OFFICE OF THE CHILD ADVOCATE REPORT

CHILD FATALITY INVESTIGATIONS
Zion Nicholas
Angel Cartagena
Philip O'Donnell

OFFICE OF THE CHILD ADVOCATE
Kevin M. Ryan, Esq., Child Advocate
Arburta E. Jones, M.P.A., Chief of Staff
Lisa Eisenbud, M.S.W., Director of Child Welfare Monitoring
John A. Ducoff, Esq., Director of Litigation
Brian Hancock, Esq., Senior Assistant Child Advocate
LaShanda D. Taylor, Esq., Assistant Child Advocate
Edward J. Wisniefski, M.Ed., Investigator

135 West Hanover Street, 3rd Floor
Trenton, New Jersey 08625

33 Washington Street, 2nd Floor
Newark, New Jersey 07102

June 15, 2005

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INTRODUCTION

In December 2004, the Office of the Child Advocate (OCA) issued a report of Child Fatality Investigations for 2004, including findings with respect to the child welfare system's involvement 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). Upon the release of that report, the OCA indicated that there were two (2) additional child fatalities in 2004 that met the OCA's established investigative criteria[1] and would be the subject of a future report. This investigative report includes findings in connection with those remaining two child fatalities from 2004 and in connection with one child fatality from 2005. The OCA evaluated the performance of DYFS in responding to allegations of abuse or neglect, 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 to an allegation of abuse or neglect, and to understand the efforts of the child welfare system to identify and respond to the needs of children prior to the fatality. Our examination of each of these cases places the 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 for reform.

In one of these cases, DYFS' involvement preceded ongoing reforms in child welfare initiated by the State's settlement of a federal class action lawsuit with Children's Rights, Inc. The lynchpin for these reforms continues to be the willingness of the State Legislature to provide the funding necessary to strengthen the safety net for children at risk of abuse and neglect. This report underscores the importance of the Legislature's ongoing support for the child welfare appropriation recommended by Acting Governor Richard Codey this year. This report makes clear that there are many opportunities a reformed child welfare system can seize upon to strengthen New Jersey's families and save our children. As the stories of these children unfold, the importance of child welfare reform becomes inevitably clear.

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

Name	Date of Birth	Date of Death	County
Zion Nicholas	June 1, 1999	March 23, 2004	Passaic
Angel Cartagena	September 5, 2004	November 15, 2004	Mercer
Philip O'Donnell	September 10, 1998	February 22, 2005	Middlesex

[1] The Office of the Child Advocate committed to conduct in-depth reviews of the child welfare system's interactions with families whose children died due to suspected abuse or neglect in 2004 after an involvement with the New Jersey Department of Human Services, Division of Youth and Family Services (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 screening of allegations, investigative practices, case handling, decision-making, documentation, and the inadequacy of prevention and reunification services for families. To the extent these issues were elevated in our December 2004 report, the concerns are incorporated here by reference.

Investigations and Ongoing Case Management

The Child Welfare Reform Plan emphasizes hiring experienced and appropriately prepared workers, reforming training for the workforce, and implementing reasonable and appropriate caseloads. Some of these foundational elements of reform were not yet in evidence in our review of these cases, though the most recent of these cases occurred just 8 months into the first year of reform.

It is essential that documentation of case management activity be accurate from the point of screening through the life of the case. The cases in this report bear numerous inconsistencies between the case file, the referral response reports and the DYFS staff interviews with the OCA. In addition, there are instances of missing documentation and documentation that was not prepared contemporaneously with the noted events. In one instance, the documentation of the investigation occurred after the death of the child. A delay in transcribing case record documentation increases the likelihood of inaccuracy. Such delays may also leave gaps in information, impairing other staff's ability to intervene on behalf of the family in the absence of the assigned investigator or permanency worker.

Generally, the investigations were not in-depth, which could be a function of training, supervision, caseload size or other factors. In one instance, the investigation was thwarted because the investigator did not ameliorate an existing language barrier between her and the family/potential witnesses. In another investigation, the case manager did not make personal contact with all primary and collateral contacts, including the alleged perpetrator, and failed to inspect the child's alleged injuries.

In these cases, the onus of acquiring services necessary to stabilize or reunite the family was frequently placed on the primary caregiver. DYFS staff was not well versed in available services or how to access services for the families. In some instances, the parent was delayed or denied services based on their inability to pay. In one case, the DYFS investigator could have worked effectively with the County Welfare Board to assure a family's access to desperately needed financial assistance, medical coverage and mental health services, but did not, and explained to the OCA that DYFS did not typically engage welfare agencies in this way. In another of these cases, the DYFS case manager believed agency policy prohibited paying for reunification or treatment services to separated parents. A parent's inability to pay for services should not 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, assuring permanency for the children.

Although DYFS policy is evolving at an unprecedented pace in light of the Child Welfare Reform Plan, DYFS staff in these cases was insufficiently aware of emerging agency policy.

Decision Making

Generally, case practice appeared inadequately supervised to assure follow-up at key decision points. The appearance of a lack of supervision may be due in part to the absence of documentation by supervisors of their case conferences with the investigators in the case records. However, in one instance, a supervisor admitted being unaware of a potential new allegation of sexual abuse discovered by the case manager during his investigation until after the death of the child. DYFS has taken significant steps to assure that its workforce considers all relevant information through the structured decision-making process. These tools - the safety assessment, the risk assessment and the assessment of family strengths and needs - are required by DYFS at designated intervals, and are also triggered by certain case events, such as a new report of abuse/neglect on an open case. These new protocols and assessment tools can be efficacious when accompanied by quality supervision and continued outcomes-based evaluation.

Healthcare

There was a lapse in medical care for the children in two of the reviewed cases. Although previously described in our December 2004 report and incorporated here by reference, we underscore earlier concerns noted in this area. The lack of coordination of medical care and services for at-risk children continues to pose one of the most serious risks to children in State care. The Department of Human Services (DHS) will soon begin to implement a plan for children's medical care that must assure timely assessment and follow-up on the complete health care of children in its custody, care and under its supervision. There are similar concerns raised in these cases related to mental health and substance abuse services for adults/caregivers. DYFS staff should have access to a full continuum of mental health services for adult caregivers and the ability to pay for services for the uninsured.

Screening: Allegations Based System/Child Welfare Assessments

Two of these cases offer evidence of significant problems with DYFS' new centralized screening unit. These problems include miscoding of allegations, failure to obtain necessary information from callers to the hotline, and significant delays in entering data into the computer system used by DYFS case managers to track and resolve allegations.

New Jersey's present approach to determining how to respond to reports of child abuse or neglect represents an unusual hybrid of a threshold approach (known as the Allegations Based System) and a differential response approach. In New Jersey's approach, DYFS operates a centralized hotline whose screeners' decision-making is guided by whether the allegations, if true, meet delimited definitions of child abuse and neglect. If the allegations are consistent with a defined category of abuse or neglect, the report is

forwarded to the appropriate DYFS District Office (DO) intake unit for a Child Protective Services Investigation (CPS). If the allegations do not rise to the level of child abuse or neglect, but there are nonetheless broadly defined child welfare concerns, the report is forwarded to the appropriate DO for a child welfare assessment. Reports identified for a child welfare assessment (those generally deemed to present low-risk to child safety or requiring prevention services) are not conducted with the same degree of urgency or intensity as CPS investigations.

In most differential response systems, there is no prioritization of a child's safety needs over another child's prevention needs because the cases are handled by distinct teams. In New Jersey's current Allegations Based System where DYFS intake investigators have been simultaneously assigned CPS investigations and child welfare assessments, the inevitable triaging on the front lines of child welfare assessments as secondary priorities can place children at risk of harm, particularly in light of miscoding of allegations by the screener. DHS is reviewing this situation presently and may soon remedy the problem by assigning child welfare assessments to other public workers rather than its intake investigators. This should eliminate the adverse consequences of front line triaging, and enhance child safety if DHS ensures that the new workers who conduct child welfare assessments have adequate training in accessing prevention services and forensic investigations.

The OCA is concerned about the implementation of this differential response system, including (1) the adequacy of DYFS screener training; (2) DYFS worker caseloads, which are still high in many instances[2]; (3) oversight of screeners' decision-making regarding the coding of allegations and assigning responses (investigation or assessment); (4) response timeframes and assignment of response times at the hotline, known as the State Centralized Registry (SCR); (5) training for workers on existing resources and accessing services for families; and (6) the lack of prevention services necessary to support families as part of the child welfare assessment process.

