passed away during the operation, the worker returned the next day. During that visit, the worker developed a second case plan with the family. This plan provided that another family member, Mr. Walker's sister, would supervise all contact between the children and the other adults in the home. Further, the family agreed to a full physical examination for J.W. and to arrange pediatric evaluations for both siblings. Ms. Jaca, Mr. Walker, Mr. Walker's mother, and Mr. Walker's sister all signed the case plan on December 14, 2003. On that same day, J.W. was taken to the hospital for a full body skeletal examination. No problems were noted. Ultimately, the investigation concluded that J.D. had not died and that the allegations were not substantiated.

Fourth Referral – December 13, 2003

While the SPRU Worker was investigating the referral received at 8:35 a.m., the OCAC hotline received another referral (at 9:25 p.m.) reporting that approximately three weeks earlier Mr. Walker and his mother were smoking marijuana and that Mr. Walker blew marijuana smoke in J.D.'s face. It was further alleged that Mr. Walker, who is not J.D.'s father, referred to him using a racial slur. The referent also stated that the house smelled of marijuana and cat urine and that police cars had been at the residence recently. It was noted on the OCAC hotline report that these allegations were identical to those made on November 10, 2003. DYFS did not complete a separate investigation.

Fifth Referral – December 17, 2003

The fifth referral was received on December 17, 2003, at 4:00 p.m. The referent reported that Mr. Walker disciplined the children by picking them up by one arm, raising them to eye level, and smacking them. The referent also reported that Ms. Jaca would drop J.D. off at his father's home unannounced and with sparse supplies.

On December 18, 2003, Caseworker #1 met with Mr. Walker at his office. The purpose of the meeting was for Mr. Walker to submit another urine sample and to discuss the allegations received the previous day.[7] Mr. Walker denied ever picking the children up by one arm but admitted to smacking J.W. on occasion.

On December 19, 2003, the caseworker met with Mr. Walker, his mother, Ms. Jaca, Mr. Walker's sister, and J.W. During this visit, Caseworker #1 spoke with Ms. Jaca about the allegations. Although she admitted dropping J.D. off at his father's house late at night, she denied not providing adequate supplies. The investigation, completed December 19, 2003, concluded that the allegations were not substantiated.

On December 23, 2003, Ms. Jaca submitted to a drug test, which was negative for all substances.

On January 2, 2004, Caseworker #1 and the nurse consultant conducted a scheduled home visit. In accordance with the case plan developed on December 14, 2003, Mr. Walker's sister was present when they arrived. According to the contact sheet, the family was not cooperative and was extremely hostile the entire time the caseworker and nurse were in the home. Mr. Walker was yelling and cursing and was extremely threatening, and his mother was also hostile and uncooperative. Eventually, the caseworker and nurse were asked to leave the home.

Prior to the home visit, the caseworker had prepared a draft case plan. The case plan would have required the family to agree to DYFS monitoring Mr. Walker's use of substances going forward. In addition, the plan would have required Mr. Walker to agree to comply with a substance abuse evaluation; to ensure that J.D. continued to see his doctor; that the family would take J.W. to see a pediatrician; and that Mr. Walker's sister continue to supervise the family until Family Preservation Services (FPS) were implemented. Due to the family's behavior, the caseworker was unable to speak with them about the plan. As a result, the caseworker noted on the case plan that the "[f]amily refused to sign."

On January 13, 2004, the caseworker had a conference with his supervisor and the Deputy Attorneys General assigned to the case. It was determined that there was not enough evidence to file for custody or supervision and that the allegations would not be substantiated. Further, the decision was made to close the case since the family did not want services from DYFS. The next day, the caseworker contacted one of the referents and the J.D.'s father and informed them that the case was being closed because there was not enough information to litigate. Both were advised to call with any future concerns. On January 16, 2004, the caseworker called the Walker home and left a message to the same effect.

[7] The results of the drug test were negative for all substances.

Despite those messages, on January 21, 2004, the caseworker met with his supervisor and they decided to keep the case open to offer services to the family "in an attempt to assist them in dealing with their terminally ill child." That same day, the family began receiving hospice services.[8]

At some point between January 22, 2004, and January 27, 2004, DYFS transferred the case from intake to Caseworker #2, who was an on-going worker. Although there is a case transfer checklist in the file, it is undated and unsigned. The file does not contain any documented instructions or consultations regarding activities requiring follow-up; Caseworker #2, however, indicated during an interview that she met with Caseworker #1 about the case and recalled receiving a transfer summary.

On January 27, 2004, Caseworker #2 and her supervisor met with Mr. Walker and Ms. Jaca, who reported that their family had become homeless and had slept in their van the previous night in below-freezing temperatures. The family requested that DYFS assist them in finding temporary housing. During this meeting, according to the contact sheet, Mr. Walker was "extremely confrontational and volatile."

The Ocean County District office approved a check in the amount of $525 for temporary housing at a hotel in Toms River. The caseworker accompanied the family to the hotel and performed a safety assessment on the room, which was equipped with a refrigerator, microwave, crib, and two double beds. It was determined that the children were not presently at risk. While at the hotel, Ms. Jaca revealed to the caseworker that she was pregnant.

On January 29, 2004, Caseworker #2 and a FPS worker visited the family at the hotel. DYFS offered FPS to the family and they agreed to participate.[9] Those services continued until February 27, 2004.[10] With the assistance of the FPS worker the family applied for welfare benefits, hospice services, emergency temporary housing, NJ KidCare, WIC, and Medicaid; obtained baby food and diapers; and made necessary medical appointments.

On February 3, 2004, the family moved to a hotel in Seaside Heights. The caseworker visited the family at the hotel on February 4, 2004, and discovered that the room had no telephone or crib. Ms. Jaca reported that the family did not have money for food, the children still had not seen a pediatrician, and that she was not receiving prenatal care. The caseworker encouraged her to address the medical issues as well as obtain a crib for J.D.[11] Ms. Jaca stated that Mr. Walker's income tax return would arrive the next day and that she would retrieve a playpen from her father's home.

On February 5, 2004, the caseworker obtained and delivered a food basket from Hunger Relief. During the visit, the caseworker was informed that the tax return check had not arrived and that Ms. Jaca had not retrieved the playpen as she had promised. The caseworker told Ms. Jaca that he would return the next day to verify that she had obtained a crib or playpen. Instead of

[8] Medicaid paid for this service.
[9] During the January 2, 2004, home visit, FPS services were offered and Mr. Walker declined the services.
[10] The family received 35.25 face-to-face hours divided among thirteen sessions.
[11] Ms. Jaca began receiving prenatal care on March 30, 2004.

returning, however, the caseworker called the FPS worker and requested that she make the verification.[12]

Between February 6, 2004, and March 7, 2004, the caseworker requested medical records, criminal records, and child protection records on the family and spoke to doctors and service providers.[13] She also scheduled psychological evaluations for Mr. Walker, his mother, and Ms. Jaca. Also during this time, DYFS discontinued FPS and both initiated and discontinued FPS Step-Down.[14] The programs were discontinued despite a contrary recommendation from the nurse consultant.[15]

The next home visit was on March 8, 2004, at Mr. Walker's mother's home in Jackson, where the family had returned. Two days later, on March 10, 2004, Mr. Walker called the caseworker to express his dissatisfaction with DYFS. According to the contact sheet, Mr. Walker stated that DYFS had done "nothing to help him" and that if DYFS really wanted to help, it should "get him a house and fix his car."

J.D. passed away on March 14, 2004.

On March 30, 2004, Caseworker #2 called the family to remind them of psychological evaluations that had been scheduled for April 2, 2004. She also spoke with them about daycare services for J.W. and offered to pay for Mr. Walker's car to be fixed. Despite the reminder, the family missed the psychological evaluations. When the caseworker called later that day to ask why the family had missed their appointment, Mr. Walker stated that he worked the late shift and completely forgot about it. During the conversation, the caseworker informed the family that daycare services, three days a week, had been approved.

On April 5, 2004, the caseworker took the family to tour a local daycare center, but Mr. Walker did not approve of the facility. The caseworker contacted two other facilities and set up appointments for April 12, 2004.

On April 8, 2004, a litigation conference was held. According to the contact sheet, the caseworker, her supervisor and the case work supervisor argued to file for supervision of the children. This argument was based primarily on Mr. Walker's unresolved substance abuse issues. On April 14, 2004, DYFS filed an Order to Show Cause and was granted care and

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[12] During her interview, Caseworker #2 stated that the family did not obtain a crib while living in the hotel.

[13] On February 20, 2004, she conducted a Promis/Gavel Inquiry on Russell Walker. The contact sheet indicates that she found no arrest history, disposition records, incarcerations or convictions.

[14] FPS Step-Down began on March 1, 2004, and was discontinued after only one session due to the J.D.'s medical condition. The discharge summary is dated March 22, 2004.

[15] On March 12, 2004, the nurse consultant wrote a letter to Caseworker #2 recommending that DYFS "seek keeping as many services in the home as possible." The letter further states:

> They are a family that has demonstrated their ability to fall apart in the middle of a crisis and they are now able to cope with the aide of services. It would be a great disservice if they were to go from receiving 20 hours of FPS per week to zero. This would also limit the number of hours per week that there were trained professionals able to make an assessment about the safety of the children.

supervision of J.W. The court ordered Mr. Walker to comply with a substance abuse evaluation and also ordered that he and Ms. Jaca undergo psychological evaluations. Between April 14, 2004, and May 5, 2004, Mr. Walker did not drug test or submit to a substance abuse evaluation, and the psychological evaluations were not conducted.

The next court hearing was held on May 5, 2004. At this hearing, according the contact sheet, the court ordered a safety plan to be developed to avoid foster care for J.W. After the hearing, Caseworker #2 met with the family to discuss the case plan; however, Mr. Walker became confrontational and refused to cooperate. The court was advised and a return court date was set for the following morning.

On May 6, 2004, the court ordered that, in order to avoid foster care for J.W., either a relative had to move into the Walker residence or Mr. Walker had to sign an informed consent placing the child with a relative. In addition, the court ordered random drug testing, a substance abuse evaluation for Mr. Walker, and psychological evaluations. After this hearing, the family returned to the DYFS office and Mr. Walker and Ms. Jaca submitted to drug testing.[16] A case plan was developed that required Mr. Walker's sister to supervise J.W. in the home "at all times . . . until DYFS or the courts change this plan."

On May 13, 2004, the caseworker was informed that J.W. was not seen at the pediatrician for a scheduled visit the day before. That same day, the caseworker made her first unannounced visit to the home. The only persons present were Mr. Walker and J.W. The caseworker spoke to Mr. Walker about his positive drug test and he denied using marijuana. According to the contact sheet, the caseworker suggested that "he start looking into treatment options on his own." Mr. Walker explained that J.W.'s doctor appointment had been rescheduled for May 20, 2004.[17] There is nothing in the record suggesting that the caseworker inquired why Mr. Walker's sister was not present.

On May 14, 2004, and May 21, 2004, Mr. Walker tested negative for all controlled substances.

On June 7, 2004, the caseworker made a scheduled visit to the home. All family members, including Mr. Walker's sister, were present. Reportedly, Mr. Walker's sister informed the caseworker that she had been residing with the family since the case plan was initiated on May 6, 2004.

On June 18, 2004, Mr. Walker tested positive for marijuana.

By July 13, 2004, the psychological evaluations on Mr. Walker, his mother, and Ms. Jaca had been completed. The psychologist concluded that Mr. Walker should not have unsupervised contact with his children. He recommended that Mr. Walker receive substance abuse treatment and anger management. Although the doctor found that Ms. Jaca may have benefited from additional mental health interventions he concluded that she would not present a risk to her child

[16] Mr. Walker tested positive for marijuana and Ms. Jaca tested negative for all controlled substances.

[17] On May 24, 2004, the caseworker confirmed with the doctor that this appointment had been kept and that J.W. was up-to-date on her immunizations. Medical records also confirm that J.W. was seen on that date.

if she were given primary custodial responsibilities. Lastly, he determined that Mr. Walker's mother was capable of providing for her granddaughter as a primary caregiver and resource.

On July 28, 2004, Caseworker #2 made a scheduled visit to the Walker residence. Mr. Walker, Ms. Jaca, and J.W. were present. When asked about Mr. Walker's sister, Mr. Walker informed the caseworker that she was taking her son to see the doctor but that she still lived in the residence.[18] They also discussed Mr. Walker's June 18, 2004, positive drug test. He again denied using marijuana.

On August 3, 2004, the court dismissed litigation by consent of the parties. In connection with the dismissal, Mr. Walker admitted that he is an unsuitable primary caregiver for J.W. The parties agreed to enter into a case plan that required Mr. Walker and Ms. Jaca to live with Mr. Walker's mother and to continue receiving specified services. The case plan also provided that it would include the new baby when he was born.

On August 9, 2004, the family completed an intake with a local mental health services provider. The family received twelve sessions of in-home counseling, concluding on January 19, 2005.[19]

On August 18, 2004, the caseworker conducted a scheduled visit with the family. While Mr. Walker slept, the caseworker discussed a case plan with Ms. Jaca and Mr. Walker's mother. According to the caseworker's contact notes, the plan required anger management for Mr. Walker, substance abuse counseling, random drug testing, and continued in-home counseling. [20] Reportedly, the caseworker provided Ms. Jaca with information about service providers. Although services for Mr. Walker were central to the case plan and the stability of the family there is no evidence that the plan was ever discussed with him.

On August 24, 2004, according to records provided to the OCA, Mr. Walker went to a service provider to schedule an appointment for a substance abuse evaluation but was unable to do so when the issue of payment was raised. Mr. Walker was instructed to speak with his caseworker to clarify whether DYFS would authorize payment.

On September 10, 2004, Ms. Jaca informed Caseworker #2 that she had attempted to schedule an appointment for drug treatment and inquired whether DYFS would be paying for the service. The caseworker informed her that DYFS does not pay for treatment and that the fees are based on a sliding scale. Ms. Jaca then replied that it might take Mr. Walker a while to complete the treatment and anger management classes due to lack of funds.

Five days later, on September 15, 2004, Russell Walker III was born.

Two months later, on November 16, 2004, the caseworker made her first visit to the home since the birth of Russell III. There is no indication in the record, however, that the caseworker actually saw the baby. The caseworker did note that J.W. was "dressed appropriately" and was

[18] However, Caseworker #2 told the OCA that she was unaware that Mr. Walker's sister had a son and never saw him.
[19] The last visit to the home was on January 5, 2005.
[20] A copy of the case plan was not in the case file given to the OCA and was not provided upon request.

"friendly" and "full of smiles." During this visit, Mr. Walker reported that he had not participated in any substance abuse treatment. In response, the caseworker requested that he submit a urine sample two days later.[21]

The next activity on the case was two months later, on January 10, 2005, when the caseworker visited the home again. During the visit, Mr. Walker reportedly informed the caseworker that he was attending NA meetings.[22] The caseworker also noted in her contact sheet that the baby was "alert and appeared healthy" and that J.W. "looked good" and "was clean and appropriately dressed."

On February 17, 2005, the caseworker submitted a Special Approval Request for three urine screens. That request was approved on February 18, 2005. That same day, the caseworker faxed a referral to a local service provider and called Mr. Walker regarding scheduling his drug testing. In that call, she advised him that she would contact the service provider regarding his drug testing and then call him back to advise him when he should call to set up the appointment. At that time, Mr. Walker had not drug tested since June 18, 2004. The case record does not indicate any activity on the case after February 18, 2005; thus there is nothing in the record to suggest that the caseworker ever made the follow up call to Mr. Walker to instruct him to call for an appointment.[23] According to the records provided to the OCA, Mr. Walker did not begin testing until March 24, 2005.

Sixth Referral - Child Fatality – March 12, 2005

On March 12, 2005, at 7:47 p.m., the State Central Registry (SCR) received a call from the Jackson Police Department requesting information regarding DYFS' involvement with the Walker family. According to the referent, police officers responded to a 911 call at the Walker residence and, on arrival, found Russell III unresponsive. Paramedics brought Russell III to a hospital, where he was pronounced dead at 2:36 p.m. by an emergency department physician.

According to records provided to the OCA from the Ocean County Prosecutor and the Jackson Police Department, Mr. Walker stated that, after taking Ms. Jaca to work at 7:00 a.m., he drove his mother and children home. He further admitted to smoking marijuana while driving the car but denied that it had any effect on his driving. Once he returned home, his mother went to sleep and Mr. Walker fed the children. He reported giving Russell III a bottle that he propped up with a blanket on the couch. While the children ate, Mr. Walker told police that he watched a movie and fell asleep. He woke up to find Russell not breathing and he called the police at 1:52 p.m.

The medical examiner concluded that the cause of death was acute airway obstruction by emesis and aspiration and that the death was accidental. Toxicology tests showed that Russell III had trace amounts of marijuana in his system.

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[21] There is nothing in the record to suggest that Mr. Walker complied with the caseworker's request.

[22] Caseworker #2 told the OCA that Mr. Walker provided her with sign-in sheets verifying his attendance. He also showed her a list of telephone numbers and names of people from the program. She further stated that, due to the nature of the program, it would have been impossible for her to make any independent verification.

[23] The OCA requested supplemental contact sheets for any activity on the case after February 18, 2005, that may have been omitted from the record inadvertently. The supplemental contact sheets provided to the OCA on August 17, 2005, reflect case activity beginning April 6, 2005.

DYFS substantiated neglect against Mr. Walker for lack of supervision because he was under the influence of marijuana while caring for Russell III and J.W. DYFS also substantiated neglect against Mr. Walker's mother because she allowed him to care for the children knowing he was under the influence of marijuana. In addition, law enforcement has charged Mr. Walker with fourth-degree child neglect and possession of marijuana.