Where basic community services for families are not yet in place, and where DYFS staff is not yet trained on how to access services, the likelihood that child welfare assessments will strengthen families is modest. The Child Welfare Reform Plan commits DHS to contracting with community providers in the coming months to provide case management for cases opened for services following a child welfare assessment. Although this is an enormously complicated undertaking, the State should establish ample and meaningful support services for families, such as mental health, housing supports, substance abuse treatment and domestic violence support services, in order to make case management for struggling families successful. This will not be easy, and will require the Legislature's ongoing investment in the reform process.

Additionally, the time frames now in place for DYFS to respond to calls to the centralized screening hotline should be tightened. In some instances, DYFS workers are directed to respond to families up to 5 business days after the call is received by DYFS, which is simply too long to wait, no matter the information reported. DHS could also re-

[2] In April, for example, more than half of DYFS protection workers had 30 or more cases in the following District Offices: Bayonne, Bergen, Edison, Gloucester, Union East and Warren.

examine, as part of its ongoing quality assurance efforts, the criteria used to trigger an immediate response. One policy, implemented one week after the death of Angel Cartagena, as described below, includes seven criteria to determine when an "immediate response" is warranted.[3] The circumstances of Angel's case did not fall within the outlined criteria and, thus, did not necessitate an immediate response time, which is counterintuitive to the facts of the case.

Data Management

The advent of a new data management system is rarely without complication, especially one serving an agency as large as DYFS. Present difficulties stem from DYFS' need to conduct its pressing business, which it continues to do on its existing Service Information System (SIS) data management system, at the same time it designs and phases-in a new data management system, the New Jersey Statewide Protective Investigation, Reporting and Information Tool (NJ SPIRIT), which it has begun to do at the point of origination for cases: screening. A difficulty in this phase-in has been that children's information is temporarily unavailable to workers in the field - who must investigate allegations - while DYFS workers in a "production control unit" take data that has been entered into the new system by DYFS screeners, and re-enter the same data in SIS for the benefit of workers in the field.[4] The duplicate child tracking systems now in operation cause a delay in data transfer from NJ SPIRIT to SIS, leaving DYFS managers at all levels operating on inaccurate caseload information and hampering the ability of workers to access cases and track children in the system.[5] Until this deficiency is remedied, DYFS' reports on caseload size for its workforce represent estimates according to the DYFS staff we interviewed. In addition, the time lapse for full registration and tracking of cases now leaves covering workers (a worker other than the assigned worker) and SPRU (after-hours and weekend) workers with inadequate information about the status of the family.

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[3] If the centralized screener accepts a report for a child protective services investigation, rules out the seven criteria, yet still believes an "immediate response" is needed to assure the safety of the child, he or she can request a "discretionary override" from the Call Floor Supervisor. DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 208.7, Discretionary Override (11-22-04).

[4] So long as these two computer systems remain operational, DYFS should ensure that a new allegation is electronically conveyed between NJ SPIRIT and SIS each time the hotline transmits an assignment to a district office. At the time of Philip O'Donnell's death, this "bridge" clearly was not working. The OCA was advised by three DYFS employees that this is a well-known but still very common flaw in the system. Both the worker and the supervisor were unable to access web based tools (assessments) online since the O'Donnell allegation was not entered into SIS until a day after his death. Workers report completing necessary tasks by hand, and as evidenced in this case record that can lead to incomplete assessment, and duplicative work. DHS reports this has been a recognized problem since November and it is improving.

[5] In one case, the supervisor and the intake worker reported significantly different numbers when asked how many cases the worker was carrying, each sure of their accuracy. Given the extent of the discrepancy between the caseload numbers reported by the worker and the supervisor, it is questionable whether the existence of dual data systems provides a full explanation for the gap. This raises additional concerns about children falling through the cracks and remaining at risk of harm.

DHS Integration of Services to Support Families

DHS houses all of the divisions that could have strengthened the O'Donnell family, including the Division of Family Development (income assistance); the Division of Mental Health and Hospitals (treatment and recovery assistance); DYFS (child welfare services); and the Division of Medical Assistance and Health Services (health insurance). Similarly, three of those divisions could have provided a coordinated response to the family of Zion Nichols. The response of DHS to these families does not evidence a meaningful integration of related agencies working together to strengthen families and save children.

ZION NICHOLAS DATE OF DEATH: MARCH 23, 2004

On March 23, 2004, Zion Nicholas (D.O.B July 1, 1999) died from the toxic effects of Hydrocodone while in the care of his biological mother, residing in Paterson. A DYFS case manager had been in the home conducting a routine home visit a day earlier, and had seen Zion. According to that DYFS case manager, Zion and two of his siblings were sick with a cold and their mother had given them cough syrup and Motrin. His biological mother indicated in an interview with the police that a houseguest had left a bottle of a prescription medicine named Tussin X in the house. The biological mother said she gave Zion a teaspoon of the prescription medicine at approximately 8:00 p.m. However, according to the biological mother, Zion did not fall asleep until approximately 2:00 a.m. At about 6:00 a.m., she said she woke up and found Zion was not breathing. She rushed him to the hospital, where he was pronounced dead on arrival.

The county prosecutor's independent investigation indicated the biological mother's purported timeline was in error. The toxicologist indicated that one teaspoon of Hydrocodone would constitute an adult dosage, and under no circumstances should a child under the age of six be given the medication. The toxicologist further indicated that, based upon the amount of Hydrocodone in Zion's system, a teaspoonful would have been given closer to 2:00 a.m. However, since the law enforcement investigation determined the death to be accidental, no criminal charges are anticipated in this matter. DYFS substantiated neglect because Zion's biological mother gave him medication that was prescribed for an adult, placing the child at substantial risk of harm.

I. INFORMATION USED TO CONDUCT THE OCA REVIEW

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

- i. Case Chronology prepared by DYFS staff, dated November 19, 2004;
- ii. Copy of DYFS case record (April 2000 – January 2004);
- iii. DYFS Service Information System (SIS) data;
- iv. Personnel Files;
- v. Caseload information;
- vi. Interview with DYFS case manager; and
- vii. Interview with Passaic County Prosecutor's Office.

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

Zion's biological mother had a history of DYFS involvement that began in 1998. Three referrals for abuse and neglect were made in 1998 and 1999, only one of which was substantiated.

Initial Referral: March 30, 1998

The initial referral to DYFS came on March 30, 1998. The referent alleged neglect and substance abuse. DYFS conferenced the case for closing on May 8, 1998, after utilizing existing family and community resources to stabilize the family. The case was never closed and remained active until the next referral. There was no additional contact with the family during the intervening months.

Second Referral: June 27, 1998

The referent called the Office of Child Abuse Control (OCAC) at DYFS alleging that the biological mother was unfit. The referral was unsubstantiated.

Several visits to the home after this indicate the family was "doing well." The case record indicates that the case was approved for closing in August 1998. However, according to SIS the case was closed on July 14, 1998.

Third Referral: May 28, 1999

An anonymous referent called the OCAC alleging that the biological mother's child was not being properly supervised. The case was coded for neglect and a DYFS worker responded to the home. The investigator noted that the biological mother appeared to provide adequate care for the children. The allegation of neglect was unsubstantiated. The case was again approved for closing on July 13, 1999. The SIS reflects that the case was closed on August 26, 1999.

Fourth Referral: January 31, 2003

The most recent referral to DYFS occurred on January 31, 2003, for neglect when Zion's biological mother gave birth. The hospital indicated she appeared highly intoxicated. Both the biological mother and the baby tested positive for alcohol. She indicated to the DYFS case manager that she drank three beers prior to going to the hospital, but that she did not drink often. She also indicated that her mother had died of a terminal illness and two of her children had died in a house fire since her last contact with DYFS. The DYFS case manager went to the home and interviewed the maternal aunt who was reportedly surprised by the allegations against Zion's biological mother. The maternal aunt offered to care for the children in order to prevent their removal into foster care. The case manager conducted a criminal background check on the maternal aunt so the children could be placed in her care.

Neglect was substantiated since both the newborn and mother tested positive for alcohol. Zion's biological mother indicated that she had no medical coverage during her pregnancy.

Zion's biological mother signed a six-month consent on February 11, 2003 to provide legal authority for the children to be placed with her aunt. His mother also agreed to

attend out-patient drug treatment and parenting classes. She agreed to move out of the home until DYFS approved her to reside with the children and resume her role as the primary caregiver. On February 14, 2003, the case manager completed a safety assessment and determined that the children were safe in the care of their maternal aunt. On February 21, 2003, the case work supervisor approved the newborn's release from the hospital to the care of his maternal aunt.

Zion's biological mother initially attended a program for substance abuse treatment, but had to pay for it herself as she was without health insurance coverage. As a result, she withdrew from the program and applied for enrollment in another program, which cost her substantially less. She was placed on a waiting list, and began attending that treatment program in May 2003.

In June 2003, as DYFS began to consider returning the children to the biological mother's care, the case manager delved into the circumstances surrounding the death of her two children who perished in a house fire in the year 2000. The case manager determined that fire authorities ruled the fire accidental.

On October 9, 2003, the case manager conducted a home visit and found the biological mother home alone with the children. The case manager raised no concerns, although she had not yet been approved to resume primary care-giving responsibility for the children. The biological mother's visitation agreement stipulated her time with the children was to be supervised by the maternal aunt or another responsible adult.

Zion's biological mother completed the program with no positive drug tests. She continued to attend the Center of Parent Education (COPE) Program and also received services from the Emergency Child Aid Program (ECAP).[6] On December 22, 2003, the case manager completed a child safety assessment indicating that the children were safe. She was approved to return to the home as the primary caregiver, with her aunt staying in the home for two weeks as a transition. In addition, parental assistance services were increased from three times per week to five times per week. It should be noted that the six-month informed consent had long since expired; no concerns were raised and DYFS did not seek legal custody of the children. The biological mother actually returned to the home on December 23, 2003.

In January 2004, when attempting to obtain immunization records for one of the children, the DYFS case manager discovered that the he had dropped out of school two years earlier. The worker assisted the child to re-enroll in an educational program. It is unclear why the case manager was unaware that the youth was not enrolled in school during nearly a year of ongoing supervision of the family during which the child was in relative care.

In-home visits were conducted on January 15, 2004, and February 24, 2004. On each visit, the case manager indicated that the children were doing well and that the biological

[6] The Center of Parent Education (COPE) is a program that offers grief counseling and individual counseling. The Emergency Child Aid Program (ECAP) is an in-home parenting assistance program.

mother was functioning well. A positive ECAP report was received on February 20, 2004, indicating that termination of services was appropriate.

The case manager visited the home on March 22, 2004, during which the case manager noted that the three youngest children, including Zion, were sick with a cold, but otherwise appeared to be doing well. The record reflects that the children were being given over-the-counter cough syrup and Motrin. The children reportedly were active and playing among themselves and with the case manager. The biological mother indicated that she was giving the children their vitamins. She further indicated that once her case was closed, she would move to the south where she had family members. No additional concerns about the children were noted.

III. PERSONNEL AND CASELOAD INFORMATION

The supervisor received commendable and exceptional employee performance evaluations.

The case manager began working for DYFS on November 18, 2002. She managed a caseload that ranged from 7 to 14 families and 16 to 37 children. At the time of Zion's death, her caseload was 7 families and 21 children. Performance evaluations for the case manager found her to be in the commendable and exceptional range.

IV. FINDINGS AND CONCERNS

A. Reunification services to the mother were delayed based on her ability to pay for them.

Following the fourth referral DYFS determined that the biological mother required substance abuse treatment prior to family reunification. There was a delay in the biological mother fulfilling this requirement because she could not afford to pay for the service, had no medical insurance and was placed on the waiting list for a program she could afford. The case manager interpreted DYFS policy as prohibiting payment for services to the parent. Despite the fact that DYFS and the Division for Medical Assistance and Health Services (DMAHS) – which runs the State Medicaid program - are both divisions within DHS, the DYFS case manager said DYFS links clients to Medicaid by providing them with a letter in support of their application, which they take to the local welfare office, so that a separate case worker overseen by a third division within DHS, the Division for Family Development (DFD), can process the paperwork.

Reunification services should not be contingent upon a parent's ability to pay. The case manager should have had several options available to provide services to the biological mother including, but not limited to, providing services through a contracted provider or payment from already-established DYFS District Office Bank Accounts. Under no circumstances should service delivery be delayed or denied based on the parent's

financial status, especially given the stringent timeframes for reunification in the Adoption and Safe Families Act (ASFA). This case evidences a lack of understanding of family entitlements and a lack of available resources to ensure provision of services to the family.[7]

B. There was a lapse in routine medical care for the children while in the DYFS-approved relative care placement.

An interview of the nurse at the hospital after Zion's death revealed that there were problems establishing routine medical care for the children while they were under DYFS supervision. On January 4, 2004, Zion's doctor indicated that Zion needed vaccines. The doctor further indicated that he had seen Zion in September 2003 for a cold and cough. Zion's last well-baby check-up was in May 2003. The concern about a lack of routine medical care for Zion is heightened because Zion was in relative care placement at the time the medical care should have been obtained. The lack of coordination of medical services for at-risk children presents an exigent need for New Jersey to assure timely assessment and follow-up on the complete health care of children in our custody, care and supervision.

The State began providing Medicaid for the children on February 14, 2003, yet there was no follow-up to assure the children were benefiting from the coverage. In fact, the DYFS case manager indicated that the only follow-up she conducted to ascertain the children's medical care came in the form of requests for collateral information forwarded to the children's doctors at six-month intervals.[8]

C. The overall case practice was inadequately supervised to assure follow up at key decision points.

1. The children were not interviewed in the course of DYFS investigations or during visits with the family. Case practice focused on the adults and their perspectives of the family's strengths and needs. By the fourth investigation, DYFS had implemented the safety assessment/structured decision-making process statewide and, in fact, the case manager completed a safety assessment on February 14, 2003. However, there is no indication that the case manager met the requirement to see and interview each child based on the documentation of the visit.

2. During the investigation of the fourth referral the case manager learned that two of the children died in a house fire. This fact escaped scrutiny for 6 months. The biological mother identified this loss and the loss of her mother to a

[7] Services required to prevent placement or to effectuate the reunification plan should not be delayed or denied based on the parent's ability to secure and pay for services. *See N.J.A.C.* 10:129A-2.4

[8] The DYFS policy, *New Manual IIR, Forensic Investigations,* Section 308, Child Protection Investigation Workflow now requires collateral contacts to be in-person or by telephone.

terminal illness as precipitating events in her alcohol abuse, yet there is no indication that she was directed to support services to address her grief and loss. Similarly, there is no indication that these matters were addressed with the surviving siblings/grandchildren to strengthen them emotionally. Although neither of these tragic events presents a child protective services concern, there are underlying child well-being issues that could have been addressed.

3. The children were exposed to people for whom DYFS had no information. On two occasions the case manager visited the home only to find the children in the sole care of the father of one of the children about whom nothing was known, and for whom it appears no background check was conducted. In addition, the maternal aunt was approved as the primary caretaker for several weeks before a background or police check was completed. Additionally, two people were identified as babysitters for the maternal aunt while she worked. Finally, the case manager had no independent knowledge of the house guest who left the medication that was ultimately administered to Zion. In fact, the case manager only knew the name of the person from her conversations with the police subsequent to Zion's death.

4. The case manager did not follow up when she found the children alone with the biological mother prior to her being approved to resume primary care taker responsibilities. In this case, that lapse proved to be inconsequential. However, supervised visitation and contact with children are generally established as a preventative or protective measure until such time as the potential caregiver has demonstrated the capacity to independently supervise the children. Until the case manager can document the habilitation of the respective party, the prevention and safety plan should be diligently regarded by all parties to minimize the risk of child maltreatment.

5. There was an open case on the family for nearly a year before the case manager discovered that one of the children dropped out of school. It is problematic that it took the case manager this long to make that determination.

D. Delay in provision of financial support to the relative caregiver.

DYFS Relative Care policy found in the Field Operations Casework Policy and Procedures Manual, II H 200 establishes policy for a relative to serve as a placement option for children. The policy requires the assessment of a relative who is interested in providing care for a child requiring placement by DYFS using the standards of the DYFS Relative Care Permanency Support Program, regardless of whether the relative is seeking financial assistance. The policy provides for presumptive eligibility of the relative caregiver to receive financial support for the placement. In this case, the SIS reflects that the relative caregiver did not begin to receive support payments for the children until August 2003, six months after the placement was made by DYFS. Although the caregiver was provided with a retroactive payment for the children, the relative caregiver was left without assistance to provide for the children in the interim. Such a lapse could

discourage some potential caregivers from making their homes available to children and jeopardize children's well-being by depriving them of funds necessary for their care.