III. OTHER RELEVANT INFORMATION

Each caseworker and supervisor assigned to the case had appropriate education and training for his or her position. With the exception of one supervisor, all received favorable and/or exceptional Performance Assessment Review ratings throughout his or her employment with DYFS. One supervisor, however, received an "unsatisfactory" interim evaluation rating in March 2005, the month of Russell's death. According to the evaluation, the supervisor failed to meet individual job responsibilities relating to supervision of casework, case practice, personnel and sick leave, customer service, job knowledge/skills, and problem solving. It was further noted that that the supervisor "experienced difficulty in completing assigned tasks and influencing his workers to complete work in a timely manner." The OCA was not able to determine what professional development and support opportunities were provided to the supervisor, or other remedial actions were taken, to address the noted deficiencies from the review of the file.

IV. OCA'S FINDINGS AND CONCERNS

A. DYFS' visits to the home were sporadic and announced.

Between the initiation of the case on November 10, 2003, and the death of Russell III on March 12, 2005, the caseworkers assigned to the case made a total of fourteen home visits.[24] Although between November 2003 and February 2004 the visits were twice a month, beginning in March 2004 the visits became more sporadic. There were no visits in April; two in May; one visit each in June, July and August; no visits in September and October; one visit in November; no visits in December; one visit in January; no visits in February or March. The longest period between visits was nearly three months and the shortest was one day.

"At the time of the first contact with the parent, the Case Manager will need to determine on a case by case basis whether subsequent visits will be announced or unannounced. This determination should be discussed with the parent and be part of the case plan between the parent and the Case Manager."[25] The case record does not contain any evidence to suggest that the caseworker addressed and decided whether visits would be announced or unannounced, and does not indicate that the caseworker ever discussed this issue with the family. The only mention in the case record of the visits indicates that in the case plans dated January 2, 2004, to

[24] These visits occurred on November 10, 2003, December 12, 2003, January 2, 2004, January 28, 2004, February 4, 2004, February 5, 2004, March 8, 2004, May 6, 2004, May 13, 2004, June 7, 2004, July 28, 2004, August 18, 2004, November 16, 2004, and January 10, 2005. The visit made by the SPRU worker in response to the report received on December 13, 2003, is not included.

[25] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.C., Section 408.

June 2, 2004, January 28, 2004, to July 28, 2004, and August 17, 2004, to February 17, 2004, the in-person visitation (MVR) schedule was every four weeks.

Of the fourteen visits, only one (other than the initial visit) was unannounced despite evidence that the family was violating the case plan and putting the children at risk.[26] For example, on May 13, 2004, Mr. Walker was home alone with J.W., which was a direct violation of the case plan that had been signed a week earlier. Despite that fact, the caseworker did not continue making unannounced visits to the home to verify whether Mr. Walker's sister was living at the residence as required by the case plan. Moreover, she did not even address that violation with the family.[27] The next visit to the home was not until nearly a month later, June 7, 2004, and it was scheduled.[28]

B. The caseworker told the family that they would have to pay for court-ordered services.

On two separate occasions, the caseworker informed Mr. Walker that he needed to locate drug treatment services on his own. Further, the caseworker told the family that DYFS did not pay for such services, even though they had been court-ordered. During one conversation, Ms. Jaca indicated to the caseworker that drug treatment and anger management services would be delayed if the family bore financial responsibility.

The case remained open due to Mr. Walker's unresolved substance abuse issues. In fact, during her last visit to the home on January 10, 2005, Caseworker #2 told Mr. Walker that the case would not be closed until "the substance abuse issues are addressed and we get several negative urines." Thus, drug testing and counseling were services required by Mr. Walker. Without these services, his case remained open and the children were in jeopardy of being removed from the home. Despite this crucial need, in September 2004, the family was told that they would have to fund the services.

Five months later, in February 2005, the caseworker applied for and received approval for three urine screens for Mr. Walker. Had this been done in August when the case plan was written, Mr. Walker could have begun testing on August 24, 2004 (the day that he went to the provider and was turned away). Instead, the testing was delayed until after Russell III's death.

C. DYFS did not follow the recommendations of mental health professionals.

The court ordered Mr. Walker, his mother, and Ms. Jaca to submit to psychological examinations. These evaluations were completed on July 13, 2004. In the report, the psychologist made several recommendations for services. None of these services, however, were

[26] During her interview with the OCA, Caseworker #2 estimated that she made six or seven unannounced visits.
[27] During her interview with the OCA, Caseworker #2 stated she remembers Mr. Walker's sister being at the home every time that she was there. However, if there had been a violation of a case plan, she should have had a case conference with her supervisor.
[28] Similarly, on July 28, 2004, the family was again found to be in violation of the case plan. This time, the caseworker did inquire about Mr. Walker's sister's whereabouts but did not conduct subsequent unannounced visits.

provided by DYFS or incorporated into the case plan.[29] In the case of Ms. Jaca, that failure is particularly troubling. Her psychological evaluation indicated that she had ongoing mental health needs and recommended intensive individual psychotherapy for her as a "means of providing support and guidance for her in dealing with the inevitable stresses involved in raising a newborn, particularly given the fact that she has experienced the death of a child within the past year." He also recommended a psychiatric evaluation and medication. With the seriousness of those issues, DYFS should have ensured that Ms. Jaca received services.

D. DYFS discontinued supportive services despite a clear need.

The nurse consultant working on the case wrote a letter recommending that FPS continue based on the family's ongoing needs. Despite this recommendation from a professional familiar with the family, DYFS discontinued the services and, from March 1, 2004, to August 9, 2004, the only support the family received was five home visits from the caseworker. In August 2004, DYFS initiated in-home counseling through a local provider. When that service ceased on January 19, 2005, however, the family was left without any support until Russell III's death on March 12, 2005.

E. DYFS approved case closure while unresolved child welfare concerns existed.

On January 13, 2004, DYFS decided to close the case despite that it was aware of evidence suggesting that Mr. Walker had substance abuse issues and that those issues posed a risk to the children's safety. DYFS policy prohibits closing a case before all risks to the safety of the children are addressed and resolved. As the DYFS Field Operations Casework Policy and Procedures Manual states: "CPS cases may not be terminated solely upon the request of the client or upon the client's refusal to cooperate, even in those situations where a client initially requested the service. All information regarding the case must be taken into consideration to ensure the safety and well-being of the child prior to the termination of the case."[30] Termination is only appropriate when "the child's life or safety is not in danger."[31] When DYFS decided to close the case, Mr. Walker had one positive drug test and one negative drug test and had not been tested in nearly a month. Based on that evidence, DYFS could not reasonably have concluded with confidence that Mr. Walker's substance abuse issues were resolved, eliminating the risk that they presented to the children.

[29] Caseworker #2 stated that individual counseling and services for battered women were offered to Ms. Jaca but she declined participation.
[30] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.C., Section 2001 (emphasis added).
[31] DYFS Filed Operations Casework Policy and Procedures Manual, Chapter II.C., Section 2002 (4/1/2003) (emphasis added).

F. The relationship between DYFS and the Deputy Attorneys General must be clearly defined.

On January 13, 2004, the caseworker and his supervisor met with the Deputy Attorneys General and they collectively decided that there was insufficient evidence to file for supervision of the children. It is not entirely clear from the record whether the ultimate decision not to file for care and supervision of the children in January 2004 was made by the caseworker and his supervisor or the Deputy Attorneys General. However, according to the contact sheet, on January 2, 2004, after the family refused FPS, the caseworker told the family that the services would be court-ordered if they did not agree to them. Therefore, it is possible that the caseworker and the supervisor believed the case appropriate for filing and the ultimate decision not to file was made by, or impacted by, the attorneys who were assigned to represent DYFS. In a complex case such as this one, the caseworker and the supervisor often have much more knowledge and insight about a family and its needs. As a result, there should be a clear definition of the relationship between DYFS employees and Deputy Attorneys General that emphasizes the value of that knowledge and insight, which may often suggest that the views of the caseworker and supervisor should be entitled to a real degree of deference.[32]

G. The case was not properly supervised.

During the month of Russell III's fatality, Caseworker #2's caseload consisted of twenty-five families and fifty-eight children. This represented a slight decrease from the previous two months when she was responsible for twenty-six families and fifty-nine children. In her interview, Caseworker #2 initially stated that she did not believe her caseload affected her ability to handle the Walker case. However, she later explained that her high caseload forced her to prioritize cases and some, such as this one, were "pushed to the back burner." As her inability to conduct home visits on a regular and consistent basis attests, she was clearly overburdened and in need of supervisory direction and consultation. Despite this fact, a review of the caseworker's contact sheets contained in the case file reveals that the supervisory review at this time (and at earlier points in the case) was lacking.

The DYFS Administrative Policy and Procedures Manual requires supervisors to conference all cases with assigned workers periodically.[33] For new workers (those with less than one year of experience), the conferences are to be weekly and the entire caseload is to be fully conferenced each month.[34] Additionally, the supervisor must review contact sheets every thirty days at minimum, but may review them more frequently as circumstances in the case or other factors require. "After each review, the supervisor initials and dates the last entry on the contact sheet."[35] During her interview with the OCA, Caseworker #2 said that when she initially received the case, she conferenced with her supervisor "quite often." Subsequently, the

[32] In December 2004, as part of an enforceable element of New Jersey's Child Welfare Reform Plan, DYFS and the Department of Law & Public Safety developed dispute resolution protocols to address conflicts between DYFS employees and Deputy Attorneys General. That process, incorporated into each agency's policies, escalates the matter progressively within each department until the conflict is resolved, and may address the concerns raised here.
[33] DYFS Administrative Policy and Procedures Manual, Chapter I.F., Section 202.
[34] DYFS Administrative Policy and Procedures Manual, Chapter I.F., Section 202.1 (11/30/98).
[35] DYFS Administrative Policy and Procedures Manual, Chapter I.F., Section 207.

caseworker was transferred to a different unit and she was assigned to a new supervisor. Reportedly, she met with this supervisor every other month to speak about the Walker case.

This lack of supervisory oversight is also apparent by the contact sheets. The majority of the sheets were not signed by the supervisor, indicating that they had not been reviewed. Of the contact sheets that had been reviewed, an overwhelming number were signed on March 14, 2005, two days after Russell III's death.

H. DYFS did not investigate similar, but not identical, allegations separately.

On December 13, 2004, at 9:25 p.m., OCAC received a referral alleging that three weeks earlier the referent had witnessed Mr. Walker and his mother smoking marijuana and that Mr. Walker blew marijuana smoke in J.D.'s face. The referent also indicated that Mr. Walker referred to J.D. using a racial slur. The OCAC screener noted on the report that the allegations were the same as those reported on November 10, 2003. No investigation was conducted.

"If more than one referral on the same incident of abuse or neglect is received, it is unnecessary to do separate investigations or complete additional DYFS Forms 9-7."[36] However, the referral made on December 13, 2003, was not identical to the previous referral. Although both referents alleged the use of marijuana, neither referent provided a specific date of the incident. Thus, it would have been impossible for the screener to determine whether the referents were reporting the same occurrence. In addition, the December 13, 2003, referral included an allegation of emotional abuse that was not reported on November 11, 2003.[37]

I. The caseworkers did not effectively intervene to ameliorate the risks to the children associated with parental substance abuse.

Drug use and abuse present serious risks to child safety. As a result, it is important for caseworkers to recognize when drug use is an issue in the case and to help parents and other caregivers obtain appropriate treatment. Caseworkers must also be trained regarding the physical and emotional effects of parental drug use on children.

Mr. Walker tested positive for marijuana three times prior to Russell III's death. After each positive test, he denied using marijuana. At one point, his mother told the caseworker that she had never seen her son smoke marijuana and that he had never done so in the home or around the children. Mr. Walker's only "admission" that he used drugs was over a year after the case opened when he told the caseworker that he was attending NA meetings.

The caseworkers' lack of initiative regarding Mr. Walker's substance abuse issues may have resulted from a determination that the drug use had no direct effect on the children. In fact, the Chronology Report prepared by DYFS after the fatality states that the November 10, 2003, allegations were "unsubstantiated due to [Mr. Walker's] drug use having no impact on the care of the children." This highlights a lack of training on the effects of parental substance abuse and the risks that it presents to child safety.

[36] DYFS Field Operations Casework Policy and Procedures Manual, II.B., Section 1219 (emphasis in original).
[37] The November 11, 2003, referral was coded as Family Problem, Parent - Substance Abuse.

J. DYFS permitted the family to remain in a hotel room without a crib and telephone.

After ascertaining that the Seaside Heights hotel room did not contain a crib or telephone, the caseworker should have relocated the family to another room or hotel. Even if Ms. Jaca had been able to procure a playpen or crib for J.D., the family would have been left without a telephone. In the records provided to the OCA by a service provider, it was noted that the family had no means of "obtaining help at night." Further, it would have been difficult for the family to make necessary doctor's appointments without a telephone. Moreover, by February 4, 2004, J.D.'s brain tumor had returned and he was experiencing partial paralysis on his left side. The caseworker should not have permitted a family with a terminally ill child to stay in a room without appropriate bedding and a telephone.

ZACHARY GIACOBBE – DATE OF DEATH: June 27, 2005

On June 27, 2005, one-month-old Zachary Giacobbe was allegedly killed by his twelve-year-old uncle, T.G., who reportedly has developmental disabilities, impulse control disorder, attention deficit and hyperactivity disorder (ADHD), and autism. Zachary was found by his mother in a pool behind the home he and his parents shared with other family members. At the time of Zachary's death the Giacobbe family was the subject of an open DYFS investigation. DYFS' final contact with the family was on June 6, 2005, three weeks before Zachary's death.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The OCA collected information from various sources to conduct an in-depth review of DYFS' involvement with the Giacobbe family prior to Zachary's untimely death, including:

i. CCAPTA Notice
ii. DYFS Case Record;
iii. DYFS Case Chronology
iv. DYFS personnel records
v. Interviews with DYFS employees
vi. Official report from the Gloucester County Medical Examiner
vii. Educational and medical records for T.G., the child who allegedly killed Zachary

II. REVIEW OF DYFS INVOLVEMENT WITH THE FAMILY

DYFS received eight referrals regarding the Giacobbe family.

Initial Referral – July 14, 1995

On July 14, 1995, an unidentified referent called DYFS and alleged that the Giacobbe residence, which at the time housed four adults, seven children, and multiple pets, did not have running water and had sustained fire damage that had not been repaired. The referent further alleged that Atlantic City police had found Mr. Giacobbe's three-year-old son wandering around outside alone. The DYFS investigation found that neglect was unfounded, and the case was closed at intake based on the conclusion that the children were not at risk.

Second Referral – August 30, 1995

On August 30, 1995, DYFS received a call alleging that Mr. Giacobbe often physically harmed his eleven-year-old and nine-year-old children. The referent further stated that Mr. Giacobbe neglected his then two-year-old son, T.G., by failing to change his diaper or feed him. During the investigation, Mr. Giacobbe and the children denied the allegations. As a result, DYFS concluded that they were unfounded.

Third Referral – December 11, 1996

The third referral alleged that S.G., a child living in the Giacobbe home, had swelling above his nose and that his nose may have been broken. S.G. initially claimed to have fallen out of bed, but later said that he was punched in the nose by an eighteen-year-old living in his home. The DYFS caseworker investigated and concluded that the abuse was unfounded because the child was accidentally hit by another member of the family while they were playing. It was later determined by a physician that the swollen area above S.G.'s nose was a growth abnormality, not the result of injury.

Fourth Referral – April 16, 2003

On April 16, 2003, DYFS received a call alleging that T.G. had missed thirty days of school. The referent also reported that she saw T.G. in his underwear inside the family's van and that his parents did not know where he was at the time. The referent also indicated that T.G. had a black eye that his stepmother claimed was an infection, but that she had not taken him to the doctor.

DYFS concluded that the allegation of neglect was unfounded. With regard to the school absences, DYFS noted that T.G. is a "special needs child" who had excessive absences because the school could not control him and his parents had kept him out while they were adjusting his medication. With regard to the black eye, DYFS concluded that T.G. had an eye infection that caused the bruising.

Fifth Referral – June 3, 2003

DYFS received another call regarding T.G. on June 3, 2003. The caller reported that T.G. had a bruise on his right eye and that, when asked what happened, T.G. said "Mommy did it." Despite that, DYFS concluded that the allegation was not substantiated. Moreover, at some point after this call, Mr. Giacobbe became angry and argumentative with school staff. As a result of that conduct, a school employee called DYFS because she did not feel the children were safe with Mr. Giacobbe. According to the Referral Response Report, DYFS again concluded that that allegation was unsubstantiated.

Notably, during the investigation, Mr. Giacobbe told the DYFS worker that T.G.'s behaviors could be difficult to handle and that he could be very aggressive and prone to acting out. The DYFS file also indicates that the caseworker explained to T.G.'s parents that he required careful supervision due to his behavioral issues.

Sixth Referral – June 29, 2003

On June 29, 2003, an unidentified referent called DYFS and indicated that the Giacobbes brought their two-month old child into the emergency department with what appeared to be dog bites on his face. DYFS investigated and concluded that there was no evidence of abuse or neglect, despite that the injury occurred while the child was visiting his grandparents. On a subsequent home visit, DYFS reinforced the need for the parents to find a pediatrician and keep

their children's medical appointments. The stepmother located several doctors, none of whom were taking referrals. DYFS closed the investigation.

Seventh Referral – April 30, 2005

The referent reported that the home did not have electricity, food, or running water. DYFS coded the referral as environmental neglect. The responding SPRU workers noted that the home had working electricity powered by a gas generator, running water, and food. They determined that the allegation of environmental neglect was unfounded, but instructed the father to clean the home as there was debris throughout the house. The SPRU worker's report also indicated that T.G. "appeared to be mentally retarded" and "prefer[red] to crawl on all fours." The SPRU worker referred the case to Intake for follow up, but concluded that there were no concerns at the time.

An intake caseworker visited the home a few days later. She noted numerous dirty dishes around the kitchen and instructed the parents to clean the home. Approximately two weeks later, the caseworker visited the home again and found it in better condition than on the last visit. Based on those findings, she determined that environmental neglect was unfounded. During the course of her investigation she also obtained facts about T.G.'s condition and noted that he needed constant attention. At the conclusion of her investigation, in early June 2005,[38] she found that the children were safe and indicated her intent to close the case.

Eighth Referral – Child Fatality – June 27, 2005

At 11:32 a.m. on June 27, 2005, a DYFS worker received a call from the Franklinville Police Department to report the drowning of an infant in a pool. The case was coded as inadequate supervision and assigned to the Gloucester County District Office for an immediate response.

During the course of the investigation, DYFS took statements from a number of family members. Mr. Giacobbe's thirteen–year-old son indicated that he heard Zachary crying at approximately 4:30 a.m., but that the crying stopped shortly thereafter. At some point between 4:30 a.m. and 7:00 a.m., Mr. Giacobbe's six-year-old son reported that he saw T.G. outside with Zachary and told him to "put the baby down." The six-year-old then attempted unsuccessfully to wake Zachary's parents, Mr. Giacobbe's twenty-year-old son and his girlfriend, and tried to get Zachary from T.G., but T.G. was holding on to the baby so tight that he could not. Subsequently, Zachary's mother awoke, noted that the baby's cries had not woken her up, and went to check on him. She could not find Zachary so she woke the baby's father and confirmed that he did not have Zachary. She then searched the house and the yard, eventually discovering Zachary in the pool. He was not breathing and was bleeding from the ears. The Medical Examiner found that the cause of death was a fractured skull due to blunt-force trauma to the head.

[38] The caseworker's Child Protective Services Report is undated; the last MVR occurred on June 6, 2005.

III. OTHER RELEVANT INFORMATION

The caseworker assigned to this family at the time of the fatality began working for DYFS as a Family Service Specialist Trainee in November 2004. She was promoted to Family Service Specialist II in April or May of 2005. No performance evaluations were available at the time of the OCA's review. At the time of the fatality her caseload was fourteen families, consisting of twenty-eight total children.

IV. OCA'S FINDINGS AND CONCERNS

A. T.G. and his family were not provided with necessary services and supports.

As early as 2003, DYFS had reason to believe that T.G.'s behavioral issues posed a risk of harm to himself and to others. Specifically, in the late spring and early summer of 2003, DYFS was advised that school staff had trouble controlling his behavior, that he had excessive absences due to this behavior, and that, according to his father, he could be aggressive. Based on those facts, the DYFS caseworker concluded that T.G. required strict supervision as early as the summer of 2003.[39]

DYFS also knew or should have known facts that raise serious questions about T.G.'s parents' ability to supervise him adequately. Specifically, DYFS was aware that in April 2003, T.G. obtained the keys, left the house, and climbed into the family van without his parents' knowledge. Had DYFS run a police check in connection with the April 30, 2005, referral, they may have uncovered that in August 2004 local police found two of the Giacobbe children unsupervised and in the street. Even with those facts indicating that T.G. posed a risk of harm, needed to be carefully supervised not to hurt himself or others, and could have been without that supervision, DYFS took no steps to obtain the family services to assist them with T.G. That failure is particularly disconcerting in light of two facts: the Division of Developmental Disabilities (DDD), which has the capacity to provide services to children with developmental disabilities and their families, is within DHS, as is DYFS; and DYFS has now, since Zachary's death, apparently sought fit to apply to DDD for services for T.G.

B. Children in the home did not receive appropriate medical care.

Three incidents raise concerns regarding the manner in which DYFS attempted to ensure that the Giacobbe children received appropriate medical care. First, in April 2003, DYFS received an allegation that T.G. had a black eye. T.G.'s stepmother indicated to DYFS that it was caused by an infection, but that she had not taken T.G. to see a doctor. Even though T.G.'s stepmother admitted that she had not sought medical treatment for an infection that was so severe that it

[39] DHS reviewed T.G.'s Individual Education Plan (IEP) after the fatality and has indicated to the OCA that it does not suggest that T.G. posed a risk of harm to himself or others. The IEP likely portrays a more comprehensive and accurate picture of T.G. than do DYFS' occasional interactions recorded in its casefile, so DYFS may well have been incorrect in its assessment of the risk T.G. posed to others. The DYFS caseworker did not, however, review the IEP at the time of her involvement, so the IEP does not explain DYFS' failure to link T.G. and his family to services.

caused T.G. to have bruising around his eye, DYFS concluded that the allegations of neglect were unfounded.[40]

Second, in June 2003, in response to an allegation that another child in the family was bitten by a dog, DYFS encouraged the parents, who had just moved to the area, to find a pediatrician. T.G.'s mother identified several doctors, but none were accepting new referrals. Despite that T.G.'s mother had failed to identify a pediatrician, DYFS nonetheless closed the investigation.

Finally, in June 2005, a few weeks prior to the fatality, DYFS sought and received medical collaterals on all children in the Giacobbe home. In all cases, the clinician had no concerns that the children may have been abused or neglected. However, the collaterals also indicated that T.G.:

- did not have any medical or mental health issues, despite that his diagnoses reportedly included autism and ADHD;
- did not require special care or medications, despite that he had been taking Risperdal, 4.5 mg/day; and
- appeared to be developing normally, despite that he is reportedly moderately mentally retarded with an IQ of 55 and a limited vocabulary.

The DYFS caseworker recognized only one of those three discrepancies, that pertaining to medication, but nonetheless indicated that the case was to be closed with no mention of follow up with the physician to reconcile even that discrepancy.

C. DYFS did not effectively intervene in response to evidence of potential educational neglect.

During the investigation of the April 30, 2005, referral, DYFS learned that three of the children had a significant number of absences from school (twenty-three, twenty-nine, and thirty), and that one child was to repeat kindergarten because he was cognitively behind his grade level and age group in all areas. T.G. had been absent thirty days because, according to his parents, the school could not handle his uncontrollable behavior. T.G.'s absences are particularly troubling because of his reported diagnoses of ADHD, autism, developmental disabilities, and impulse control disorder; and because, as DYFS was aware, T.G. was functioning on the level of a three-year-old, did not use complete sentences, and apparently preferred crawling on all fours. Children with those issues have an acute need for consistent education to maintain and increase educational gains.[41]

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[40] *See N.J.S.A.* 9:6-8.21(c) (defining "Abused or neglected child" to include "a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian . . . to exercise a minimum degree of care (a) in supplying the child with adequate medical or surgical care though financially able to do so.") (emphasis added).

[41] Snell, M.E. (1997). "Teaching Children and Young Adults with Mental Retardation in School Programs: Current Research." *Behavior Change*, 14(2): 73 – 105; Summers, J.A., Hoffman, L., & Marquis, J. (2005). "Measuring the Quality of Family – Professional Partnerships in Special Education Services." *Exceptional Children*, 72(1): 65 – 81; Trout, A.L., Nordness, P.D., & Pierce, C.D. (2003). "Research on the Academic Status of Children with Emotional and Behavioral Disorders: A Review of the Literature from 1961 to 2000." *Journal of Emotional and Behavioral Disorders*, 11(4): 198 – 210; Zijlstra, H.P., & Vlaskamp, C. (2005). "The Impact of Medical Conditions on the

Those facts should have raised two concerns to DYFS: first, the likelihood that T.G.'s uncontrollable behavior extended to home as well, further suggesting that DYFS should have attempted to link the family to support services to assist with T.G.; or, second, the possibility that T.G.'s Individual Education Plan was not appropriate because it was not enabling him to attend school consistently. The record does not indicate, however, that the DYFS caseworker took any action to address either concern. In such instances DYFS should minimally (1) establish contact with the school and the family to ascertain what steps the educational community has taken to resolve identified problems; and (2) determine if the parents need guidance to advocate effectively for the child and provide support in the process as deemed appropriate.

Support of Children with Profound Intellectual and Multiple Disabilities." *Journal of Applied Research in Intellectual Disabilities,* 18(2): 151 – 161.

ALANA DUFF - DATE OF DEATH: July 20, 2005

On July 20, 2005, twenty-eight-month-old Alana Duff was found submerged in a poorly-maintained swimming pool located in the Duff family's backyard. At the time of her death Alana was home with her twelve-year-old sister and her sister's twelve-year-old friend. No adults were home at the time of Alana's death. The Medical Examiner ruled the death an accidental drowning.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

i. CCAPTA Notice dated July 21, 2005
ii. DYFS Case Record
iii. DYFS SCR Policy as of July 11, 2005
iv. Interim DYFS SCR Policy and Training Materials
v. Personnel Records
vi. Caseload information
vii. Interviews with DYFS employees
viii. Law enforcement records
ix. Ocean County Police Academy training requirements and curriculum on child abuse and neglect.
x. New Jersey Police Training Commission Basic Course Manual
xi. Ocean County Medical Examiner's Report

II. REVIEW OF DYFS INVOLVEMENT WITH THE FAMILY

Initial Referral - July 11, 2005

On July 11, 2005, an anonymous referent called DYFS and alleged that Alana's birth mother abused marijuana and prescription drugs and often left Alana's twelve-year-old sister and Alana home alone for extended periods of time. The caller also alleged that there had been a burn on Alana's foot in the recent past. The caller reported that he or she had not personally observed any of the alleged behaviors, but had learned of the concerns through a third party. SCR coded the referral for a five-day child welfare assessment. DYFS did not, however, take any further action on the call.

Second referral – Child Fatality - July 20, 2005

On July 20, 2005, the Ocean Township Police Department called SCR and advised that Alana had drowned in the family's swimming pool and that her mother was not home at the time.

III. OTHER RELEVANT INFORMATION

A. Personnel Information

The personnel records for the SCR screener, the SCR screening supervisor, the caseworker, the supervisor, and the SPRU worker did not raise any concerns.

B. Caseload Information

At the time of Alana's death in July 2005, the caseworker was carrying a caseload of thirty families and seventy children. The caseload included both child welfare assessment (CWS) and child protective services (CPS) cases.

C. Domestic Violence History

The Ocean Township Police Department investigation report describes a lengthy domestic violence history between Mr. and Mrs. Duff. Between August 15, 2003, and July 11, 2005, Mrs. Duff called police on five occasions alleging abuse and requesting assistance.

IV. OCA'S FINDINGS AND CONCERNS

The investigation of the circumstances leading up to Alana's death has reinforced a number of pre-existing concerns regarding proper coding and handling of calls at screening, caseload size, response time and training, and made apparent several other factors that, had they been different, may have prevented this tragedy from occurring. Accounts obtained through interviews revealed high levels of confusion and uncertainty regarding the policies and procedures governing screeners and supervisors at SCR and those governing caseworkers and supervisors in the field.

A. Quotas and time limitations at SCR create a disincentive for thorough and complete screening, raising serious safety concerns.

When interviewed by the OCA, the SCR screener and the screening supervisor both confirmed that screeners are governed by what essentially amounts to a quota system. They are instructed that they have a limited period of time to answer each call, a limited period of time to take the information, and a limited period of time to send the referral out to the District Office.[42] Screeners are judged primarily by the number of reports they generate. Each screener is also assigned what amounts to a quota of reports; that quota is based on the average of the total number of reports generated by the highest producing screener with that of the lowest producing screener. Quotas are recalculated monthly, but apparently average approximately 65 reports per month. Notably, the quota applies only to calls leading to the generation of a report sent to a local office. Any other calls, such as those that pertain to an open case or are coded for information and referral, are not included in the total for purposes of the quota calculation. According to the workers, SCR rewards screeners for meeting established quotas and keeping calls within the time limitations, and it has been suggested that those who do not may be punished by the loss of privileges.

Overall, the imposition of a quota system and closely watched time limitations on incoming SCR calls appears to prioritize the quantity of calls fielded by screeners over the quality of information obtained and attention paid to the matter. Given the critical importance of recording

[42] Essentially, the SCR workers indicated that this amounts to a requirement of "answer in eight, off in four, and out in thirty." This literally translates to an expectation that a screener should answer a call in eight seconds, gather all the necessary information in four minutes, and send the report to the local office within thirty minutes.

all relevant information with respect to the safety and well-being of children subject to SCR calls, obtaining the most accurate and complete information possible must be of the utmost importance. The screener in this case indicated that imposing a strict time limitation on a call is both unreasonable and unsafe, and indicated that it is not possible to obtain all the required and necessary information in such a short period of time. Moreover, by failing to count calls coded for information and referral in the totals, the system suggests that those calls are less important, creating a disincentive to invest already limited time on that call.[43]

B. SCR improperly coded the July 11, 2005 referral as a five-day Child Welfare Assessment.

DYFS policy defines abuse or neglect to include (1) inadequate supervision; (2) risk of harm due to substance abuse; and (3) a burn.[44] Any allegation of abuse or neglect requires a CPS response rather than a CWS response. The July 11, 2005, call alleged that: (1) Ms. Duff routinely left Alana and her twelve-year-old sister home alone for extended periods of time; (2) Ms. Duff abused marijuana and prescription drugs; and (3) Alana had received a burn. Each of those three fall within the definition of abuse or neglect provided by DYFS policy. Therefore, each of those three independently required a CPS response, which would have been required to occur at the latest within twenty-four hours. Despite that, the screener coded the referral to require a CWS with a response time of five business days.

The interviews and documents in this case suggest that the referral was coded for a five-day CWS response because of ambiguities in the call regarding when the alleged incidents had occurred, the fact that the caller had not directly observed the allegations, and that there was no prior history of DYFS involvement with the family. It appears that these factors received weightier consideration than the nature of the allegations and risk of harm to the children, despite specific instruction in DYFS policy that screeners should not base coding decisions on considerations such as the perceived veracity of the caller and or absence of past involvement with DYFS.[45] This suggests a lack of training on DYFS policies for screeners that is disconcerting.

[43] DHS has disputed the existence of a "quota" system. As DHS has described the process, each screener has an optimal number of calls, 100, that he or she should take during one month. As the OCA understands DHS' description, calls that the screener handles as information and referral do not count in that number. One hundred calls per month averages out to five calls per day, although, of course, calls are not received in such a scheduled fashion. As DHS describes it, the system does not include any type of punishment unless a screener does not meet half (fifty) of the optimal number. Screeners also receive certificates as an incentive to maintain optimal levels. DHS indicated unequivocally that there is no four-minute limit on telephone calls, and described anecdotally calls in which screeners spent thirty or forty-five minutes talking with callers. Even if DHS' description of this system is entirely accurate, however, the SCR workers interviewed by the OCA perceived this system to include strict limitations on the amount of time they could spend on each call, mandatory quotas, and punitive measures for failure to meet those quotas. Those screeners are likely proceeding based on that perception, which means that there is a real risk that they are rushing through calls. Thus, even if DHS' description is accurate, at a minimum screeners plainly need more and better training regarding this system.

[44] DYFS Field Operations Casework Policy and Procedure Manual, Chapter II.B., Section 208.1.

[45] DYFS Field Operations Casework Policy and Procedure Manual, Chapter II.B., Section 205.

C. Training is inadequate within the SCR and coding policy was unclear.

During interviews of the screener and the screening supervisor, it became evident that they had numerous concerns regarding the manner in which they were trained on DYFS policy and performance of their respective duties. Prior to beginning in their respective positions, neither the screener nor the screening supervisor received formal training with regard to their roles and responsibilities. Rather, the screener revealed that she shadowed another screener for two days and was given a binder to review. After two months at SCR, the screener received one day of training on the Allegations-Based System that SCR employs to identify allegations of abuse or neglect.

Because of the lack of training and continuing uncertainty, the screener revealed that she conferenced approximately 95 percent of all calls with a supervisor prior to making a coding decision. In fact, during the July 11, 2005, call, the screener placed the caller on hold in order to conference with the supervisor. While on hold, the caller hung up. As a result, the screener lost the opportunity to obtain necessary additional information. Although DYFS policy requires screeners to make decisions independently and only directs them to conference with a supervisor when "unsure," the screener here was routinely "unsure" due to the lack of adequate training and guidance.

Moreover, both the screener and the supervisor indicated that part of the uncertainty regarding policy was due to the rapidity with which policy was changing and the manner in which it was communicated to and within SCR. Both the screener and the screening supervisor disclosed that they frequently received group emails from administration informing them of "practice tips" and that these "tips" often provided the first notice of an important policy change. They also reported that they often learned about policy changes after they had been rolled out at the district office level. The screening supervisor also indicated that two trainings, one at the Training Academy and one on the Allegations-Based System, had provided contradictory and conflicting information.

D. The SCR did not notify or transmit the CWS report to the District Office within the prescribed timeframe.

DYFS policy requires the SCR screener, or screening supervisor where the screener is not yet certified, to assign an accepted CPS report or CWS referral to the local office within one hour of receiving the reporter's call at the SCR.[46] In the instant matter, the call was received at approximately 11:30 a.m. The screening supervisor did not accept the report and enter the referral into NJ SPIRIT until after 5:00 p.m. Consequently, the referral was not received and reviewed by the local office until the morning of July 12, 2005.

E. The caseworker did not conduct the child welfare assessment within the designated response time.

DYFS policy at the time of the incident required the caseworker on a child welfare assessment to "contact the child and family, in person, to initiate an assessment of the family's need for

[46] DYFS Field Operations Casework Policy and Procedure Manual, Chapter II.B., Section 209.4.

services, within five (5) business days of the SCR transmitting the assignment to the District Office/Local Office/ARC." The case was transmitted to the local office at approximately 5:23 p.m. on July 11, 2005. The case was assigned to the caseworker at approximately 9:00 a.m. on July 12, 2005. Using July 12, 2005, as the transmission date, in person contact with the child and family and the initiation of a child welfare assessment should have taken place no later than July 19, 2005. As of July 20, 2005, the date of Alana's death, the caseworker had not made any contact with the child or family to initiate the child welfare assessment. Failure to initiate the child welfare assessment within the required time frame left the children at continued risk of harm

F. The caseworker's caseload was excessive.

The caseload assigned to the caseworker at the time of Alana's death exceeded the caseload maximum limit set by the Child Welfare Reform Plan -- fifteen families per caseworker -- by 200 percent. In addition to approximately twenty-six ongoing cases, the caseworker was responsible for two CPS investigations requiring immediate responses and two CWS cases, including the Duff assessment, during the week that the fatality occurred. It appears that this workload may have contributed to the caseworker's failure to respond within five business days as required by policy. During the interviews, the OCA was also advised that caseloads of seventy children or higher were not uncommon in the Ocean County District Office at the time of the fatality, caseworkers are overwhelmed and lack support, and that more caseworkers are sorely needed in that office.