E. The newborn remained in the hospital for two weeks after medically cleared for discharged.

After the Fourth Referral, the infant remained in the hospital for two weeks awaiting a relative care placement. It is unacceptable that a baby would be allowed to stay in a hospital for this length of time where health concerns did not require such a stay and a relative was available to care for him. The OCA's review of the baby's complete hospital and child welfare records indicates no medical justification for the infant's last two weeks of hospitalization in February 2003. Since that time, as part of the child welfare reform plan, DHS has made a concentrated effort to end the practice of boarding newborn infants in hospitals. In its March 2005 Monitoring Report, the New Jersey Child Welfare Panel noted that "OCS has substantially reduced the problem of 'boarder babies' staying in the hospital when they no longer require medical care because appropriate relatives or foster parents are not available for them."

ANGEL CARTAGENA DATE OF DEATH: NOVEMBER 15, 2004

At approximately 12:15 p.m. on November 13, 2004, Angel Cartagena, Sr. called 911 and reported that he found his two-month-old son, Angel Cartagena (D.O.B September 5, 2004), unresponsive on the couch in the family's home. The Hightstown Police responded, revived the child and transported him to Robert Wood Johnson Medical Center (Hamilton). Angel was then transferred and admitted to the Pediatric Intensive Care Unit (PICU) at the Bristol-Myers Squibb Children's Hospital in New Brunswick. At the time of admission, Angel had massive brain swelling and retinal hemorrhages. He was diagnosed with Shaken Baby Syndrome and it was determined that the abuse had occurred 24 to 92 hours prior. Angel remained in the PICU until his death on November 15, 2004.

At the time of Angel's death he was living with his biological mother; biological father, Angel Cartagena, Sr.; maternal aunt and his maternal aunt's paramour. Additionally, it has been reported that Angel had been cared for by two babysitters during the month of his death.

Angel's father, Mr. Cartagena, has been arrested in connection with Angel's death. The Mercer County Prosecutor's Office is continuing to investigate the case.

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 Cartagena family prior to Angel's untimely death, including:

- i. CCAPTA Notice dated November 15, 2004;
- ii. Case Chronology prepared by DYFS Staff (undated and preparer's name omitted);
- iii. Copy of DYFS Case Record (from November 3, 2004 to November 14, 2004);
- iv. Medical Records regarding Angel Cartagena;
- v. Personnel records of the DYFS Case Manager;
- vi. Personnel records of the DYFS Supervisor;
- vii. Caseload information re: the DYFS Case Manager (August-December 2004);
- viii. Caseload information re: the DYFS Supervisor (August-December 2004);
- ix. Discussion with Mercer County Investigator;
- x. Discussion with Mercer County Prosecutor;
- xi. Interview with referent; and
- xiii. Interview with the DYFS Case Manager.

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

Initial Referral: November 3, 2004

The initial referral was received on November 3, 2004 at approximately 10:55 a.m. The referent reported that a pediatrician examined Angel Cartagena for possible physical abuse at the request of his biological mother. She reported to the doctor that on November 2, 2004 at approximately 5:00 p.m., Angel Cartagena's biological father, Mr. Cartagena, picked him up from his babysitter's home. An hour later, while changing Angel's diaper, Mr. Cartagena claimed to have noticed blood in the child's stool and on the diaper.

The pediatrician examined Angel and found bruising on his right thigh. She concluded that he had been cradled with the right hand and the left hand was used to hold his right thigh very tightly leaving a finger mark. The pediatrician suspected the possibility of child abuse.

Several hours after receiving the report, DYFS called Angel's biological mother to obtain the last name of Babysitter A. According to the response report, the biological mother did not know the babysitter's last name but provided some personal information about her. DYFS' centralized screening unit performed a background Child Abuse Registry Inquiry (CARI) check on the biological mother and Mr. Cartagena. According to the response report, no prior DYFS records were found for the biological mother but the central registry contained an "Angel Cartagena" in a case with a different KC number, where there was a "confirmed fondle/touch" to a ten-year-old relative.[9]

The referral was coded as physical abuse and assigned a 24-hour response time. According to the referral response report, the case manager received the referral on Thursday, November 4, 2004 and met with her supervisor that same day.

According to her referral response report, the case manager's first contact with the family was at approximately 4:30 p.m. on November 4, 2004. Her report indicates that she met with the biological mother in her home in Hightstown. Since Mr. Cartagena was not home at the time of the initial visit, the case manager returned to the home at 7:30 p.m. that same evening. The case record reflects that there was no answer upon her return visit so the case manager left her business card and a note that she would return on November 9, 2004.

Contrary to the information in the referral response report, the DYFS case manager revealed to the OCA that she did not make contact with the family on November 4,

[9] There is nothing in the case record that confirms or refutes that the "Angel Cartagena" who abused his niece and the birth father are one and the same. OCA staff requested the case from DHS. The case record for the noted perpetrator does not contain the DYFS 9-7 form. The only notation regarding the allegation is listed in the Service History portion of an assessment document. The file contains no identifying information about "Angel Cartagena" such as a date of birth or social security number.

2004.[10] According to the case manager, she received two referrals on November 4, 2004. She responded to the Cartagena home first but no one was home so she responded to her other referral. Reportedly, she continued her investigation of the other referral until 11:00 p.m. and did not return to the Cartagena home that day. The case manager stated that she was not at work on Friday, November 5, and did not return to the Cartagena home until Monday, November 8, 2004.

On November 8, 2004, the case manager met with the biological mother for the first time. The child and the child's maternal aunt were also present during the initial visit; however, Mr. Cartagena was absent. According to the referral response report and OCA interview, the case manager spoke with the biological mother about Angel, his injuries, and future child care arrangements. She provided the case manager with the Babysitter A's first name and address. She further stated that Angel had been cared for by Babysitter A for three weeks but that the family would make other arrangements. The referral response report indicated that the biological mother answered the questions to the best of her ability considering the language barrier (the biological mother is Spanish-speaking and the case manager was not conversant in Spanish).

Per the case manager's referral response report, the November 8, 2004 visit also included a conversation with the biological mother about the persons residing in the home and her relationship with Angel's father. She informed the case manager that the only persons living in the two-bedroom apartment were Angel, Mr. Cartagena and herself, and that things were "good" between her and Mr. Cartagena. The biological mother further stated that she was "ok" with the child being cared for by Mr. Cartagena. The case manager toured the apartment, which she found to be "very clean and organized," and noted that Angel had sufficient food, diapers, clothes, and toys. She also observed Angel while he slept and wrote in her referral response report that he was clean, had rosy cheeks, good skin color, and smelled of baby powder.

Prior to leaving, the case manager had the biological mother sign authorizations for the release of Angel's medical records from Robert Wood Johnson – Hamilton (ER) and the child's pediatrician. These releases, although in the file, are undated. The biological mother also signed an Acknowledgement of Receipt of Notice of Privacy Practices. This document is dated November 4, 2004 although the case manager told the OCA that she did not make contact with the biological mother on that date. The case manager also discussed a safety plan with the biological mother and informed her that she would return to speak with Mr. Cartagena.[11] The biological mother provided the case manager with her work schedule (6 p.m. – 1 a.m.) and the work schedule of Mr. Cartagena (9 a.m. - 5 p.m.).

According to her referral response report, the case manager called directory assistance on November 9, 2004 for the referent's telephone number. She contacted the number and

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[10] The case manager referred to the case record to refresh her memory during the interview with OCA.

[11] According to the case manager, in the safety plan the biological mother agreed not to use Babysitter A as a child care provider and to re-arrange her work schedule until alternate arrangements could be made. However, according to DYFS record, this plan does not exist.

left a message for the doctor to return her call. However, the DYFS case chronology indicates that her initial call to the doctor was on November 4, 2004 and that a second call was made on November 9, 2004. Although not documented on her referral response report, a letter in the file indicates that on November 9, 2004, the case manager sent a request for police background checks on Mr. Cartagena and the biological mother to the Hightstown Police Department.

During her interview with the OCA, the case manager stated that she called directory assistance on November 8, 2004, to obtain the referent's fax number in order to send her medical inquiry form. When the facsimile came back "failed attempt" the case manager contacted directory assistance again and was given a telephone number. She then contacted the number and was told that it was the wrong number. According to the case manager, she ultimately received the referent's correct number and sent out the faxed medical inquiry on November 10, 2004. The case record lacks a completed inquiry and the referral response report does not indicate that an inquiry was sent.