G. Police may not have adhered to existing policy regarding mandatory reporting to DYFS.

The police investigation report contains a record of a number of domestic violence calls at the Duff home. That history raises important broad-based policy and practice questions with respect to the relationship between domestic violence and child abuse reporting. According to the materials that are taught at the county's police academy, it is clear that officers are taught that a DYFS report is necessary when children witness serious domestic violence or where evidence of a pattern of domestic violence in the home exists.[47] The record here indicates that children were present on at least two of the occasions in which police were called to the home due to domestic violence; despite that, there is no record that DYFS was called. For example, on July 20, 2005, officers responded to a call from Ms. Duff alleging that she had been repeatedly struck in the face, observed visible signs of trauma, and noted that Ms. Duff appeared to have a broken nose. Alana was present at the time the alleged incident occurred. Failure to report the incidents to DYFS resulted in missed opportunities to offer prevention services and supports to the family

H. Pool Safety and Code Enforcement

After the fatality, neighbors told police that they had contacted DYFS and/or the police repeatedly with allegations of lack of supervision and specific concerns about children playing

[47] The training session offered at the county police academy on child abuse and neglect and reporting responsibilities is thoughtfully designed and competently taught by a qualified child welfare professional. However, this training may be the only formal training on the topic many officers receive. Course content may vary by police academy.

unattended and dangerously in the pool and surrounding area. A review of all police reports on the address did not reveal any record of such calls. Similarly, documents produced by DYFS show no record of SCR calls received on the Duff home other than those of July 11, 2005, and July 20, 2005.

However, if either the police or DYFS had been contacted with reports concerning the pool, it is uncertain what, if any action would have been warranted by either party. At best, police action may have resulted in a visit to the home to inform the parents of the complaint and ask that due care be exercised in the future. A call to DYFS depending on the allegations could qualify as an immediate safety concern, but would more likely lead to an information and referral, either to the police or to code enforcement depending on the nature and subject matter of the complaint.

ELIJAH HANSON - DATE OF DEATH: July 21, 2005

On July 21, 2005, Elijah Hanson, who was two and one half years old, drowned after falling into the family's swimming pool. Elijah lived with his birth mother, sister, and maternal grandparents. According to local law enforcement, Elijah's mother stated that she was in the backyard with Elijah but went inside the house for a moment, leaving him unattended. When she returned she found Elijah face down at the bottom of the deep end of the pool. She called 911 and paramedics responded and transported Elijah to the hospital, but medical personnel were unable to resuscitate him.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The OCA collected information from various sources to conduct an in-depth review of DYFS' involvement with the Hanson family prior to Elijah's death, including:

i. DYFS Case Chronology;
ii. Copy of DYFS Case Record;
iii. Personnel Files;
iv. Caseload information; and
v. Local law enforcement investigation report.

II. REVIEW OF DYFS INVOLVEMENT WITH THE FAMILY

Elijah's mother had a history of DYFS involvement that began in 1995. DYFS received ten referrals between 1995 and 2005.

Initial Referral - March 6, 1995

On March 6, 1995, a referent called DYFS and alleged that Elijah's mother had physically and emotionally abused her stepdaughter, the daughter of her then-husband. DYFS concluded that physical abuse was unfounded, and the child's father agreed to arrange for counseling.

Second Referral - October 13, 2003

After their divorce, Elijah's mother's ex-husband alleged that she and her paramour, Elijah's father, neglected two children (his daughters with Elijah's mother) based on alcohol abuse and domestic violence. The SPRU worker's report indicates that Elijah's mother had been "concerned with her own drinking" and "notice[d] that she is drinking a bit too much lately." In addition, after the SPRU worker asked about a number of small bruises on her arm and thigh, she also stated that she and Elijah's father argue and fight and "sometimes get physical." Elijah's mother agreed to counseling if DYFS would help her find an appropriate service provider and assist with payment, whether through insurance or directly.

The supervisor instructed the caseworker to refer Elijah's mother for a substance abuse evaluation, assess Elijah's father for alcohol-related issues, provide Elijah's mother with counseling information, and refer both parents for anger management counseling.

The caseworker followed up with the family on October 16, 2003. During this visit, both Elijah's mother and father denied having problems with alcohol and denied that any domestic violence had taken place. Both agreed to submit to substance abuse evaluations and signed a case plan stating that they would not abuse alcohol while supervising the children. The substance abuse evaluations were scheduled for November 25, 2003. Ultimately DYFS did not find evidence to support the allegations and concluded that neglect was unsubstantiated. DYFS did not complete the findings report for this referral until February 22, 2004.

Third Referral - October 31, 2003

On October 31, 2003, local law enforcement contacted DYFS and alleged that Elijah's mother and father were abusing alcohol and, as a result, were neglecting the children. DYFS, which received the call two hours after law enforcement had spoken to Elijah's mother, interviewed both parents and concluded that neither was intoxicated. However, child welfare concerns were noted. The Documentation of Response report recommended running an SIS/Perpetrator check on Elijah's father, that both parents should submit to a drug test as soon as possible, and that DYFS should collect pediatric collaterals for Elijah and his mother's youngest daughter.

On November 1, 2003, the case was re-referred to SPRU for follow-up. The investigating SPRU worker indicated a concern that Elijah may have suffered from Fetal Alcohol Syndrome and again recommended obtaining pediatric collaterals to facilitate possible intervention. The investigating SPRU worker also identified Elijah's mother's questionable stability and sobriety as a concern.

On November 25, 2003, Elijah's mother's substance abuse evaluation scheduled in connection with the October 13, 2003, referral concluded that she was in need of counseling, but that she did not need inpatient alcohol counseling. She was referred to a local service provider. Elijah's father did not appear for his evaluation.

Fourth Referral - November 29, 2003

Elijah's mother's ex-husband reported to DYFS that Elijah's mother attempted suicide on Thanksgiving. She was subsequently admitted to the hospital, and was discharged on December 2, 2003. At the time of her discharge, she denied that she had attempted suicide but admitted that she had a drinking problem and that she had been the victim of domestic violence. As a result, she moved in with her parents. Following a conference with the supervisor, the caseworker informed Elijah's mother that DYFS would allow Elijah to remain in her care if she and her parents signed a case plan that required her parents to supervise her when with her children. The caseworker visited the home on December 3, 2003 and received assurances that the maternal grandfather would provide supervision during the day because he did not work. The next day, the caseworker met with Elijah's mother and the maternal grandparents to go over the case plan. Although the case plan was not included in the file provided to the OCA, according to the contact sheets the case plan required that Elijah's mother continue to reside with her parents and receive counseling, which was scheduled to begin on December 17, 2003. The

caseworker also explained that Elijah could visit with his father at any time, but that he had to be supervised by his maternal grandparents.

Fifth Referral - December 6, 2003

On December 6, 2003, DYFS received allegations regarding Elijah's mother's parenting, including that Elijah's mother violated the safety plan by visiting with Elijah's father unsupervised. DYFS did not substantiate neglect, but did note concerns regarding substance abuse issues.

On December 8, 2003, Elijah, his mother, and maternal grandfather met with the caseworker and supervisor to review the case plan. They also executed an updated plan that emphasized that the children were to be supervised by one or both of their maternal grandparents at all times. The case plan further reiterated that Elijah's mother would receive counseling services. The caseworker also spoke to Elijah's father by telephone to explain the plan to him and to inform him that he was scheduled for a substance abuse evaluation on January 8, 2004.

Sixth Referral - February 13, 2004

On February 13, 2004, DYFS received a referral alleging that Elijah's mother had been driving while under the influence of alcohol with children in the car and was with the children unsupervised in violation of the case plan. Although DYFS did not substantiate the allegation that she was driving under the influence, DYFS' investigation revealed that she was, in fact, caring for the children without supervision. The Documentation of Response report recommended the development of a new case plan explicitly identifying those activities that Elijah's mother was permitted to do with her children unsupervised. It also recommended that the caseworker assess the possibility of counseling for the children. On March 24, 2004, after Elijah's mother's urine tests had returned a negative result, the caseworker and supervisor discussed the case and decided that the provision in the case plan requiring supervision could be lifted.

Seventh Referral - July 31, 2004

On July 31, 2004, local law enforcement contacted DYFS to report that Elijah's mother was intoxicated while caring for her children and that she and Elijah's father had been involved in an incident of domestic violence. The police also indicated that they had observed signs of physical injury and an open box of wine in the family's car. After further investigation, DYFS substantiated neglect against both parents. Despite that the case plan provision had been lifted, the case supervisor advised the responding SPRU worker that Elijah's mother was not allowed to have unsupervised contact with her children and that there was no excuse for her to have been unsupervised. The SPRU worker prepared another case plan stating that Elijah's mother would not be alone with her children and that the maternal grandparents would supervise her contact with her children. Elijah's mother signed the case plan.

Eighth Referral - August 20, 2004

The referent alleged that Elijah's mother took Elijah to his father's home without supervision in violation of the case plan. A SPRU caseworker responded and found the mother with the father and Elijah unsupervised. During the investigation, Elijah's father voiced his concern regarding a possible conflict of interest because Elijah's mother's ex-husband's paramour had some kind of relationship with a DYFS supervisor in the office of supervision.

Ninth Referral - May 25, 2005

Elijah's half-sister (the daughter of his mother and her ex-husband) claimed to have nonspecific memories of sexual abuse by an identified perpetrator. The prosecutor's office declined to proceed with a criminal investigation due to the lack of clarity of the allegations. There is no K-8 registered and the findings of this referral are unknown.

Tenth Referral – Child Fatality - July 21, 2005

On July 21, 2005, local police were dispatched to the residence of Elijah and his mother. Elijah, his baby sister, and his mother had been in the back yard when she went into the house and left both children unattended. When she came back outside, she could not find Elijah. After searching in front of the house, she discovered Elijah face down in the deep end of the pool. Elijah was transported to the hospital where emergency personnel attempted to revive him. He was pronounced dead shortly after his arrival.

III. OTHER RELEVANT INFORMATION

Four different case managers provided services to this family from October 2003 through July 2005. Personnel records reveal that the staff had appropriate education and experience for the performance of their duties. Employee performance reviews revealed that there were concerns raised from time to time regarding high caseload numbers, completion of MVRs, completion of findings reports (K-8s), maintenance of case records, and referral of families for appropriate services. Performance ratings ranged from unsatisfactory to exceptional (100 percent). Caseload size for the case managers at varying point of time are as follows:

- **October 2003 – December 2003**
  Low of 42 families and 88 children in October 2003
  High of 57 families and 108 children in December 2003
- **January 2004 – August 2004**
  Low of 34 families and 52 children in January 2004
  High of 49 families and 87 children in August 2004
- **September 2004 – March 2005**
  Low of 10 families and 18 children in June 2005
  High of 18 families and 31 children in February/March 2005
- **April 2005 – July 2005**
  Low of 17 families and 41 children in April 2005
  High of 25 families and 56 children in July 2005

IV. OCA'S FINDINGS AND CONCERNS

A. DYFS' referrals for and linkages to services were inconsistent.

On December 6, 2004, the case plan signed by Elijah's mother provided that she was to receive psychotherapy, substance abuse treatment, psychiatric evaluation, anger management, domestic violence counseling, and parenting classes. Other than confirming with Elijah's mother that she was receiving these services during the course of subsequent telephone calls and visits, the caseworker performed no collaterals to verify that she was receiving and benefiting from them.

Five of the nine referrals before Elijah's death involved allegations of alcohol abuse. Despite that it was scheduled, Elijah's father never submitted to a substance abuse evaluation and DYFS did not ensure that he did so.

In addition to Elijah, there were two older siblings involved from his mother's previous marriage. On August 2, 2004, during an MVR, the eldest daughter, age thirteen, expressed a desire to attend counseling with her mother to work on their relationship. Despite that this was discussed again on November 8, 2004, and that Elijah's mother agreed to it, there is nothing in the case record indicating that DYFS followed up on that suggestion. One month later, a service provider relayed to the caseworker that the eldest daughter did not wish to undergo counseling with her mother.

On September 20, 2004, a court ordered family therapy. This order came after the eldest daughter had been admitted to a clinic. Despite the court order, there is no indication in the case record that DYFS ensured that the family received therapy.

B. DYFS did not adequately follow up on medical care.

On November 1, 2003 the SPRU worker noted that Elijah exhibited signs of possible Fetal Alcohol Syndrome. This is mentioned once and there is no evidence of any follow up. There is no additional discussion of medical care for Elijah until September 10, 2004, when Elijah's mother called the caseworker to say that she was receiving prenatal care and that Elijah was seeing a pediatrician at a local practice. It was, however, later determined that Elijah was not receiving care from the identified pediatrician. DYFS never determined who Elijah's pediatrician was or if, in fact, he had a pediatrician at all.

C. DYFS' repeated use of a case plan to ensure safety was not effective.

This case demonstrates a history of repeated violations of agreed-upon case plans. In three documented instances, DYFS concluded that Elijah's mother violated the terms of the case plan by caring for her children without the supervision of her mother or father. Clearly Elijah's mother and her paramour were not committed to the case plan and DYFS should have considered other strategies to promote the safety of the children.

D. DYFS did not consistently comply with the MVR schedule.

The case record reflects that regular visits with the family did not occur until January 1, 2004, when the first MVR was recorded. From January 1, 2004, until May 26, 2005, the case record records that seventeen MVRs had taken place, eleven with Elijah's mother and six with her ex-husband. Lack of consistent MVRs, during which the case manager and the family review the case plan and progress towards goal attainment, often leads to years of "agency involvement" with the family without ameliorating the risk of future maltreatment.

E. DYFS did not routinely collect and consider information from collateral sources to assess and plan for the family

There were three children involved who were at risk of abuse and/or neglect. On October 31, 2003, it was recommended that DYFS obtain pediatric collaterals for Elijah and the youngest daughter. There is no indication, however, that DYFS did so. There is no further mention of the children's collaterals until March 30, 2005, when the case was being prepared for transfer. The tasks that were to be completed included contacting schools and pediatricians. There is no indication that this occurred.

F. DYFS did not adequately address other open DYFS cases.

On December 16, 2003, in preparation for transfer, the case supervisor noted that Elijah's mother's ex-husband's live-in paramour had an open DYFS case. In addition, the record contains no mention of Elijah's father's history with DYFS until October 7, 2004, despite that DYFS had had an open case on him for nearly a full year in which it had substantiated neglect. There was no further discussion of either incident in the case record, suggesting that DYFS did not consider them when determining how best to serve Elijah going forward.

G. This case suffered from a high turnover rate, impairing any one caseworker's ability to fully engage the family.

At the time of this review, this case had been open for services for twenty months. In the course of twenty months this case had been assigned to five different supervisors and four different caseworkers. Excessive turnover hampers any one caseworker or supervisor's ability to become familiar with the family, to understand the family's strengths and needs, and to ensure continuous and coordinated casework and follow up.

KELLY ANN TOZER - DATE OF DEATH: July 30, 2005

On July 30, 2005, eighteen-month-old Kelly Ann Tozer died after drowning in the above-ground pool in her resource family's backyard during a family party. It is unclear how Kelly Ann got into the pool. The official cause of death was asphyxia due to drowning.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The OCA collected information from various sources to conduct an in-depth review of DYFS' involvement with Kelly Ann prior to her death, including:

i. DYFS Case Chronology;
ii. Copy of DYFS Case Record (January 2004 – July 2005);
iii. Hospital records for Kelly Ann Tozer;
iv. DYFS Service Information System (SIS) data**;**
v. Interview with representatives of DHS Office of Licensing
vi. Communications with Atlantic County Prosecutor's Office;
vii. Communications with Egg Harbor City Code Enforcement;
viii. Review of Egg Harbor City Police reports;
ix. Copy of Institutional Abuse Investigation Unit record;
x. Atlantic County's Office of the Medical Examiner's Report of Postmortem Examination;
xi. Resource family's Office of Licensing file; and
xii. Resource family's Southern Regional Foster Home Unit file.

II. REVIEW OF DYFS INVOLVEMENT WITH KELLY ANN TOZER

Kelly Ann Tozer was born on January 10, 2004, in her mother's home and both were then transported to a local hospital for medical treatment. On January 11, 2004, Kelly Ann was transported to a larger hospital's Neonatal Intensive Care Unit for continuing medical treatment. The next day, a hospital staff person contacted DYFS and reported that Kelly Ann's mother had tested positive for drugs and had admitted to using a number of substances shortly before Kelly Ann's birth. The staffer also reported that Kelly Ann was suffering from drug withdrawal. DYFS investigated the allegation and opened a case to provide services to Kelly Ann and her mother.

On January 14, 2004, a DYFS-contracted nurse evaluated Kelly Ann. The nurse concluded that Kelly Ann met the classification for a medically fragile child,[48] and that, if Kelly Ann were to be placed in foster care, she should be placed in a Special Home Service Provider (SHSP).[49]

[48] A medically fragile child means "a child who is between the ages of birth and three years and exhibits functional limitations identified in terms of moderate to marked developmental delay and psychosocial elements requiring nursing care over and above routine nursing baby care." 37 *N.J.R.* 2807(a) (proposing *N.J.A.C.* 10:122C-1.3).
[49] Special Home Service Provider foster homes serve children who are medically fragile and in need of temporary out-of-home placement. *Id.* (proposing *N.J.A.C.* 10:122C-1.2(b)(2)).