According to the referral response report and OCA interview, at 5:19 p.m. on November 9, 2004 the case manager made her third and final visit to the Cartagena home. Mr. Cartagena was not home and the case manager again met with the biological mother and Angel. Angel was sleeping and the case manager observed him to be "breathing, pink in color and healthy." The case manager spoke with the biological mother about her child care arrangements and was informed that Angel had not been cared for by Babysitter A since November 2, 2004. According to her referral response report, the case manager asked whether the biological mother needed daycare through DYFS and she declined, stating that her family had been assisting her with Angel. When interviewed by the OCA, the case manager stated that the biological mother did not want any services from DYFS because "she basically didn't know who we (DYFS) were." According to her referral response report, the case manager questioned the biological mother about her family and was told that she had a six-year-old son who lived with her mother in Ecuador and that her father had passed away right before Angel's birth.[12] She reported feeling "Ok, Ok" and "so-so a little" sad about her father's death. The referral response report indicates that the case manager left her name and telephone number and advised the biological mother to have Mr. Cartagena contact her immediately.

The referral response report indicates that the case manager met with her supervisor on November 10, 2004. According to the DYFS case chronology, a referral was made for the DYFS nurse consultant to conduct a follow up home visit and to obtain collateral information from the referent. During her interview, however, the case manager stated that no such referral was made to the nurse consultant. Although she has used the nurse consultant in the past, she did not request her assistance with this case because Angel was not medically-fragile.

Statements given during the OCA interview and the case manager's referral response report support that the case manager had a face-to-face interview with a doctor who

[12] When questioned, the case manager stated that she did not learn this information until November 15, 2004, after Angel's hospitalization.

examined the child on November 15, 2004. The doctor confirmed that this meeting took place on that date. On that same day, the case manager spoke with Angel's regular pediatrician.

The case manager stated in her interview that she also met with the biological mother, the maternal aunt and Babysitter A on November 15, 2004. There is nothing in the referral response report regarding those interviews.

Second Referral: November 13, 2004 – Child Near Fatality

The second referral was received on November 13, 2004 at approximately 7:07 p.m. from the Hightstown Police Department. The caller reported that around 12:15 p.m. the police department received a 911 call regarding a baby being unresponsive at home. The police responded and the baby was revived and transported to Robert Wood Johnson Medical Center (Hamilton). Later, he was transferred and admitted to the PICU in New Brunswick. According to the DYFS response report, the caller informed the DYFS hotline screener at the SCR that the baby had massive brain swelling and had been diagnosed with Shaken Baby Syndrome.

Upon receipt of the referral, SCR made several unsuccessful attempts to contact the primary Special Response Unit (SPRU) worker.[13] At 8:49 p.m. SCR contacted the SPRU Supervisor for further instruction. The SPRU supervisor advised SCR to assign another SPRU worker since the primary worker was not available. SPRU Worker B was assigned to respond to the referral between 8:54 p.m. and 9:50 p.m.

After receiving the referral, SPRU Worker B spoke with the SPRU Supervisor and the Hightstown Police. Upon learning from the Hightstown Police that the biological mother spoke "no English," he obtained the assistance of a Spanish-speaking SPRU Buddy and responded to the hospital. His referral response report states that he arrived at the hospital at 10:00 p.m.

At the hospital, SPRU Worker B reviewed Angel's chart which indicated that Angel was found by police to be in respiratory arrest and that blood was found in his throat prior to intubation by EMS. The Hightstown Police informed SPRU Worker B that, according to the doctor, the probable cause of the blood was pneumonia unrelated to the abuse. The Hightstown Police went on to explain to SPRU Worker B the circumstances surrounding the child's admission to the hospital. According to the Hightstown Police, the child was on his back, not breathing, with skin grey and pupils fixed and dilated when the detective arrived. Mr. Cartagena reported finding Angel in this condition when he returned from smoking a cigarette with a friend outside of the apartment.

Recounting the details of the conversation between the police and the family, the Mercer County Investigator told SPRU Worker B that the biological mother, maternal aunt and her paramour said that Angel seemed fine when they left home for work that morning.

[13] November 13, 2004 was a Saturday.

The biological mother did not have any suspicions about Mr. Cartagena, but the maternal aunt seemed to be suspicious of him.

After the conversation, SPRU Worker B updated the SPRU Supervisor who, in turn, consulted with a DYFS senior staff member. At their direction, SPRU Worker B asked the charge nurse to ensure that all visits between Angel and his biological parents were supervised.

With the assistance of his Spanish-speaking SPRU Buddy, SPRU Worker B was able to speak with the biological mother. She told SPRU Buddy and SPRU Worker B about her son in Ecuador and reported being depressed since her father's death, two weeks after Angel's birth.

Once again, SPRU Worker B spoke with the SPRU Supervisor, who had no further instruction to provide him that evening. At 8:55 a.m. the next morning, SPRU Supervisor called SPRU Worker B requesting a status on Angel's condition. According to his referral response report, SPRU Worker B called PICU and was informed that Angel was on a respirator and dopamine drip. This information was communicated to the SPRU Supervisor and to a Supervising Family Service Specialist I (casework supervisor) from the DYFS Mercer County District Office.

III. PERSONNEL AND CASELOAD INFORMATION

Personnel and related records regarding the Case Manager

According to the information contained in the case manager's personnel file, she holds a Bachelor of Arts Degree with a major in Sociology (conferred May 2003). She began her employment with the Division on October 20, 2003, as a Family Service Specialist Trainee (FSST) with the Mercer District Office. On February 20, 2004, she successfully completed her probationary period. She received a "commendable" rating on her Performance Assessment Review (PAR) for the September 1, 2003 – August 31, 2004 rating period.

Although not indicated in her personnel file, the case manager reported to the OCA that she was promoted to Family Services Specialist II (FSS II) in December 2004.[14] Her personnel file indicates that she attended 11 new worker training courses (179 hours) from November 15, 2003 - July 15, 2004.

During November 2004, the month of her involvement with the Cartagena family, a document provided by DYFS indicates that the case manager managed a caseload consisting of 9 families and 12 children. This represented an increase from her October 2004 caseload of 6 families and 7 children. The month after her involvement with the

[14] Promotion from Family Service Specialist Trainee to Family Service Specialist II is a routine matter for each trainee that satisfactorily completes the probationary period and related new worker training. The job title of Family Services Specialist II was subsequently renamed Forensic Investigator.

family, the case manager had her highest caseload in 5 months, 22 families and 45 children.[15]

Personnel and related records regarding the Supervisor

According to the information contained in the supervisor's personnel file, she holds a Bachelor of Arts Degree with a major in Communications (conferred May 1993). The supervisor began employment with DYFS on January 20, 1998, as a Family Services Specialist Trainee (FSST) with the Mercer District Office. On July 20, 1998, she successfully completed her probationary period.

During her tenure at DYFS, this employee received a number of promotions. On January 30, 1999, she was routinely promoted to Family Services Specialist III (FSS III); on February 26, 2002, she was promoted to Family Services Specialist II (FSS II); on June 1, 2002, she was promoted to Family Services Specialist I (FSS I); and on August 21, 2004, she was promoted to Supervising Family Services Specialist II (SFSS II). Throughout her employment with DYFS, the supervisor has enjoyed an overall employee performance rating of "exceptional."

The supervisor's personnel file indicates that she attended 21 DYFS-related training sessions (204 hours), including new worker training. Her most recent training was in July 2004.

IV. FINDINGS AND CONCERNS

A. There are numerous inconsistencies between the case file, the referral response reports and the case manager's interview.

The last date of case work activity documented in the file originally provided to the OCA was November 10, 2004. Subsequently, the OCA interviewed the case manager on March 4, 2005 and received an updated (and amended) referral response report from her. After carefully reviewing the DYFS case file, the two DYFS referral response reports and OCA's taped interview with the DYFS case manager, the OCA has discovered numerous discrepancies that raise questions regarding the accuracy of the documentation and integrity of the DYFS Cartagena investigation.

1. Initial contact with the family

Both referral response reports provided by DYFS indicate that the case manager's initial contact with the family was on November 4, 2004. In fact, the reports indicate that the case manager made two visits to the home on that date. Bolstering this account is a document signed by the biological mother that is dated November 4, 2004. However, during her interview, the case manager acknowledged that she did not make contact with

[15] In August 2004, the case manager's caseload was 17 families and 40 children and in September 2004, it was 16 families and 35 children.

the family on November 4, 2004. According to the case manager, she did not speak with the biological mother until November 8, 2004, five days after the referral was made and four days after she received the case. This later account calls into question the validity of the signed document and means that DYFS did not timely investigate the referral.

2. Missing documentation

According to the referral response report and the interview with the case manager, several documents that should be in the file, are missing. Those documents include the medical inquiry form, police background check, nurse consultant referral form, notes from meetings between the case manager and her supervisor, and the case safety plan. At a minimum, the absence of these documents raises concerns about internal office organization, record keeping integrity and logistical protocols, and at worst, raises questions about the record's veracity and the overall integrity of the investigation.

a. Medical inquiry form

During her interview, the case manager stated that on November 10, 2004, she sent a medical inquiry form to a cooperating doctor who had examined Angel. This action is neither documented on the referral response report nor is there a copy of the medical inquiry form in the case record. It should also be noted that the OCA reviewed Angel's medical file from the same doctor and a DYFS medical inquiry form is not contained in that file.

b. Police background check results

The case record provided to the OCA includes a letter dated November 9, 2004 to the Hightstown Police Department requesting police checks on Mr. Cartagena and the biological mother. However, this action is not documented on the referral response report and the results are not in the case record.

c. Nurse consultation sheet

As previously stated, the case chronology provided to the OCA indicates that a referral was made to a nurse consultant on November 10, 2004. During her interview, the case manager stated that a nurse consultation sheet must be completed in order to obtain the services of the nurse consultant on a particular case. She further stated that she did not make a referral in this case and no nurse consultation sheet is in the case record indicating otherwise.

d. Notes from meetings between the case manager and her supervisor

The case manager's referral response report indicates that she met with her supervisor on November 4, 2004 and November 10, 2004 and indicates the notes from those meetings were in the case record. However, the case record provided to the OCA does not contain any notes from these case conferences.

e. Safety plan

The referral response report states that the case manager spoke to the biological mother about the safety plan. In her interview, the case manager stated that the plan addressed the allegations and stated that the parents would not have Babysitter A provide child care for Angel and that they would rearrange their work schedules until alternate arrangements could be made. The case manager further informed the OCA that, although she discussed the plan with the biological mother, she did not recall whether the biological mother signed it. However, the safety plan was not in the case record provided to the OCA. On March 4, 2005, the OCA requested a copy of the safety plan from DYFS. At that time, the OCA was notified that no plan existed because the investigation was not complete.

3. Case activity not properly recorded

As discussed above, the case manager reported to the OCA that she performed case activity that is not documented in her referral response report. At the very least, this indicates that case notes on the initial investigation were not written contemporaneously. After her interview, the case manager provided the OCA with an updated copy of her referral response report on March 4, 2005. The last recorded activity in the report provided to the OCA with the case record was on November 10, 2004, whereas the updated report included case activity through November 15, 2004.

The updated referral response report was also amended to include additional information about the visits to the home. This information, added after the OCA received the case file, includes, among other things, a description of Angel's size and weight and more details about the case manager's conversations with the biological mother. This delay in transcription is extremely problematic because the added content was potentially influenced by the child's fatality.

B. The centralized screening worker failed to obtain critical information from the reporter.

One of the primary goals of centralized screening is to provide consistent, appropriate screening of reports of suspected child abuse or neglect and requests for child welfare assessments statewide. DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 202, SCR- Purpose and Goals (11-22-04). As such, the screening worker must record the information provided by the referral source promptly and accurately. Additionally, the worker must elicit as much information from the caller as

possible. When the person making a report is a medical or other professional, the worker is mandated to obtain additional information from him or her, including the caller's name, title, specialty, professional or institutional affiliation, and find out when he/she will be available to be re-contacted by the Child Protection Worker, the intake Supervisor, and/or by a DYFS Pediatric Consultant (nurse or physician). DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 217.4, Professionals Making Reports and Referrals (7-1-04) (amended as DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 216.4, Professionals Making Reports and Referrals (11-22-04)).

The centralized screening worker who completed the DYFS 9-7 regarding the November 3, 2004 referral did not obtain the requisite information from the caller. Other than noting that she was a medical personnel, there is no contact information or institutional affiliation listed for her, nor is there any notation regarding her availability to be re-contacted. In an interview with OCA staff, the referent indicated that the centralized screening worker did not ask about her availability for future contact nor did he mention the possibility of a DYFS worker re-contacting her. According to the referent, the centralized screening worker told her that "DYFS will take care of it" and seemed "indifferent" to the report.[16]

The absence of this information directly impeded the case manager's ability to contact the referent. The case manager's records indicate that in order to contact the referent, she contacted directory assistance and was provided with the number. The records further indicate that she left at least one message at that number. The referent told OCA staff that she has not been reachable at that number since September 2002 when she relocated to her current practice and cannot access messages left at her previous number.

Because the centralized screening worker did not obtain the referent's telephone number, the case manager was unable to contact her in a timely manner. During her interview with the OCA, the case manager described the difficulties that she had contacting the doctor. Both she and the referent report that they did not speak with one another until November 15, 2004, the day of Angel's death.

C. The centralized screening worker did not accurately complete the DYFS screening intake form.

Centralized screening workers must be trained on how to properly complete the DYFS screening intake form. The accuracy of the information provided to the case manager through this document impacts that worker's ability to fulfill his/her duties. If information is omitted or inaccurate, there may be a delay or misdirection of the investigation.

[16] The referent told OCA staff that she found the reporting process "complicated" and that it took her approximately 30 minutes to make the report.

The centralized screening worker who completed the screening intake form regarding the November 3, 2004 allegations made several mistakes. Some of the mistakes appear to have been due to human error, while others seem to have been due to improper training.

The initial report was received by SCR at 10:55 a.m. on November 3, 2004; however, the first page of the DYFS intake form indicates that it was received at 2:21 p.m. There is a notation on the second page that "the referral was taken at 10:55 a.m. at SCR, unalbe [sic] to update time on report." Because of the discrepancy between the time the report was actually taken and the time recorded on the first page of the form, it is unclear whether the case was assigned to a Case Manager within the mandated timeline.[17] It is imperative that screening workers be provided proper training on how to input information on the form and reinforcement of the need to record information accurately.

Other errors on the DYFS intake form are apparent because the recorded information conflicts with established facts. It is unclear whether the errors stem from how the information was inputted or how the information was reported. These errors include: (1) the gender of the child is listed as female instead of male; (2) the child is listed as an adopted child rather than a birth child; (3) the location of the child's bruise is listed as being on his left leg when the doctor's report indicates that the injury is on the right leg; (4) the biological mother is listed as a reference person rather than a parent; and (5) the biological mother's race is listed as "Black/White" rather than "Hispanic or Latino Origin." These errors, especially regarding the child's gender could have resulted in confusion as to the identity of the abused child and could have hindered the investigation. Further, had the screening worker accurately listed the birth mother's race as "Hispanic or Latino Origin," the need for a Spanish-speaking worker/interpreter may have been flagged at the onset.

Centralized screening workers are now using NJ SPIRIT instead of the former intake form, known as the DYFS 9-7. NJ SPIRIT is a web-based application that allows child protective service reports to be sent electronically to the appropriate field office. Proper utilization of this system could facilitate more timely responses to reports, but effective training will remain crucial. In order to ensure the effective operation of the new system, screening workers must be trained properly and information must be inputted accurately.

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[17] DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 218, Timelines for Action (7-1-04) mandated the SCR screener to transmit the Form 9-7 to the field office within one hour of the referral and a worker and supervisor be assigned within 2 hours of receipt from SCR. The current DYFS policy, DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 217, Timelines for Action (11-22-04), requires the SCR screener to assign an accepted Child Protective Services Report or Intake Summary to the field office within one hour and the Child Protection Worker to initiate the investigation within 2 hours (for immediate) or within 24 hours (for 24-hours). Under the policy in effect at the time, if the referral was made at 10:55 a.m., the 9-7 should have been transmitted to the field office by 11:55 a.m. and the worker should have been assigned by 1:55 p.m.

D. The centralized screening worker and supervisor did not assign an appropriate response time to the report.

The time frame for response is based upon the information gathered through a thorough screening. DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 303, Time Frames for Initial Response (3-5-97) (amended 4-4-05).[18] The initial referral was coded for a 24-hour response. However, due to the circumstances of the report (the age of the child, the nature of the abuse, and the anonymity of the perpetrator), it should have been coded for an "immediate" response. The DYFS Field Operations Casework Policy and Procedures Manual outlines situations requiring immediate response. "The Division shall respond immediately upon receipt of the referral when the screening indicates that: … (7) The severity of a referral situation is in doubt." DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 303.1, Situations Requiring Immediate Response (6-25-01) (amended as DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 208.6, Determining Need for "Immediate" Response (11-22-04)).