The court granted DYFS custody of Kelly Ann on January 22, 2004. During that time, Kelly Ann was transferred to a third hospital for ongoing medical treatment. She remained there until she was discharged on March 11, 2004, and placed in her first and only placement, a DYFS-approved SHSP home.

Kelly Ann's DYFS case was assigned to the Cape May District Office from April 2004 through June 2, 2004. During that time, her caseworker [Caseworker #1] conducted two MVRs, one of which included a Safety Assessment, and noted that Kelly Ann appeared healthy and the home appeared safe. In addition, a DYFS-contracted nurse visited the home in May and did not report any problems. An unknown DYFS employee also completed a Children in Placement Assessment based on a May 11, 2004, visit to the resource home. In a description of the home's physical structure, the assessor noted the backyard had an above-ground swimming pool.

On June 2, 2004, Kelly Ann's case was transferred to the Southern Regional Adoption Resource Center and subsequently assigned to Caseworker #2. The case file shows that Caseworker #2 conducted eight monthly MVRs between June 17, 2004, and January 14, 2005. The caseworker noted at the July 2004 MVR that "for fun, the foster mother will take Kelly with her to the pool and she'll have her sit in a little inflated chair." The caseworker also conducted a Safety Assessment in November 2004 and found no safety or risk factors present in the home. During that same time period, once in July 2004 and once in October 2004, a DYFS-contracted nurse visited Kelly Ann. At the latter visit, the nurse determined that Kelly Ann was no longer medically fragile.

On March 2, 2005, Kelly Ann's case was transferred to Caseworker #3. Caseworker #3 conducted four monthly MVRs, the last of which occurred on July 7, 2005. The caseworker's supervisor accompanied her to the July 7, 2005, MVR, the purpose of which was to complete the adoption paperwork. During that visit, the caseworker met with all of the home's occupants with the exception of one of the resource mother's birth children. Although he was in the home at the time of the visit, the caseworker noted in her contact sheet that "[the son] is sleeping as he hurt his arm yesterday. [The resource mother] told worker that he is on a new medication that made him dizzy last night and he fell and hurt his arm on the door in the kitchen." It appears, however, that the resource mother failed to disclose additional information regarding the incident to the caseworker and neither the caseworker nor the supervisor asked additional questions regarding the son's injuries, despite the police's arrival at the home during the MVR. Although the caseworker did not include this detail in the contact sheet she prepared after the MVR, during an interview with the IAIU investigator assigned to Kelly Ann's case after the fatality, the caseworker advised the investigator that "on 7/7/05 while she was visiting with the family, the police came to the house to check on [the son] because he fell onto the kitchen door earlier, breaking the glass." Local law enforcement records demonstrate that the resource father and the couples' two oldest children were arrested on July 7, 2005, at approximately 12:30 a.m., after an altercation involving all three. The oldest child received medical treatment for cuts to his arm at a local hospital and was released later in the morning. It is unclear to the OCA why neither the caseworker nor the supervisor thought it unusual that the police were aware of the son's injury, and why neither asked the family additional questions regarding the incident.

The resource family was in the process of adopting Kelly Ann at the time of her death in July 2005. The case record reflects that the three caseworkers who managed Kelly Ann's case between April 2004 and July 2005 complied with DYFS' policy regarding MVRs. Except for one month,[50] Kelly Ann was visited monthly between April 2004 and July 2005. The caseworkers observed Kelly Ann in the home and met with or observed[51] all of the household members present at the time of the visit, with the exception of the oldest child during the July 2005 MVR as previously noted.

III. REVIEW OF THE INVOLVEMENT OF THE OFFICE OF LICENSING AND THE SOUTHERN REGIONAL FOSTER HOME UNIT

The resource family moved to their first home in New Jersey in the summer of 1999. The family was in the process of adopting a child under the supervision of New York's child protective service agency, which requested via the Interstate Compact that New Jersey conduct a Home Study. In October 1999, the family applied to become resource parents in New Jersey.

On April 27, 2000, a contract provider completed the Home Study report and recommended that the family be approved for one placement and for referral to the SHSP program. On that same date, the resource parents signed the Checklist for Standards for Foster Homes, which includes a provision that "the foster parent demonstrates a willingness to notify DYFS within one working day of any civil or criminal charges brought against the foster parent, foster child, or any household member."

On June 27, 2000, a Foster Care Specialist conducted a Reconciliation Visit and the family was approved for certification as a SHSP home the same day. In July 2000, two foster children were placed in the home.

In September 2000, the Southern Regional Foster Home Unit (SRFHU) received an allegation that the resource father used marijuana and that the family was in the process of being evicted. An employee advised the complainant to contact the Atlantic District Office to report the problem and the complainant said that he or she would. A note at the top of the contact sheet reads "Referred to B.O.L. [DHS' Bureau of Licensing, the predecessor to the Office of Licensing (OOL)]." There is no indication in the file that the SRFHU took any steps to contact the resource family regarding the substance abuse allegation or their pending eviction.

The BOL learned of the allegation on September 29, 2000. An inspector from the B.O.L.'s Foster Home Unit (FHU), the predecessor to OOL's Resource Home Unit, visited the home on October 5, 2000. The complaint form described the allegation as "smoke marijuana." The inspector's "interview and tour of house revealed no evidence of marijuana being smoke[d] in house." The BOL inspector cited the family for a number of violations, including the swimming

[50] Kelly Ann's case was reassigned in February 2005 and six weeks lapsed between the January 2005 MVR and the next MVR in March 2005.

[51] One of the resource family's children is unable to communicate and their two toddlers were often shy and reticent in speaking with the caseworkers, but at every visit during which the children were present the caseworkers did not note any problems.

pool at the property. The inspection violation report states that "swimming pool water shall be up to code - water shall be clean - dirty water/pool not use/empty."

The family moved to a new home sometime after the October 5, 2000, inspection. On November 29, 2000, an inspector visited the family at the new residence. The inspector wrote on the Foster Home Inspection/Violation report that the citation issued on October 5, 2000, regarding the swimming pool was abated on November 29, 2000, because there was "no pool." During the inspection, the inspector cited the home because there were more than five children residing there, including medically fragile foster children and birth children, without the requisite administrative approvals.

In July 2002, DYFS received an allegation that the resource mother appeared overwhelmed by the number of children in her home (four children under the age of five) and that the children's diapers were dirty and soiled. The case was referred to the B.O.L.'s Foster Home Unit. An inspector visited the home and did not confirm the allegations, but did cite the family for having an older child sharing a room with three foster children who were toddlers and infants. The resource mother reported that she would move the older child from the room once another child in the home left for college.

In August 2002, one of the resource parents' adult children was arrested and charged with an offense. There is no record in the file indicating that the resource parents notified DYFS of their son's arrest, contrary to DYFS policy.

Also in August 2002, a BOL inspector conducted a bi-annual inspection as part of the license renewal process. He issued a citation because the home, which had a large pond in the backyard filled with still, green water, was not free of standing water as required. He also cited the family because he found peeling paint on the master bedroom ceiling and the closet door in the children's room. At a re-inspection on October 11, 2002, the inspector noted that the three issues had been abated and re-issued the family's license through June 27, 2005.

In May 2004, DYFS notified the resource parents, via letter, that it had learned that a September 2002 lead test for one of their children had resulted in higher than average results. DYFS also apparently notified Atlantic County's Division of Public Health (DPH). Atlantic County's DPH inspected the home and notified the BOL that the resource home had multiple areas with lead paint. The county found an excessive amount of paint chips in the window wells of the enclosed porch, the kitchen, the downstairs bathroom, and all of the bedrooms.

Also in May 2004, the Southern Regional Foster Home Unit (and possibly a staff person at the Southern Regional Adoption Resource Center) learned that the fingerprint check for one of the resource family's adult birth children indicated that he had been arrested in 2002, had been charged with three drug-related offenses, and had completed the Pre-Trial Intervention program in 2004. The record does not indicate that the caseworker was made aware of that information, nor does the record reflect that the resource family was ever confronted about its failure to disclose the arrest to DYFS.

In August 2004, Atlantic County's DPH ordered the family to begin lead paint abatement within 10 days from receipt of the notice. The resource father received the construction permit to begin the lead abatement on August 17, 2004.

In October 2004, a DHS Office of Licensing inspector conducted an annual inspection of the home, during which she noted chipping paint on the baseboard heater in the porch. In November 2004, the inspector contacted the SRFHU for assistance in locating the resource family's three adult children's fingerprint records, two from November 2003 and one from 2001. A week later, the OOL advised the SRFHU that no further children could be placed with the resource family until the lead issue was addressed.

It is important to note that the resource family's child tested with an elevated lead level in September 2002, DYFS learned of the test results and notified the family in May 2004, and the OOL closed the home to additional placements in November 2004. However, between September 2002 and November 2004, at least seven children were placed with the resource family for vacation placements.

The resource family's foster home license was valid through June 27, 2005. A July 18, 2005, Foster Home inspection report noted that the lead abatement project was almost complete and a lead clearance inspector planned to return in September 2005. The family was not cited regarding the swimming pool. The home was certified and issued a license valid through June 28, 2008, with capacity for one child.

IV. REVIEW OF RESOURCE FAMILY'S INTERACTIONS WITH MUNICIPAL BUILDING DEPARTMENT

The resource family's home is located within Egg Harbor City. Egg Harbor City requires its residents to obtain a Zoning and Construction Permit prior to the installation of an above-ground pool. The city follows the International Residential Code 2000, New Jersey Edition (the Code), which regulates the design and construction of above-ground pools as well as barrier requirements for limiting pool access.[52] The Code requires that when the means of access to an above-ground pool is a ladder:

> The ladder or steps shall be surrounded by a barrier which meets the requirements of Section AG105.2, Items 1 through 9. When the ladder or steps are secured, locked, or removed, any opening created shall not allow the passage of a 4-inch-diameter (102 mm) sphere.[53]

Under the Code, there must be a barrier (*i.e.*, a fence or wall) surrounding the pool's ladder that is at least 48 inches tall and has a gate that accommodates a locking device. The requirement is the same whether the ladder is permanently attached to the pool or is detachable and removed when the pool is not in use.

[52] International Residential Code Sections AG 103 and 105.
[53] *Id.* Section AG105.2(10) and (10.2).

The Egg Harbor City Police Department photographed the resource family's pool on July 30, 2005, as part of its investigation into Kelly Ann's drowning. The photographs include several of the pool's detachable ladder. There is no barrier of any kind limiting access to the ladder.

On September 13, 2005, Egg Harbor City's Building Department advised the resource family, via letter, that its department had no record that the resource family applied for the proper permits to install the pool and that the City would issue a summons if the family failed to apply for the permits. As of November 2005, the family had applied for and received the proper permits but the city had not yet done the necessary inspection.

V. OCA'S FINDINGS AND CONCERNS

A. The Office of Licensing did not ensure that the family's pool complied with local building ordinances.

An OOL inspector conducted a re-inspection at the resource family's home on July 18, 2005. As part of that inspection, the OOL's Foster Home Inspection/Violation report required the inspector to determine whether the family's pool complied with local ordinances. The inspector indicated that it did. The IAIU investigator assigned to investigate Kelly Ann's death spoke with an OOL official during the course of her investigation in order to verify whether the family's pool complied with local ordinances and was informed that "OOL does not need to see a pool permit and that it is left up to the Township to ensure the family has the proper permits." The IAIU investigator subsequently called Egg Harbor City's Building Assessment Office and was informed that the family did not have a permit to install its pool. Based on the Code, the Egg Harbor City Police Department's July 30, 2005, photographs of the resource family's pool and detachable ladder, and a subsequent conversation with an Egg Harbor City construction official, the resource family's pool did not comply with Egg Harbor's ordinance because it lacked a barrier limiting access to the pool's ladder. Therefore, it appears clear that the OOL inspector did not, as required, ensure that the pool complied with municipal ordinances.

In a conversation with OOL officials, the OCA confirmed that OOL does not require inspectors to contact local municipalities in order to ensure that resource families' pools comply with local ordinances. While the presence of a gated fence in this case may not alone have prevented this tragic death, it would have at least provided an additional access barrier to the family's swimming pool. According to statistics published by Safe Kids Worldwide, drowning is the leading cause of accidental injury-related death among children ages one to four, there are approximately 300 residential swimming pool drownings each year, and more than half of these drownings occur in the child's home pool.[54] Eight children, all under the age of 16, drowned in New Jersey between June 20, 2005, and July 24, 2005. Of those eight children, four died in backyard pools and the two youngest victims were two years old.[55] Kelly Ann, 19 months old,

[54] www.safekids.org, (visited November 16, 2005).
[55] Ralph R. Ortega and Suleman Din, *State suffers 7 drownings in 5 days*, Newark Star Ledger, July 25, 2005. At least five children drowned prior to Kelly Ann's drowning on July 30, 2005. Two were Alana Duff and Elijah Hanson, also discussed in this report. The remaining children may or may not have been involved with DYFS.

drowned in her resource family's backyard pool on July 30, 2005, only a few days after a newspaper article highlighted the elevated number of child drownings in the State.[56]

DYFS proposed new regulations governing requirements for resource family parents in 2005 and anticipates the regulations will be effective February 2006.[57] In the proposed regulations, certain licensing requirements are classified as Level I or Level II requirements.[58] A Level I requirement is "a licensing requirement . . . with which a resource family parent . . . must be in full compliance to receive or maintain a license."[59] Under the proposed regulations, the requirement that a resource family's pool meet all applicable local ordinances is classified as Level I.[60] As a result, the failure to comply could preclude OOL from issuing the license. However, this policy's effectiveness suffers from the same flaw that current policy does: it depends upon the inspector's knowledge of local ordinances during visual inspection of a resource family's home and the expectation that resource families comply with local ordinances when installing pools. As noted in this case, the resource family failed to obtain the town's approval prior to installing the pool and the pool did not comply with local ordinances, but the inspector who visited the home in July 2005 failed to cite the family. The result would likely have been the same even under the proposed regulations. As a result, the proposed regulations do not eliminate this concern.

B. The Office of Licensing conducted a cursory inspection of the resource home after receiving an allegation that the resource father abused drugs.

The licensure of foster homes requires that resource parents and other household members shall not abuse alcohol or drugs.[61] Further, the OOL may suspend a resource family's license if it fails to comply with the licensing requirements.[62]

In October 2000, the BOL visited the resource home after receiving an allegation that the resource father used marijuana. The inspector's report indicates that he toured the home and did not note the presence of marijuana. After speaking with OOL officials, it is the OCA's understanding that these allegations should have been investigated by the IAIU. It is unclear why the BOL was instructed to investigate the allegations.

In January 2004, DYFS developed and implemented a policy to assess children's safety in out-of-home placements. As noted in DYFS policy, New Jersey's Child Safety Assessment process brings consistency to the criteria used by DYFS, DHS' Institutional Abuse Investigations Unit, and the Public Defender Conflict Unit when conducting child protective service investigations

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[56] *Id.*
[57] OOL is currently drafting a policy that will establish procedures further clarifying some of the regulations for Resource Family Homes; creating a Technical Assistance Manual for inspectors; and revising its Resource Home Inspection/Violation report to reflect the new regulations. Each of these changes is anticipated to be completed by February 2006, when the new regulations become effective.
[58] 37 *N.J.R.* 2807(a).
[59] *Id.* (proposing *N.J.A.C.* 10:122C-1.3(b)).
[60] *Id.* (proposing *N.J.A.C.* 10:122C-4.1(a)(3)(ii)).
[61] *N.J.A.C.* 10:122C-1.5(f).
[62] *N.J.A.C.* 10:122C-2.10(b)(1).

and other assessments to determine whether children in out-of-home placements are safe.[63] There are nineteen safety factors that must be considered when assessing a child's safety. The instructions accompanying the form provide examples to illustrate each safety factor. Three of the safety factors are (1) violence among adults living in or having access to the home seriously impairs the necessary supervision or care and/or physical safety of the child; (2) physical conditions in the home are hazardous and immediately threaten the child's safety, for example, conditions in the yard/outside property are hazardous and accessible to children; and (3) drug and/or alcohol use by caregiver(s) or others living in or having access to the home places the child in immediate danger. The OCA recommends that if it has not already done so, OOL should consider the utility of adopting the criteria utilized by DYFS and IAIU in assessing children's safety and its relevance to OOL licensing inspections.

C. The Foster Home Unit did not contact the resource family after receiving an allegation of substance abuse regarding the resource father and learning that the family was being evicted from its home, nor did they assure that a referral was made to IAIU for investigation of the allegation.

Persons interested in becoming resource parents must provide references as part of the application process.[64] In September 2000, shortly after the BOL licensed the resource family, individuals visited the SRFHU and advised them that they wished to withdraw their recommendations due to the resource father's drug use and the family's pending eviction from the home. Two foster children were residing in the home as of July 2000. The SRFHU advised the individuals that the family was already licensed and were directed to report their allegations to the Atlantic County District Office. The SRFHU erred in judgment when advising the referent to notify the Atlantic County District Office of their concerns. The allegations should have been referred to the IAIU screener for assessment and assignment to a regional IAIU office for investigation. In addition, once the SRFHU was aware of the allegations they were responsible to assure the information was forwarded to the proper unit of the Division, rather than shifting the burden of the referral back to the referent.

The OCA reviewed basic case information on DYFS' Service Information System (SIS)" for the two foster children and there are no records of the allegations against the resource parents. The SRFHU staff did notify the BOL of the allegations, however there is no record that any SRFHU staff person ever contacted or visited the family to discuss either of the allegations.

D. The Special Home Service Providers did not have current Infant CPR certifications as required by DHS regulation.

A SHSP foster home serves children who are medically fragile and are in need of temporary out-of-home placement.[65] Foster parents licensed as SHSP providers must maintain a current certification in infant cardio-pulmonary resuscitation (CPR).[66]

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[63] DYFS Forms Manual, Form 22-6.
[64] *N.J.A.C.* 10:122C-2.4(a).
[65] *N.J.A.C.* 10:122C-1.2(b)(2).
[66] *N.J.A.C.* 10:122C-1.15(a)(1). The proposed regulations contain a similar requirement. 37 *N.J.R.* 2807 (proposing *N.J.A.C.* 122C- 5.7(b)(1)).

In September 2002, the OOL advised the Southern Regional Foster Home Unit that the resource father needed a current CPR certificate. The family's file contains a copy of the father's CPR certificate valid through April 30, 2002. There are no additional records of CPR certification for the resource father in the file. In September 2004 and January 2005, the OOL advised the SRFHU that a foster parent in the home needed a current CPR certificate. The OOL's notice does not identify which resource parent required a new certificate.

An August 2, 2005, Case Chronology prepared by DYFS staff referred back to the July 7, 2005, MVR and noted that all family members were certified in CPR. However, on August 3, 2005, the OOL again advised the Southern Regional Foster Home Unit that one resource parent in the home needed an up-to-date CPR certification. As previously noted, the resource father's CPR certificate expired in April 2002. The resource mother's CPR certificate recommended renewal in September 2004 and the case file does not contain a more recent certificate. Based on the records provided to the OCA, it appears that neither resource parent had an up to date infant CPR certification, which violated the requirements to be a SHPS provider set forth in DHS' regulations.[67]

Although the case record indicates that neither parent held a current certification, the Case Chronology prepared after Kelly Ann's death reports that all family members were CPR certified, apparently based on representations made by the resource parents during a July 2005 MVR. Enforcing the licensing restrictions in the existing and proposed regulations requires that copies of current certifications must be present in the appropriate files. Under the current and pending regulations, assertions made by resource parents without the accompanying documentation cannot be permitted to satisfy this licensing requirement.

E. DYFS regulation assigns resource parents the responsibility for reporting civil or criminal charges against them, foster children, or other household members, creating the possibility that they will fail to do so.

DYFS requires resource parents to notify a DYFS representative "within one working day of any civil or criminal charges brought against the [resource] parent, foster child, or any household members."[68] Failure to comply with the provisions of the licensure of resource homes can result in the suspension of the license. In 2004, the FCU learned that one of the resource family's adult children had been arrested in 2002. The resource family apparently did not disclose that to DYFS. Similarly, an entry in the resource family's file after Kelly Ann's death notes that a DYFS employee advised the FCU of the July 7, 2005, arrests of the resource father and the two adult children, as well as the 2004 arrest of one of the resource family's adult children. None of those arrests were apparently disclosed either.

OOL inspected the resource family home on July 18, 2005, which was required in order for the resource family's license to be re-issued. There is no indication that the OOL was aware of the July arrests. There is also no record in the files provided to the OCA for this review that the

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[67] *Supra* n.14.
[68] *N.J.A.C.* 10:122C-1.12(h).

resource family's failure to disclose either incident or the possible repercussions of failing to disclose the arrests was ever discussed with them. On August 2, 2005, OOL advised the resource family that they had been licensed for three more years.

DHS' proposed 2005 regulations include a provision requiring that resource parents immediately notify the OOL, during business hours, or the State Central Registry, after hours, of any current arrests, criminal convictions, or guilty pleas of a resource family parent or household member.[69] Pursuant to the proposed regulations, any requirement not specifically noted to be a Level I requirement is a Level II requirement.[70] The notification provision is a Level II requirement. Under the proposed regulations, if the OOL finds a resource family to be in violation of one or more Level II requirements, the family must abate the violation by the date specified in the violation notice. Failure to abate the violation by the next licensing inspection authorizes the OOL to issues a Level I citation for non-compliance.[71]

It is problematic that both the current and proposed regulations require resource families to self-report criminal involvement, but a family's failure to do so may not be immediately realized by DYFS and children could be at risk. As demonstrated in this case, the resource family failed to disclose arrests of household members on two separate occasions. DHS did not learn of the adult child's 2002 arrest until almost two years after the arrest, despite yearly inspections by OOL. In fact, the arrests of the father and two oldest sons occurred the same day of a caseworker's visit, but DHS still did not learn about them timely. DHS should develop policy that will strengthen and buttress the self-reporting requirement in order to ensure that it learns about criminal conduct. The current Live-Scan (electronic) fingerprinting process permits a "flag" to be placed on finger prints under certain circumstances to permit automatic notification to the appointing authority of any arrests made. DHS should fully explore the feasibility of requiring a flag on fingerprints of resource family providers.

F. It is unclear whether DYFS has complied with policies governing lead exposure.

DYFS' lead poisoning policy, effective November 5, 2003,[72] recognizes the dangers that lead exposure creates for young children and that children in foster care are at high risk for exposure.[73] The childhood blood lead testing guidelines recommend "test[ing] infants who live in a home with another child who has already been diagnosed with lead poisoning" and "test[ing] birth, foster, and adoptive siblings, six years old or younger, currently and/or previously residing with the child identified as having elevated lead levels."[74] DYFS caseworkers "should ensure that all children on [their] caseload have a primary health care provider. The worker must document the results of any blood lead tests and any related follow-up in the child's case file." [75]

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[69] 37 *N.J.R.* 2807(a) (proposing *N.J.A.C.* 122C-3.4(b)(3)).
[70] *Id.* (proposing *N.J.A.C.* 122C-1.3).
[71] *Id.* (proposing *N.J.A.C.* 122C-105(c)).
[72] DYFS' previous policy, effective June 5, 1981, did not delineate the responsibilities reflected in DYFS' 2003 policy.
[73] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.K., Sections 708.1, 708.2.
[74] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.K., Section 708.5.
[75] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.K., Section 708.3.

In May 2004, DYFS advised the resource family that it had learned that another child living in the home had tested with higher than average levels of lead in September 2002. DYFS appropriately notified Atlantic County of the child's elevated lead blood level. Atlantic County's Division of Public Health's Environmental Health Unit inspected the resource family's home in the summer of 2004. The inspection found an excessive amount of paint chips in the window wells of the home's enclosed porch. Case notes in Kelly Ann's file and those in the resource family's licensing file conflict regarding whether the children were permitted to play in the enclosed porch during the lead abatement project.

The OCA's file review of the resource family's licensing file and case notes in Kelly Ann's file indicate that at least seven foster children were placed with the foster family for vacation placements between April 2003 and June 2004. As the OCA's review is limited to Kelly Ann's case file, it is unclear whether the other children residing in the home were ever evaluated for lead poisoning. If DYFS has not already done so, the OCA recommends that any children placed with the resource family should be tested for lead poisoning.

JASIAH WOODS - DATE OF DEATH: August 1, 2005

On August 1, 2005, at approximately 9:00 a.m., Jasiah Woods' mother awoke and went to check on him. She found him lifeless and blue and saw blood around his nose and mouth. She called 911, and an ambulance responded. Jasiah was transported to the hospital, where he was pronounced dead at 10:14 a.m. The medical examiner reported that Jasiah had bruises on his forehead, stomach area, left shoulder, and left foot heel area. Jasiah also had old rib cage fractures that had healed, and had sustained multiple fractures on his skull. Based on that evidence, the medical examiner concluded that the cause of death was Battered Child Syndrome and ruled his death a homicide. The Jersey City Police Department conducted an investigation and initially charged Jasiah's fourteen-year-old half-brother, J.D., but those charges were subsequently dropped. The investigation is ongoing.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

The OCA collected information from various sources to complete an in-depth, independent review of the child welfare system's involvement with the Woods family prior to Jasiah's death. That information includes:

i. CCAPTA Notice, dated August 4, 2005
ii. DYFS Case Chronology
iii. Partial copy of DYFS Case Record (January 2003 to August 2005)
iv. DYFS Case Record for KC#528956 (December 2001 to February 2002)
v. DYFS Service Information System (SIS) data
vi. Personnel records of relevant DYFS employees
vii. Caseload information for DYFS Caseworker
viii. Medicaid encounter data
ix. Medical records from various providers

II. REVIEW OF DYFS INVOLVEMENT WITH THE FAMILY

Initial Referral - June 11, 2000

On June 11, 2000, DYFS received a call that alleged that J.N., Ms. Woods' two-year-old child, had a burn on his hand following a visit with Ms. Woods.[76] According to the DYFS Case Chronology prepared after the fatality, the East Orange District Office investigated and concluded that the burn was an accident caused by another minor child. As a result, DYFS did not substantiate abuse or neglect.

Second Referral - January 19, 2003

On January 19, 2003, DYFS received a call from a referent alleging that J.D., another child of Ms. Woods, had left home after an argument between the two. A SPRU worker responded and

[76] DHS has been unable to produce a file regarding this referral. In fact, the serial number provided for this allegation actually corresponds to another allegation received on December 18, 2001.

spoke with the referent, who advised that J.D. was afraid to go home. J.D. told the worker that he went to the store with his friends and when he returned his older sister told him that Ms. Woods said he was not be allowed back into the home. J.D. also confirmed that he was afraid to return home. The worker noted that J.D. appeared thin for his age.

The worker also spoke with Ms. Woods, who indicated that she had had not been able to find J.D. because he apparently had left the house to go to the store with his friends. She became upset, but denied that she had said he could not come home. She also indicated that she had contacted the police regarding J.D. because he was supposed to remain at home due to an incident involving a theft, and that the police had come by the home looking for him. She told the worker that J.D. had been classified, had behavior problems, and was not doing well in school. Ms. Woods also reported that although J.D. was attending counseling, however she did not think the counseling was helping him. Ms. Woods asked that DYFS open a file to provide help with J.D. She also admitted that she would on occasion swat J.D. on the behind with an open hand as punishment, but indicated that she did not believe that conduct rose to the level of abuse. The worker concluded that the children were safe and, after ensuring that J.D. was no longer scared to return home, drove him there. The SPRU worker advised Ms. Woods that the District Office would be in touch with her. The DYFS report on this incident includes a recommendation that the District Office obtain collaterals, interview the other children in the home, and determine whether the family had a history with the local family crisis intervention unit. No immediate issues or tasks where identified. The worker also noted that the home appeared to be clean and appropriate.

On January 21, 2003, a DYFS worker went to the Woods home for the follow up visit. She saw J.D. and indicated that he looked healthy. The worker also spoke with Ms. Woods, who informed the worker that she had discussed the situation with her mother and that they wanted to handle the problems with J.D. "within the family." Ms. Woods also advised that her mother was going to take custody of J.D. The worker asked for contact information for Ms. Woods' mother and indicated that she intended to recommend closing the case. There is no indication that the worker collected collateral information from any source or conferenced with a supervisor. It is also unclear whether, in fact, the case was closed. There was no additional contact with the family until the next referral was received in December 2004. The case record reflects that the case manager was intermittently on leave. There is no documentation regarding coverage for the case in the absence of the assigned case manager, nor explanation for lack of contact with the family during periods when the worker was present at work.

Third Referral - December 19, 2004

On December 19, 2004, DYFS received a referral indicating that Ms. Woods brought Jasiah to the emergency room with second-degree burns on his left upper thigh. DYFS assigned the referral an immediate response time. The SPRU workers arrived at the hospital at 4:45 p.m., where they observed Ms. Woods sitting next to Jasiah. They noted that there were no marks or bruises other than the burn mark, although they indicated that he appeared to have difficulty breathing. Ms. Woods explained that Jasiah's pediatrician had indicated that he was a "congested child." Ms. Woods stated that her mother was caring for the children while she was at work, and that Jasiah had accidentally rolled off a bed and become caught between the bed and

the radiator when her mother left the room. The workers also spoke with medical personnel, who indicated that the injury was consistent with the burn of a radiator. The doctor stated that he was concerned with the lack of supervision because the burn was extremely deep, meaning that Jasiah must have been against the radiator for a lengthy period of time.

After Jasiah was discharged, the SPRU workers accompanied Ms. Woods to the home. On arrival, Ms. Woods immediately began yelling at two of her children who were home and had been cleaning the floor. The workers noted that both children appeared to be skinny and small for their age, although they appeared healthy. All of Ms. Woods's children appeared unkempt, were wearing dirty clothes, and needed to be bathed. The workers described Ms. Woods as being cold with her children and they observed her place Jasiah down on the sofa with no precautions as to his safety. J.D. was noted to immediately show care and concern for Jasiah.

Both J.D. and one of the other children spoke with the SPRU workers regarding the burn. The other child, a female, reported that although she was home at the time she had been watching television and did not see anything happen. J.D. explained that his grandmother had gone downstairs to speak to him and his friends, leaving Jasiah unattended in her bedroom. His grandmother went back inside, reportedly to use the bathroom, when she heard Jasiah scream.

The workers observed that the house was unkempt, with dirty sheets on the bed and garbage on the floor. They instructed Ms. Woods to clean the house and offered to provide services. The workers also explained to Ms. Woods that her mother could not care for her children pending the completion of the investigation and final recommendations. They were unsuccessful in speaking with Ms. Woods's mother that evening. The SPRU workers also conducted a Safety Assessment and found the children to be safe. They made a number of recommendations, including that the District Office should conduct an immediate interview with Ms. Woods's mother, follow up with Ms. Woods concerning the discharge information received at the hospital for Jasiah, provide the family with CHORE services, refer J.D. to Value Options,[77] complete school and pediatric collaterals, and complete a substance abuse assessment on Ms. Woods.

On December 20, 2004, forensic workers visited the home and met with Ms. Woods and Jasiah.[78] They were shown the room where Jasiah had been left unattended by his grandmother, as well as Jasiah's own room and crib. They were unable to examine the injury, as Jasiah's bandages had just been changed, and were unsuccessful in speaking with Ms. Woods's mother. The caseworkers returned the next day and meet with Ms. Woods's mother. She explained that she watches the children at night while her daughter is at work. She confirmed that she was caring for Jasiah the night he sustained the burn, and her explanation of what occurred is consistent with what had been reported. The caseworkers were also successful in examining the burn and took photographs of it.

The findings of the report were that neglect was unfounded. This finding is unreasonable given that Jasiah was only five months old at the time and had been left completely unsupervised by the maternal grandmother. Although the specific amount of time he was alone is not recorded,

[77] Value Options is the State's contracted services administrator of children's behavioral health services.

[78] On August 2, 2005, the caseworker indicated that all of her documents reflecting activity in late December 2004 had been lost and, as a result, she was recreating the contact sheet entries for that time period.

medical professionals indicated he must have been pressed against the radiator for a long period of time. The child sustained a significant injury. Neglect should have been substantiated.

Beginning approximately four months later, on April 12, 2005, the worker made attempts to obtain various medical collaterals. DYFS did not receive collateral records concerning the December 19, 2004, incident until April 25, 2005, when that information was received by a member of a DYFS Impact Team. The file does not indicate that the worker completed any of the remaining recommendations, or that the worker ever conferenced the case with a supervisor.

On April 13, 2005, a caseworker conducted a home visit. The worker saw the grandmother and three of the children, including Jasiah, but did not see Ms. Woods or her eleven year-old daughter. During this visit the grandmother indicated that J.D. assisted her in caring for Jasiah. The caseworker did not determine the extent to which the grandmother relied upon J.D. The caseworker left her card and asked that Ms. Woods contact her so that they could arrange a time for a visit. Five days later, on April 18, 2005, the caseworker returned to the home and met with Ms. Woods, Jasiah and Ms. Woods's eleven-year-old daughter. The worker found the home and children to be neat and clean. Ms. Woods reported that J.D. was on probation, that they had been in court earlier that day, and that they would be returning the following day. She also informed the caseworker that she had returned to the hospital a couple of times for Jasiah's follow up care, but that she could not afford to keep returning there so she applied the medication on Jasiah herself. The caseworker advised Ms. Woods to take Jasiah to see his pediatrician, and she agreed that she would.

DYFS made unsuccessful attempts to visit the Woods family on May 2, 2005, May 12, 2005, May 20, 2005, and July 5, 2005. During that time, the caseworker also called at least once and left a message asking Ms. Woods to contact her.

Fourth Referral – Child Fatality – August 1, 2005

As indicated, on August 1, 2005, DYFS was advised that Jasiah had passed away.

III. OTHER RELEVANT INFORMATION

The OCA reviewed the personnel file of the caseworker and found nothing remarkable regarding education and experience. Between October 2002 and August 2005, the caseworker's caseload consisted of as many as seventy-eight families and 130 children and as low as fifteen families and twenty-two children. At the time immediately preceding Jasiah's death, she had a caseload of nineteen families and thirty-seven children.

The OCA also received and reviewed the personnel file for the supervisor on the case at the time of Jasiah's death. That review was unremarkable and did not raise any specific concerns.

IV. OCA'S FINDINGS AND CONCERNS

A. Lack of referrals for necessary services

The Woods family presented with issues regarding J.D.'s behavior, the habitability of the home, supervision of the children, and the ability to access medical care for Jasiah's burn. Despite that, DYFS provided no services during the entire time between the initial referral in January 2003 and Jasiah's death in August 2005. Admittedly, Ms. Woods did indicate that the family did not want DYFS' help in connection with J.D.'s behavior. With the remaining issues, however, there is nothing in the record to indicate that she declined services (and, in fact, the record affirmatively indicates that she seemed receptive to some services).

B. Lack of evidence in the case record of any follow up

In January 2003, Ms. Woods advised the caseworker that J.D. was going to move in with her mother in an attempt to address his behavioral issues. In response, the caseworker indicated that she intended to discuss case closure with her supervisor. There is nothing in the record to suggest that DYFS took any action to attempt to ensure that the proposed living arrangement would address J.D.'s issues.

In addition, the SPRU workers who responded to the referrals recommended that the DYFS district office caseworker conduct appropriate follow up, including interviewing the children, obtaining school and pediatric collaterals, obtaining substance abuse assessments, and determining whether the family had a history with other service providers. The caseworker did not comply with many of those recommendations and, for those that she did, did not do so timely. As a result, much of DYFS' involvement with the Woods family was without the benefit of any collateral information.