The report was for possible physical abuse of a two-month-old child. Although the reporter and the birth mother alleged that the babysitter, Babysitter A, was the perpetrator, the centralized screening worker had no way of accurately ruling out all other possible perpetrators. Specifically, it was unknown whether the biological father, biological mother, or any other person with continuing access to the child caused the injury. By coding a 24-hour response time, the centralized screening unit potentially left the child at risk for ongoing abuse.

Likewise, DYFS' current policy would leave a child with similar injury at risk for ongoing abuse. That policy, implemented a week after Angel's death, includes seven criteria to determine when an "immediate response" is warranted. The circumstances presented in this case do not fall with the outlined criteria and, thus, would not necessitate an immediate response time.[19] DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 208.6, Determining Need for "Immediate" Response (11-22-04).

E. The Case Manager failed to respond within the assigned field response time.

Although coded for a 24-hour field response time, the case manager reported to the OCA that the case "came in as immediate." Thus, she believed that the nature and seriousness of the allegation required immediate action. Despite this belief, she admitted to the OCA

[18] Where policy amendment has no effect on the analysis, the amendment date is noted parenthetically without further explanation.

[19] If the centralized screener accepts a report for a child abuse/neglect investigation, rules out the seven criteria, yet still believes an "immediate response" is needed to assure the safety of the child, he or she can request a "discretionary override" from the Call Floor Supervisor. DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 208.7, Discretionary Override (11-22-04).

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that she did not make contact with the family until 5 calendar days after the referral was received at the SCR, on November 8, 2004.

By way of explanation, the case manager told OCA staff that she attempted to contact the family on November 4, 2004 but "it was very very rainy that night and nobody was home." The case manager stated that she went to respond to another immediate referral until approximately 11:00 p.m. that night. The case manager stated that she did not return to the Cartagena home that evening because of the weather and fear for her own safety. The case manager further stated that she called her supervisor that night and informed her that she would return to the Cartagena home the next day or "the next day [she] returned back to work."

The case manager reported that she did not work on November 5, 2004 (Friday), November 6, 2004 (Saturday), or November 7, 2004 (Sunday) nor did she request coverage for this case. On November 8, 2004 (Monday), she made her first contact with the family. Due to her actions, and the failure of her supervisor to reassign the initial response to another case manager in the unit, the child remained at-risk in a potentially abusive situation for four days.

Under DYFS policies implemented on December 30, 2004, the case manager would have been required to make contact or "good faith effort" to see the child within 24 hours of the SCR Screener assigning the report to the field office for investigation. As such, she would have been required to make a minimum of three attempts to see Angel within the first 24 hours instead of only one. DYFS Field Operations Casework Policy and Procedures Manual, II R Child Protection Investigations, 402, Good Faith Effort (12-30-04).

F. The Case Manager failed to make personal contact with all primary and collateral contacts, including the alleged perpetrator.

The DYFS Manual entitled *District Office Case Handling Standards for Screening, Investigation & Initial Child Welfare Assessment* (March 1996) states:

> *During the initial field investigation, the response worker makes personal contact and collects information from all primary witnesses and persons involved in the incident(s), including the alleged perpetrator (if not barred from doing so by the police or the county prosecutor's office), as soon as possible after the immediate physical safety of the child or other endangered family members is assured and any necessary medical treatment has been provided.* (p.21)

According to both her referral response report and interview, the case manager made three attempts to make personal contact with the biological mother, Mr. Cartagena, and Angel at their home. The referral response report indicates those attempts occurred on November 4, 2004 at 4:30 p.m., November 4, 2004 at 7:30 p.m. and November 9, 2004 at 5:19 p.m. However, the case manager indicated during her interview that those attempts

occurred on November 4, 2004, November 8, 2004, and November 9, 2004. While she reports being able to make personal contact with the biological mother and Angel during two of those visits, she consistently failed to make contact with Mr. Cartagena.

The case manager's attempts to contact Mr. Cartagena were limited to three visits to the home. She made no telephone calls to the home or to Mr. Cartagena's place of employment. On November 9, 2004, the case manager's visit occurred 19 minutes after Mr. Cartagena was scheduled to leave work. She admitted in her interview that she was only in the home 10 to 15 minutes and did not want to wait for Mr. Cartagena because the biological mother did not know when he would be home. No further attempts to contact Mr. Cartagena were made after November 9, 2004 and the case manager never spoke with him.

The case manager told OCA staff that she believed that the child was not in any immediate danger since Babysitter A was the alleged perpetrator and she would have no further contact with the child. However, since Mr. Cartagena had not been ruled out conclusively as the perpetrator, she should have contacted and interviewed him.

Additionally, the case manager should have made efforts to contact Babysitter A. However, she made none despite having Babysitter A's address and telephone number. During her interview, the case manager stated that she "was going to speak with her eventually" but wanted to speak with Mr. Cartagena first. DYFS Field Operations Casework Policy and Procedures Manual, II C Protective Services, 411, Order of Interviews (12-22-03) indicates a preference for interviewing non-offending parents, guardians and caregivers prior to alleged perpetrators; however, the policy states that this schedule "may not always be feasible, realistic or appropriate." Further, since Mr. Cartagena had not been conclusively ruled-out as the perpetrator, even policy would not suggest that he be interviewed prior to Babysitter A.

Upon learning that Babysitter A only spoke Spanish, the case manager stated that she requested the assistance of a Spanish-speaking DYFS colleague. According to the case manager, she contacted Babysitter A on November 15, 2005. There is nothing in her referral response report indicating that this contact was made.

Lastly, the case manager admitted to the OCA that she does not routinely speak with doctors in the course of her investigations. Her intention was to fax a medical inquiry to the referent and place the completed form in the file. On April 4, 2005, DYFS formalized a new policy contrary to this practice. Policy clearly states that "[i]t is not acceptable to mail a collateral contact form to a school, doctor, or other source." DYFS Field Operations Casework Policy and Procedures Manual, II R Child Protection Investigations, 801, Collateral Contacts (4-4-05). Further, DYFS Field Operations Casework Policy and Procedures Manual, II R Child Protection Investigations, 1805, Requirements for Initial Investigation (12-30-04) requires the case manager to interview the reporter and the physician who treated the current injury, if other than the reporter.

G. The Case Manager failed to ameliorate the existing language barrier.

Although the case manager was unaware of the biological mother's inability to speak English prior to her initial contact with her, she was aware of the fact during and after that first visit. In her referral response report, the case manager made several references to the biological mother's limited knowledge of the English language. "Mom…answered every question to the best of her abilities, language barrier-Spanish speaking family" and "Mother nodded her head up and down as yes she understood." In her interview, the case manager said that the biological mother spoke in "broken English" and she used "hand gestures" to communicate with her because she was "Spanish-speaking only."

Despite her knowledge of the language barrier and the recommendation in her referral response report "assistance with Spanish speaking worker to return to home," the case manager made at least one subsequent visit to the home without the assistance of Spanish-speaking buddy or an interpreter. During her interview, the case manager initially stated that she had planned to have an interpreter speak with Mr. Cartagena at the same time that he spoke with the maternal aunt and Babysitter A. Subsequently, she stated that she returned to the home without an interpreter because she had been informed that Mr. Cartagena spoke English.

After the case manager's first visit with the biological mother, she reportedly had a telephone conference with her supervisor. The notes from that conference are not in the case record so the substance of the conference is unknown. If one assumes that the case manager informed her supervisor of the language barrier, the supervisor should have assigned a bilingual "buddy" or assured the availability of an interpreter throughout the investigation. The role of the supervisor is to assign "a buddy to accompany the primary response worker as necessary." DYFS Field Operations Casework Policy and Procedures Manual, II C Protective Services, 404, The Supervisor's Role in Investigations (2-24-97).

In addition, DYFS Field Operations Casework Policy and Procedures Manual, II B Initial Response, 1227, Foreign Language Interpreters (3-7-97) indicates that "[w]hen the client family does not speak a language [in which the] assigned worker is conversant, the services of an interpreter are obtained. Do not rely on other family members or friends to provide interpreting services." This policy also provides for DYFS to pay for the service if necessary.