C. Untimely case activity

The caseworker also did not record case notes contemporaneously with the date of the occurrence. There are several contact sheets, mostly regarding the visits to the Woods home, that indicate that the date of the attempted contact and the date of recordation were months apart. Delays such as these significantly increase the possibility that records will not comprehensively describe DYFS' interactions with a family, which impairs the system's ability to serve them.

Additionally, there was a five-month delay between the December 2004 incident and when DYFS began collecting collateral information. That delay highlights the lack of timely action on the part of the caseworker, which in turn affects the ability of the caseworker to make appropriate linkages and the supervisor to ensure that the family is being serviced.

D. Missing documentation

As previously noted, the Woods family had two different DYFS case records – one that was opened in 2000 and one that was opened in 2003. Both case records were requested by the OCA

for the purpose of investigating DYFS' interaction with the family. Both case records are incomplete.

The earlier of the two files does not contain the information identified in this report as the initial referral. The OCA review of the earlier DYFS involvement with the family has been somewhat limited in this case based on these "lost files," and therefore the OCA was only able to learn about this particular referral utilizing a review of the SIS data and the Case Chronology. No explanation was provided regarding the missing documentation, except to report that it was in the possession of an employee working on the case closing initiative and was somehow misplaced.

The file opened in 2003 does include a notation in the case record indicating that a portion of the documentation was lost. This entry is dated August 2, 2005, the day after Jasiah passed away.

E. Review of medical information

It is unclear based on the documentation received by the OCA whether a DYFS nurse ever reviewed this file. What is clear, however, is that Jasiah was not current on his immunizations and several of the children had been flagged for high lead levels but were not receiving treatment. DYFS, whether through the caseworker or a nurse, should have attempted to ensure that the children received necessary medical treatment.

F. Investigatory conclusions

During the course of DYFS' investigation into Jasiah's burn, Jasiah's grandmother admitted that she had left Jasiah on the bed and that Jasiah had fallen off the bed and become trapped between the bed and the radiator. In addition, hospital personnel treating Jasiah indicated that the severity of his burns suggested that he had been left between the bed and the radiator for a significant period of time. The unfounded findings of the investigation are not reasonable; neglect should have been substantiated.

BABY GIRL HARVEY – DATE OF DEATH: August 27, 2005

On August 31, 2005, newborn Baby Girl Harvey's body was found by a police officer in the bedroom of Laura Harvey, her mother. Her body had been wrapped in a pillow case and a garbage bag and placed in a trash can. The police also recovered the umbilical cord and a utility knife, which had been wrapped in a towel and placed in the trash can, as well as a plastic bag containing the placenta from Ms. Harvey's car. The Middlesex County Medical Examiner found that Baby Girl Harvey was born alive on August 27, 2005, and that the cause of death was hypothermia, a deficiency in the amount of blood in the body, and mechanical asphyxia due to neglect. Ms. Harvey was arrested on September 22, 2005, and charged with manslaughter.

At the time of this incident, Ms. Harvey was living with her seventy-year-old father and twelve-year-old son. Her son had been diagnosed with cerebral palsy, developmental impairment, attention deficit and hyperactivity disorder, and a seizure disorder. Ms. Harvey's father cared for her son while she was at work. She concealed her pregnancy and the delivery of the baby from her father.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

i. CCAPTA notice
ii. DYFS Case Record
iii. DYFS Case Chronology
iv. Law enforcement records
v. DYFS personnel records
vi. Medical records for Ms. Harvey
vii. Records from the New Jersey Division of Developmental Disabilities (DDD)
viii. Official report from Middlesex County Medical Examiner's Office

II. REVIEW OF DYFS INVOLVEMENT WITH THE FAMILY

One referral was received by the Edison District Office regarding the Harvey family prior to the death of Baby Girl Harvey.

Initial Referral – December 28, 2004

On December 28, 2004, the State Central Registry (SCR) received an anonymous call expressing concern regarding Ms. Harvey's treatment of her son. The referent alleged that:

- The child weighed between 60 and 65 pounds because he would not eat;
- Ms. Harvey said she did not get him Christmas gifts because she believed he would be dead;
- Ms. Harvey hit him, causing him to fall to the ground; and
- Ms. Harvey spent all of her time with her boyfriend, leaving her son alone with her seventy-year-old father.

The referral was coded as a child welfare assessment and assigned a five-day response time.[79] The intake supervisor subsequently upgraded this case to a twenty-four-hour response time.

On December 29, 2004, the caseworker and supervisor completed a Pre-Investigative Conference form. According to the form, the worker was to make a home visit to discuss the allegations with Ms. Harvey, check to see if her son appeared undernourished and if he was eating, check for food in the house, and determine who was responsible for him when Ms. Harvey was not home. The worker was also to gather collateral information from the son's school, his pediatrician, and the police.

On December 30, 2004, the caseworker made the first home visit.[80] Ms. Harvey was not home, but the worker interviewed her father and her son. The caseworker confirmed that Ms. Harvey's father provides childcare, that her son has special medical and developmental needs, and that her son had received Christmas presents. Her son also denied that his mother hit him. The worker assessed the condition of the house and reported that there were no safety concerns. Later that day, Ms. Harvey was interviewed at the DYFS District Office. She denied all of the allegations against her and expressed concern about her son's weight. Ms. Harvey indicated that she had discussed this concern with his neurologist and they needed to evaluate him further to determine if his loss of appetite was associated with his medications. The worker requested that Ms. Harvey schedule an appointment with her son's pediatrician, as he had not had one since July 2004. The worker also gave her an application for services from DDD and noted that the case would be assessed for closing.

The worker subsequently followed up with medical and school collateral contacts and found that the child needed to complete thyroid testing and that the school had no concerns. The Criminal History Record Inquiry revealed that neither Ms. Harvey nor her father had a criminal record.

On February 9, 2005, the caseworker visited the home again and noted that Ms. Harvey's son, who claimed to be eating more, appeared to have gained weight. Ms. Harvey indicated that his neurologist reduced one of his seizure medications and, as a result, his appetite had returned to normal. She also indicated that she had scheduled follow-up visits with his neurologist and pediatrician. During the visit, Ms. Harvey also advised the worker that she was pregnant and concerned about the baby's development because she was over 35 years old and developmental problems ran in her family. She indicated that she was receiving pre-natal care and would be having genetic testing that week. Ms. Harvey asked if DYFS could assist with housing, but the worker said they could not. Ms. Harvey said she had not completed the DDD application for her son, and the worker agreed to drop it off to DDD when it was finished.

On February 16, 2005, the worker called the neurologist and was told by a nurse practitioner that there were no concerns because the neurologist was monitoring the change in medication and

[79] It is difficult to understand how these allegations, which include physical abuse and malnourishment, were initially coded for a five-day child welfare assessment. These concerns have been raised and discussed comprehensively in the OCA's prior Child Fatality Investigation reports and will not be duplicated here, although they are incorporated by reference.

[80] The initial response was completed within the designated time frame.

Ms. Harvey was bringing her son to his appointments. The caseworker closed the case on February 18, 2005, finding that the child was doing well and in a safe environment.

Second Referral – Child Fatality – August 31, 2005

On August 31, 2005, DYFS received a referral reporting that police found Baby Girl Harvey's body wrapped in a towel and a plastic bag and put in a trash can in Ms. Harvey's room. The caller stated that Ms. Harvey reported leaving the placenta in her car. The caller expressed concerns regarding the safety of her older son and requested that DYFS intervene on his behalf. Ms. Harvey was taken for a medical and psychological examination, and DYFS determined that her son would be safe in the care of his grandfather while DYFS applied for custody.

III. OTHER RELEVANT INFORMATION

The supervisor in this case has been a DYFS employee since 1988, holding the titles of Family Service Specialist III, II, and I, before receiving a promotion to Supervising Family Service Specialist II. His personnel file indicates that he received commendable ratings as a Family Service Specialist, although he did receive an interim unsatisfactory rating as a Family Service Specialist I. There is no record that he attended any additional training once he was promoted to Supervising Family Service Specialist II. Of note, this supervisor was also the supervisor in another fatality case that occurred in February 2005, also investigated by the OCA.

During the time this case was open, the caseworker had a fairly steady caseload. In December 2004, she had seventeen families and twenty-seven children on her caseload. This dropped slightly to fourteen families and twenty-one children in January 2005, and increased marginally to fifteen families and twenty-four total children in February 2005, the month in which the Harvey's case was closed. She began working for DYFS as a Family Service Specialist Trainee in 2002. In 2003, she passed the Family Service Specialist Trainee examination and was promoted to Family Service Specialist II. She received satisfactory performance evaluations in both positions. As of June 2005, she was promoted to the position of Supervising Family Service Specialist II. There is no documentation in her file reflecting any training she received during her tenure at DYFS.

IV. OCA'S FINDINGS AND CONCERNS

A. Documentation in the case record does not reflect supervisory guidance and review.

On December 30, 2004, the caseworker completed a Safety Assessment for Ms. Harvey's son and concluded that he was residing in a safe environment. However, according to DYFS policy, "[t]he child safety assessment process includes - and requires - a conference with the immediate Supervisor."[81] There is no documentation in the case record demonstrating that the caseworker and supervisor ever discussed the caseworker's assessment of the child's safety. Similarly, there is no documentation demonstrating that the worker and supervisor discussed the overall assessment of the family when deciding whether to close the case.

[81] DYFS Forms Manual, Form 22-22.

The case record contains contact sheets memorializing in-person visits to the family on December 30, 2004, January 4, 2005, and February 9, 2005, as well as a contact sheet documenting a February 16, 2005, phone conversation between the caseworker and a nurse practitioner at Ms. Harvey's son's neurologist's office. However, the supervisor did not sign off on any of those sheets until February 18, 2005, the day the case was closed. DYFS policy requires that "the supervisor review[] all Contact Sheet entries every 30 days, or more frequently if the case warrants."[82] The contact sheets for the December 30th home visit and January 4th telephone call were not reviewed by the supervisor within this timeframe. Contact sheets are also to be completed for conferences between the caseworker and supervisor.[83] If these conferences occurred, they were not documented in the case file.

B. There is no documentation demonstrating that the caseworker followed through in connecting the family with DDD.

The DYFS case record indicates that the caseworker asked Ms. Harvey if her son was receiving services from DDD. When Ms. Harvey said that he was not, the caseworker provided her with an application. During a subsequent home visit, Ms. Harvey told the worker she had not completed the application and asked the worker if she would drop it off for her once it was complete to ensure that it got to DDD. The worker reportedly agreed, but there is no further indication in the case record of what happened regarding Ms. Harvey's application.

A review of all documents that DDD has on file for this family revealed that Ms. Harvey applied for services for her son twice, once in 1995 and once in 1997. In response to the 1995 application, DDD requested additional information on two separate occasions. This information was not provided, and the case was closed on January 5, 1996. The case was re-opened in November 1997 when Ms. Harvey completed another application. DDD again requested additional documentation on two separate occasions, but none was provided. The case was closed again on June 2, 1998. DDD, however, has no record of a third application for services in 2005. As a result, it appears that the caseworker did not ensure that Ms. Harvey completed the application and submitted it to DDD before DYFS closed its case, leaving Ms. Harvey and her son without services. That failure is particularly disconcerting in light of the fact that both DYFS and DDD are located within the Department of Human Services, providing the opportunity for coordination of services. Despite that, there was no meaningful coordination here.

C. The caseworker did not provide sufficient support to Ms. Harvey to address her needs and concerns prior to case closing.

Ms. Harvey told the caseworker that she was concerned about her pregnancy because of her age and her family history regarding developmental disabilities. She also indicated that she was concerned about housing and asked the worker if DYFS could help. The caseworker indicated that DYFS could not help with housing and did not offer assistance with Ms. Harvey's concerns regarding her pregnancy. According to DYFS policy, however, "advocacy occurs when a client's

[82] DYFS Forms Manual, Form 26-52.
[83] DYFS Forms Manual, Form 26-52.

physical environment or needs are contributing to anxiety or unhealthy living conditions, and the worker helps to alleviate the problem by acting on the client's behalf to obtain better housing, better job opportunities, medical care, welfare or other financial benefits to which the client might be entitled."[84] Despite that policy, the caseworker did not provide Ms. Harvey with assistance, support, or guidance regarding the concerns she raised (even though at least one, housing, was specifically authorized by DYFS policy). Moreover, the supervisor authorized closing the case without ensuring that the caseworker addressed these circumstances.

[84] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.C., Section 1607.

JEREMY CELENTANO – DATE OF DEATH: October 18, 2005

On August 16, 2005, Jeremy Celentano left the foster home where he had lived for the first year of his life to live with his father, Darren Celentano, who had regained custody a few weeks earlier. Two months later, on October 18, 2005, Jeremy Celentano died as a result of multiple skull fractures. Law enforcement officials have charged Mr. Celentano with murder.

I. DOCUMENTS USED TO CONDUCT THE OCA REVIEW

i. Copy of DYFS Case Record
ii. Copy of DYFS Case Chronology
iii. Laboratory Drug Screen (August 20, 2004)
iv. Home Care nursing records
v. Daycare records
vi. Law enforcement records
vii. Pediatric Clinic Medical records

II. REVIEW OF DYFS INVOLVEMENT WITH THE FAMILY

Initial Referral - August 14, 2004

Jeremy was born on August 14, 2004. On that same day, DYFS received a call alleging that Jeremy's mother and Jeremy both tested positive for cocaine and opiates. Jeremy's mother admitted that she had used cocaine four days earlier, but denied recent heroin use and stated that she had been involved in a methadone maintenance program. Subsequently, Jeremy tested positive for Hepatitis C and experienced seizures while in the hospital. Based on those facts, DYFS substantiated neglect.

On August 18, 2004, DYFS completed a Family Risk Assessment. The case supervisor invoked a discretionary override to raise the risk level from moderate to high. Additionally, DYFS completed an in-home Safety Assessment and Jeremy's mother signed a fifteen-day consent to the child's placement. Mr. Celentano did not execute the consent. Jeremy remained at the hospital for ongoing evaluation and treatment.

Also during August, Mr. Celentano participated in a substance abuse assessment. He admitted to a history of alcohol and marijuana use, but indicated that he had last used marijuana several years earlier. The Certified Alcohol and Drug Counselor (CADC) reported that Mr. Celentano appeared "stable" and was not a threat to himself or others, and that he was "aware of" coping skills, cooperative, and willing to receive services. In addition, Mr. Celentano completed two random urine screens, both of which were negative. The counselor made no treatment recommendations.

On September 3, 2004, Jeremy's mother signed a six-month consent for the child's placement. Six days later, on September 9, 2004, she entered a community-based inpatient substance abuse treatment program. On that same day, the hospital advised DYFS that Jeremy had been cleared for discharge two days earlier.

On September 21, 2004, on the recommendation of DYFS' nurse consultant, DYFS placed Jeremy into a specialized resource home for medically fragile children. The nurse also recommended follow-up with a pediatric infectious disease specialist and pediatric gastroenterologist, as well as developmental evaluations at appropriate intervals. The DYFS nurse also suggested that Jeremy participate in an Early Intervention Program and indicated that Jeremy may require physical, speech, and occupational therapy due to the drug exposure. The DYFS nurse visited Jeremy at the resource home on at least one occasion, October 7, 2004.

On October 26, 2004, Jeremy's mother left substance abuse treatment before completing the program. She met with the caseworker to discuss her reasons for leaving. During that meeting, she expressed her desire to regain custody of Jeremy. As a result, the DYFS worker attempted to find her another treatment program. The discharge paperwork from the program indicated that Jeremy's mother had shown a decline in behavior and participation. The program recommended intensive inpatient treatment to address her substance abuse and psychological issues.

Subsequently, Jeremy's mother enrolled at another substance abuse detoxification program. On December 3, 2004, staff at the new detoxification program reported that she continued to do well in treatment and had requested visits with her son. However, one month later, on January 6, 2005, the program unfavorably discharged Jeremy's mother for confrontational and disobedient behavior.

On February 17, 2005, a court hearing regarding Jeremy's custody occurred. Jeremy's mother and father did not appear. The court ordered that DYFS continue its efforts toward reunification. On February 25, 2005, DYFS filed an Order to Show Cause for custody, care and supervision of Jeremy. On February 28, 2005, the court granted that application. Once again, Jeremy's mother and father did not appear. The court ordered Jeremy's mother to submit to a substance abuse assessment and to comply with treatment recommendations, to attend a psychological and/or psychiatric evaluation, and to obtain counseling. Additionally, the caseworker advised the court that Jeremy's father did not have substance abuse issues, but that DYFS' attempts to assist Jeremy's mother with treatment had been unsuccessful.

On March 9, 2005, the court held another hearing and continued DYFS' custody of Jeremy. Mr. Celentano was present, and the court did not order any services. The court ordered weekly visitation between Mr. Celentano and Jeremy, supervised by the resource mother, and that reunification efforts were to continue.

During April, the DYFS nurse visited Jeremy at his resource home and reported that he continued to make progress. Additionally, DYFS ensured that Jeremy was up-to-date with his immunizations and updated the Safety, Risk, Strengths and Needs and Reunification Assessments.

In May, the court conducted another hearing. The court ordered that DYFS would retain custody, instructed Jeremy's mother to attend a psychological/psychiatric evaluation and a substance abuse assessment, and ordered DYFS to have the child's pediatrician and the DYFS nurse assess Jeremy's continued need for specialized foster care and whether he was appropriate for daycare. The court also amended Mr. Celentano's visitation to "as arranged;" during that

time, Mr. Celentano developed a close relationship with Jeremy's resource mother and visitation became "quite liberal."

Also in May 2005, the case was transferred to a permanency worker. That worker conducted an MVR with Jeremy at the resource home and made unsuccessful attempts to meet with Mr. Celentano. Finally, on May 19, 2005, Mr. Celentano contacted the worker and informed her that Jeremy's mother had been arrested for disturbing the peace and alleged drug use. He indicated that he refused to post her bail.

On June 21, 2005, the matter was again heard in court. Jeremy's mother and father were both present. The court ordered that DYFS assess Mr. Celentano's apartment and imposed a restraining order barring Jeremy's mother from the apartment. DYFS recommended that Jeremy's mother and father complete a parenting skills program, but that recommendation was not adopted by the court. Later that day, the worker visited Mr. Celentano's apartment and reported it to be clean and well maintained. Mr. Celentano, according to the worker, had all of the necessary provisions for the child. The worker also subsequently met with Jeremy, Mr. Celentano, and the resource mother at the resource home.

During July 2005, Jeremy's mother submitted to the psychological evaluation. The evaluating psychologist recommended that she enroll in a substance abuse treatment program immediately. Later in the month, however, she failed to appear for a psychiatric evaluation. She did appear for supervised visitation with Jeremy at the DYFS District Office on one occasion, although workers reported that she was unkempt and her clothing was dirty. Subsequently, she arrived at the District Office for another visit but left without notice before it occurred. At the end of the month, after another hearing, the court ordered Jeremy's mother to complete inpatient substance abuse treatment.

Also in July 2005, the caseworker met with Mr. Celentano and Jeremy at Mr. Celentano's home. The worker took photographs of the home and Jeremy's bedroom. The worker reported that Jeremy's room contained all of the essentials as well as toys. At the July 26, 2005, hearing, the court awarded legal and physical custody to Mr. Celentano. The worker discussed details of the child's return with Mr. Celentano and instructed him to select a pediatrician, particularly for follow-up with immunizations and Hepatitis C. Additionally, the worker recommended that Mr. Celentano apply for food stamps, Medicaid, and 4C daycare, because DYFS' assistance in that regard was time-limited.

In August 2005, the worker met with Mr. Celentano at his home and completed a Safety Assessment, Risk Assessment, and Child and Caregiver Strengths and Needs Assessments. The worker determined that the risk was low and that there was no need for safety intervention. Additionally, the DYFS nurse recommended that a nurse should be present at the time Mr. Celentano took custody to review the discharge summary, that a nurse should visit him during the first week to provide "overall education," and that Mr. Celentano should attend an infant/child CPR class. The DYFS nurse further recommended that the caseworker confirm that Mr. Celentano identified a new pediatrician and obtained all of the child's medical records for review. During a subsequent home visit, Mr. Celentano informed the worker that he and Jeremy had been having a good time and that he felt ready to be with his son. On August 17, the worker,

Mr. Celentano, the paternal grandmother, resource mother, Jeremy, and the DYFS nurse met at the pediatrician's office for the transfer of custody and Jeremy's pre-placement physical.

On August 19, 2005, the worker met with Jeremy and Mr. Celentano at home. The home was clean, well maintained, and stocked with food. Mr. Celentano was preparing to feed Jeremy. He reported that all was going well, that he had attended the follow-up medical appointment, and that he had learned a great deal about Jeremy's needs. Mr. Celentano also informed the worker that he was familiar with the staff where Jeremy was to attend daycare. The worker observed that Mr. Celentano appeared to be doing a "great job" caring for Jeremy. She also told him not to hesitate to call "911" in the event the child became ill.

The worker visited with Jeremy at his daycare. The director of the daycare center reported that the child was "great" and always had a smile on his face. She added that Mr. Celentano was easy to talk to and that he liked taking care of his son. Mr. Celentano dropped off Jeremy in the morning and Jeremy's grandmother picked him up in the afternoon.

On August 20, 2005, Mr. Celentano received in-home training regarding asthma and the use of a nebulizer. Just a few days later, on August 25, 2005, the nurse coordinator attempted to meet with Mr. Celentano, but no one was home. Mr. Celentano reportedly did not respond to telephone calls either. As a result, the case was closed due to lack of response.

On August 29, 2005, the worker transported Jeremy's mother to the hospital. The worker reported that her clothing was dirty and that she had difficulty walking. The caseworker instructed her to follow through with treatment and to keep the caseworker apprised of her whereabouts at all times. The worker also met with Mr. Celentano and Jeremy at home. Mr. Celentano indicated that he enjoyed being a father, and stated that everything was "fine." He also said that he was scheduled to take Jeremy for his shots the next day. The caseworker noted no concerns.

On September 12, 2005, the worker met with Mr. Celentano and Jeremy at home. The worker reported that Jeremy was "healthy, happy and well-adjusted to his new environment." Mr. Celentano reported that he knew how to properly care for and love his son, and said that it was a "great experience." Subsequently, the worker and supervisor also met with Jeremy's mother at the District Office. They reported that she was dressed in dirty clothing, appeared to be unclean, and seemed ill.

On October 17, 2005, Mr. Celentano brought Jeremy to see his pediatrician because the child had been vomiting. The doctor concluded that there were no signs of respiratory distress and that Jeremy did not need a nebulizer. The doctor noted that the child was alert and concluded that the child was likely teething. The doctor gave him Tylenol and sent him home.

Second Referral – Child Fatality - October 18, 2005

On October 18, 2005, DYFS was advised that Jeremy Celentano had died. The medical examiner concluded that the cause of death was blunt impact to the head. On October 20, 2005, law enforcement arrested Mr. Celentano and charged him with the death of his son. He stated

that Jeremy had become fussy during the night so he "tapped the baby's head with an open hand" in order to quiet him. When the child continued to cry and fuss, he hit him twice in the chest with a closed fist. He then admitted to dropping the baby onto the ground and Jeremy hit his head on a pile of blocks. Mr. Celentano reported that he was tired and overwhelmed.

III. OCA'S FINDINGS AND CONCERNS

It is not clear that any specific actions would have prevented this tragedy. According to the case record as well as information provided by the DYFS nurse and daycare staff, Mr. Celentano appeared to be doing well as a first-time parent. The circumstances surrounding this child's death also seem to be a significant shock to everyone involved with the family. That said, there are several significant concerns related to the manner in which the involved agencies handled this matter.

A. DYFS Case Practice Issues

Jeremy was medically cleared for discharge on September 7, 2004. Despite that, DYFS did not remove Jeremy from the hospital until September 21, two weeks later.[85] As the OCA has discussed in previous reports, the practice of allowing infants to remain in hospitals unnecessarily is very troubling.[86]

Communication between DYFS and service agencies is very important. According to the nurse coordinator, she attempted to meet with Mr. Celentano on August 25, 2005, but no one was home. He also did not respond to telephone calls, and the case was closed due to lack of response. DYFS apparently did not learn of that failure until two months later, after Jeremy's death, suggesting that DYFS has no process to ensure it is apprised of such information.

Additionally, there is no indication in the case record that the worker was aware that Mr. Celentano had been arrested on March 29, 2005, and charged with an offense allegedly related to an attempt to purchase marijuana. Had DYFS known, it may have sought court approval for additional conditions on the return of Jeremy, possibly including services related to substance abuse.

On July 19, 2005, the worker met with Mr. Celentano and Jeremy at Mr. Celentano's home. The worker took photographs of the home and Jeremy's bedroom. The home appeared to be well maintained and all of the needed provisions for Jeremy's care seemed to be present. While these aspects of the childcare are important, the worker did not seem to perform an extensive evaluation of Mr. Celentano's preparedness or abilities for parenting. It is not clear if she ever reached out to any collateral contacts of Mr. Celentano in order to have a more complete picture of his ability to care for Jeremy.

[85] In fact, there is another note in the case file that indicates that Jeremy had been cleared for discharge on September 3, 2004, which would have increased his unnecessary hospital stay by four days. Because of the conflicting information, however, the OCA has assumed for these purposes that the September 7, 2004, date is correct.

[86] *See* Office of the Child Advocate, *Child Fatality Investigations: 2004* (2004).

On June 21, 2005, Jeremy's case was heard in court. DYFS recommended that Jeremy's mother and father complete a parenting skills program. It is unclear why the court would have rejected that recommendation, which could have provided the parents with valuable skills and instruction.

B. Medical and Mental Health Care

On October 17, 2005, the morning after Mr. Celentano assaulted Jeremy according to his subsequent statement to police, two pediatricians examined Jeremy in response to his father's complaint that he was vomiting. According to the physicians' notes, they observed bruises on Jeremy's right far head, right cheek area, and upper lip. After the fatality, the medical examiner indicated that "there [was] trauma all around the head and five visible black and blue bruises on the head. There [were] three skull fractures and cerebral hemorrhage inside the layer of the head and there [were] also two isolated bruises on the chest." The medical examiner's description strongly suggests that the physicians either missed or ignored obvious signs of physical abuse, either of which is disconcerting.

At the October 17, 2005, pediatrician visit, the doctor indicated that the patient "has no significant medical history." Had the physicians taken the time to properly review Jeremy's chart they would have noted Jeremy's drug exposure at birth, history of seizures, and Hepatitis C. Jeremy's medical history should have served as a "red flag" for a more intensive evaluation of his presenting condition as well as a cause for DYFS contact.

On August 19, 2004, Mr. Celentano attended a substance abuse assessment. The Certified Alcohol and Drug Counsel (CADC) reported that Mr. Celentano appeared "stable" and was not a threat to himself or others, and was "aware of" coping skills, was cooperative, and was willing to receive services. Certified Alcohol and Drug Counselors ordinarily assess substance abuse issues. They are not by and large trained to perform comprehensive mental health status evaluations. Despite that, the worker seemed to rely on the CADC to assess Mr. Celentano's mental health. If the worker felt that she needed an assessment pertaining to Mr. Celentano's mental stability or status as a "threat to himself or others," she should have made a referral for a formal psychological and/or psychiatric evaluation. At a minimum, those evaluations may have provided a more complete picture of Mr. Celentano's skills and overall functioning.

Recommendations

DHS has already instituted measures to tackle some of the concerns that have been raised in these investigations. The OCA takes this occasion to restate and underscore its support for ongoing child welfare reform efforts. Those concerns noted and recommendations for reform from the OCA's previous Child Fatality Investigation Reports that have not been addressed to date are fully incorporated in this report by reference. Based on our investigations of these cases, and fully acknowledging both the relevant aspects of the Child Welfare Reform Plan and recently-implemented DYFS policy and initiatives, we make the recommendations that follow.

The Child Welfare Reform Plan embodies and represents a cultural change for the practice of child welfare in New Jersey. Recognizing the revision, development, and emergence of policy at an unprecedented pace, policies that in many instances represent a complete paradigm shift in case practice for veteran staff, the OCA underscores the absolute imperative of ensuring that staff at all levels of the organization and experience are fully informed of changes in policy and are trained regarding daily application. To fully embrace and effectuate the reforms, staff must understand the philosophical underpinnings of policy changes as well as how change will provide improved outcomes for the children and families they are serving.

OCA continues to have concerns about the State's implementation of a dual response at screening for either CPS or CWS. Although this is not a random sample evaluation of the dual response system, it does offer a glimpse into ways to strengthen that system. Based on the current status of training and the investigative findings in this report, it appears that DHS requires additional preparation prior to full implementation of the dual response system. Again the OCA recommends prioritization of clear, comprehensive, and effective training for staff of the SCR as the work done there establishes the groundwork for who will be serviced as well as the baseline for the level of intervention. This is not to say that a dual response system is fundamentally flawed; it is only to say that New Jersey has not yet implemented its dual response system well.

These cases generally present a picture of poorly planned and coordinated intervention with families. In several instances families were denied access to services that are either directly provided by DYFS, or through other agencies of DHS. Large gaps of time between home visits and failure to follow through on the recommendations of expert consultants were also noted. Further, these cases show evidence of very little supervisory oversight and direction. Therefore, the OCA recommends the following to DHS:

- Because of the absolutely critical role of the first line supervisor in DYFS, immediately implement the elements of the child welfare reform plan targeted at professional development and support of the supervisor; and further develop the capacity to track supervisory conferences with case managers to ensure guided and supported decision-making, contemporaneous documentation of case activity, and consistent adherence to agency policy.[87]

[87] *See* Office of the Child Advocate, *Child Fatality Investigations: 2004* (2004).

- Establish clear protocols for children and families under DYFS supervision to access services from DHS generally or the Office of Children's Services specifically, including but not limited to:

    a. Assessment and linkage of services from DDD;
    b. Timely and appropriate access to the Division of Child Behavioral Health Services;
    c. Access to parenting training, support, respite, and emergency assistance for families with children with disabilities or behavioral health issues; and
    d. Proper referral and linkages for parents with mental illness and the Division of Mental Health network of services, considering that Value Options, the State's contracted services administrator, does not provide services for adults.

- Establish clear protocols for children and families under DYFS supervision to access services at the Department of Community Affairs (DCA) and the Department of Health and Senior Services (DHSS), including but not limited to:

    a. Home visitation and other maternal child health service networks; and
    b. New and existing affordable housing and housing assistance programs.

- In June 2005, the OCA recommended that DYFS modify the timeframes of response for child welfare assessments to range between immediate and seventy-two hours depending on the nature of the report based on the conclusion that that is a reasonable standard consistent with many other child welfare dual response systems. The State responded by establishing a more stringent standard than recommended, requiring a field response to all referrals within twenty-four hours. Having had time to work under the new requirements for six months, the OCA recommends that DHS/DYFS reevaluate the appropriateness of the established time frames. Responding to all referrals within twenty-four hours, regardless of assessed risk, may well be a recipe for failure. DHS should reconsider its policy in light of its ability to meet the commitment, and the quality of response provided to determine if this more stringent measure is required to provide a reasonable measure of safety for children at risk of maltreatment.

- Children and pregnant women under DYFS supervision continue to lack adequate medical care due to the absence of medical insurance. It is imperative that DYFS employees are educated about free and low-cost health insurance programs that are available to children and families, as well as the location of Federally Qualified Health Centers in the local community; and, that they are held accountable for actively assisting and advocating for families to access health care. Maternal Child Health Consortium and home visitation programs exist for prenatal and post partum care for mother and child. The DHS and DHSS networks need better coordination to maximize the benefit of these programs for their target populations.

- Safety Plans in cases where the child was deemed to be unsafe were frequently inadequate in these cases to address the identified safety threat. An effective safety plan

must immediately remedy the safety threat. Therefore, such a plan cannot merely refer for a service that will not be initiated until a few days later or require supervision by a family member who was aware of the maltreatment and did nothing to intervene on behalf of the child. It is critical that safety assessment in the family of origin, and confirmation of safety in out-of-home placements, are recognized and considered as integral parts of every interaction with the child and family and not relegated to a pro-forma activity. Creativity and tailoring of safety plans, and ongoing case plans, to the particular strengths and needs of the family and the resources available in the community must be encouraged and supported through shared decision-making between the case manager, supervisor, and the family. The Training Academy must ensure that the workforce, many of whom are new, may not have academic training in social work, or may have been trained in the practices of the past, understand and appreciate the full value and importance of their role in keeping children safe and families strong.

The DHS Office of Licensing (OOL) has regulatory responsibility for New Jersey resource family homes. The state has an elevated obligation to ensure the safety of children removed from their homes and placed in out-of-home care of any type. Given this obligation, the OCA recommends that the OOL review policy, and revise where indicated, to ensure that licensing inspectors gather and evaluate information regarding the following areas:

- Criminal history of caregivers and other adults in the home;
- Documentation of current CPR certification for primary and secondary caregivers;
- Potential health hazards in the home, including but not limited to lead abatement; and
- Potential safety hazards associated with swimming pools.

Policy revisions promulgated to address health and safety hazards should build on information available from municipal and county governments. Standards should be revised or developed following a systemic review to optimize safety of out-of-home placements while streamlining the work of the licensing inspector. The OCA recommends collaboration with the DCA in this process.

The OCA recognizes that there is existing policy regarding these areas, and pending regulatory revisions. In their present iteration, however, they appear insufficient to address fully the concerns noted. In light of this, the OCA recommends that the OOL establish protocols to ensure that licensing inspectors follow-up with county authorities regarding lead abatement and swimming pool requirements that include accountability measures related to adherence to the policy. Enforcing the licensing restrictions in the existing and proposed regulations requires that copies of current CPR certifications must be present in case files. Under the current and pending regulations, assertions made by resource parents without the accompanying documentation cannot be permitted to satisfy this licensing requirement.

The various units of DHS responsible for resource family homes must develop a stronger communications network to support contemporaneous sharing of information to ensure the ongoing safety of the home for children, particularly when there has been an allegation of abuse or neglect. The case managers for children in the home, OOL, Regional Foster Home Units (RFHU), and the Institutional Abuse Investigations Unit (IAIU) must routinize communications

during inspections and investigations in order to have a true safety net for children in placement. It is imperative that allegations of abuse or neglect (such as a foster parent's abuse of marijuana) are treated as such, and not ferreted to the RFHU or OOL to review as violations of licensing requirements.

As previously stated, DHS' proposed 2005 regulations include a provision requiring that resource parents immediately notify the OOL, during business hours, or the State Central Registry, after hours, of any current arrests, criminal convictions, or guilty pleas of a resource family parent or household member.[88] It is problematic that both the current and proposed regulations require resource families to self-report criminal involvement because a family's failure to do so may not be immediately realized by DYFS and children could be at risk. DHS should develop policy that will strengthen and buttress the self-reporting requirement in order to ensure that it learns about criminal conduct expeditiously. The current Live-Scan (electronic) fingerprinting process permits a "flag" to be placed on fingerprints under certain circumstances to permit automatic notification to the appointing authority of any arrests made. DHS should fully explore the feasibility of requiring a flag on fingerprints of resource family providers.

In two cases here, and as also evidenced in the OCA's prior reports, the caseworkers noted in the file that the home was neat and clean. Until someone demonstrates a correlation between cleanliness and child safety, DYFS should instruct employees that this factor is, at best, hardly relevant unless the filth is severe enough to cause a real and immediate risk to the child. This both will reduce needless removals from dirty homes, and encourage workers not to write off the potential for risk in homes that happen to be spotless.

[88] 37 *N.J.R.* 2807(a) (proposing *N.J.A.C.* 122C-3.4(b)(3)).