The presence of a Spanish-speaking buddy or interpreter would have ensured there was no miscommunication and misunderstanding between the case manager and the biological mother. To illustrate this point, it should be noted that there are some discrepancies between the information reported by the case manager and information reported by SPRU Worker B who was assisted by a Spanish-speaking buddy (e.g., the date of the biological mother's father's death in relationship to the child's birth and the extent of the biological mother's depression). It should also be noted that during the initial visit, she reportedly signed several important documents, including the safety plan. Since the case manager is not conversant in Spanish, it would have been impossible for

her to appropriately engage the biological mother in developing the safety plan, or to explain the content of these documents to her prior to having her sign them.

The lack of available Spanish-speaking workers and a defined protocol for obtaining their assistance negatively affected the investigation. During her OCA interview, the case manager stated the process for obtaining a Spanish-speaking buddy was informal. No preference was given to her investigation. She informed OCA staff that since there is only one Spanish-speaking worker in her unit, she had to wait until he was available to accompany her. Reportedly, the case manager contacted the Spanish-speaking worker on November 10, 2004 and the meetings with Babysitter A and the maternal aunt were scheduled for and held on November 15, 2004. According to the case manager, she was unable to speak with the alleged perpetrator until twelve days after the abuse was reported.[20]

H. The Case Manager did not make contact with or conduct an investigation of the other persons regularly frequenting or living in the home.

According to the case manager's referral response report the maternal aunt was in the kitchen preparing dinner when the case manager visited the Cartagena home. Although the biological mother said that her sister did not live in the home, the fact that she was cooking dinner could suggest that she spent a fair amount of time in the home and had frequent contact with Angel. Additionally, she may have had information about Angel's injuries that could have assisted the case manager in her investigation. "The investigation includes contacts with those people who, by the nature of their relationship to the child, the family, the alleged perpetrator, or the incident, will be able to give the most relevant information. The Case Manager interviews any person who may have been a witness to the incident, or past incidents, and attempts to contact and interview any person who could reasonably be expected to have information relevant to the investigation." DYFS Field Operations Casework Policy and Procedures Manual II C Protective Services, 410, Interviewing, Gathering, and Verifying Information (12-22-03) (amended 4-4-05). However, the case manager did not speak with the maternal aunt. During her interview with the OCA, the case manager indicated that she did not speak with her because the maternal aunt did not speak English.

Although the language barrier prevented the case manager from speaking with the maternal aunt, the case manager should have conducted a CARI check on the maternal aunt. DYFS Field Operations Casework Policy and Procedures Manual II A General Policy and Procedures, 2004.2, Procedures for Assessing Safety (4-15-04) (amended 4-11-05). The centralized screening worker completed SIS inquiry on the parents, the biological mother and Mr. Cartagena; however, none was ever done on the maternal aunt (as would be required by the amended version of the aforementioned policy). No check of any kind was documented on Babysitter A, the alleged perpetrator.[21]

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[20] There is nothing in the referral response report indicating that the case manager contacted a Spanish-speaking buddy or that the meetings with Babysitter A and the maternal aunt took place.

[21] Even though the case manager may not have had the Babysitter A's last name, she could have used the address to obtain a last name.

I. The Case Manager did not inspect the child's injuries.

Reportedly, the case manager visited the Cartagena home on three separate occasions and met with the biological mother and Angel twice. There is no evidence that the case manager inspected Angel's injury on any of these visits. DYFS Field Operations Casework Policy and Procedures Manual, II C Protective Services, 417, Inspecting the Child for Signs of Physical Abuse (2-24-97) states:

> *If physical abuse with injuries has been alleged, or if the Case Manager has reason to believe that the child has injuries that were not mentioned in the original allegation, the Case Manager conducts a visual inspection of all child subject of the investigation and each child living in the home who may have been physically abused. The Case Manager observes for marks, lacerations, abrasions, welts, burns, and bruises.*[22]

The case manager told the OCA staff that she asked the biological mother if she could see the child's bruise but was informed that it had disappeared. Instead of asking her to remove Angel's clothing, the case manager relied on this statement. Further, the case manager stated that the child was sleeping and she did not want to wake him. The biological mother's assertion that the bruise had faded and the case manager's desire not to disturb the child do not constitute "good reason" why it would be unnecessary to conduct the required visual inspection nor was a reason documented on her response report.[23] The case manager acknowledged during the OCA interview that she should have inspected the child for injuries.

J. DYFS did not provide appropriate support services to the family (daycare, mental health evaluation/treatment).

According to the case manager's referral response report, during her visit to the Cartagena home on November 9, 2004 the case manager learned the biological mother was dealing with the pressures of parenting a two-month-old child in addition to the recent death of her father. Despite learning this information, the case manager she did

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[22] Applicable DYFS agency policy was amended subsequent to the agency's involvement with the family. Amended policy is consistent in requiring observation and documentation of injuries in cases of alleged physical abuse. DYFS Field Operations Casework Policy and Procedures Manual, II R Child Protection Investigations, 1804, Investigating a Report (12-30-04) requires the case manager investigating a report involving a bruise to verify the typology of the injury including the exact location and DYFS Field Operations Casework Policy and Procedures Manual, II R Child Protection Investigations, 1805, Requirements for Initial Investigation (12-30-04) requires the case manager to assess the child victim's physical injury.

[23] If a worker decides for good reason that it is unnecessary to conduct a visual inspection of all children in the home, the worker must document the reason for that decision clearly in the response report and must additionally report and explain the decision to his or her supervisor at the earliest possible opportunity. DYFS Field Operations Casework Policy and Procedures Manual, II C Protective Services, 417.1a, Exceptions (2-24-97).

not offer any support services to the family, such as counseling. There is a recommendation in the referral response report "Mom to complete Psychological Evaluation to rule out any depression" but no psychological evaluation was ever requested nor was this recommendation communicated to the biological mother.

In fact, during her OCA interview, the case manager could not recall why she would have recommended a psychological evaluation because she did not learn of the death of the biological mother's father until November 15, 2004. At that time, the case manager stated, she offered her grief counseling or therapy but was informed that she had already been offered services through the police department.

K. The physician was unable to determine if Angel's initial injury was due to physical abuse.

The doctor indicated that she was unable to determine if the injury was due to abuse, but she appropriately relayed her suspicions to DYFS. The standard for mandatory reporting is that there exists reason to suspect child abuse or neglect. DYFS relies on the medical community to examine children's injuries and elevate suspicions if, for example, the explanation for an injury is inconsistent with its clinical presentation. The child welfare system will be much stronger when all pediatricians consider the reporting of suspicions, not diagnoses, and when the medical community and DYFS case managers have sufficient access to the expertise and support of the New Jersey's Regional Diagnostic and Treatment Centers in the diagnosis and treatment of abuse or neglect.

PHILIP O'DONNELL DATE OF DEATH: FEBRUARY 22, 2005

On February 22, 2005, the aunt of Philip O'Donnell (D.O.B September 10, 1998) received a call from his school to inquire why the first grader was absent that day. Highland Park school officials had not been able to establish contact with Philip's mother, Alice O'Donnell. Prompted by the call, Philip's aunt reportedly went to the apartment and discovered that her nephew was deceased. Local police were called to the scene. The Middlesex County Prosecutor charged Ms. O'Donnell in connection with his death. A preliminary report from the Middlesex County Medical Examiner indicates that Philip had received an overdose of cold medicine and that he died as a result of suffocation.

The O'Donnell family's involvement with DYFS includes three calls to the State's centralized child abuse hotline regarding Philip: (1) an initial call on February 9, 2005, by a Highland Park school official, reporting that Philip, who was absent without explanation from school that day, had not been picked up by his mother the previous day; the caller indicated Philip recently revealed that his mother, the only other person living in the residence, could frequently not be awakened, and the caller expressed a concern for the child based on the caller's belief that the mother's mental health status was fragile; (2) a second call on February 17, 2005, by the same school official, to report further details about Ms. O'Donnell's mental health status and the possibility of a sexual abuse allegation regarding this child; and (3) a call from the county prosecutor's office, on February 22, 2005, to report Philip's death.

I. INFORMATION 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 O'Donnell family prior to Philip's death. That information includes:

i. CCAPTA Notice prepared by DHS, dated February 22, 2005;
ii. Child Death Summary prepared by DHS, dated February 22, 2005;
iii. Case Chronology submitted by DHS;
iv. Partial copy of DYFS Case record;
v. Caseworker safety assessment on O'Donnell family (not in DYFS file at time produced to OCA, but produced subsequently during the OCA interview with the Intake Case Manager);
vi. Personnel records of relevant DYFS employees;
vii. Copy of Philip O'Donnell's school records – Highland Park and Bayonne;
viii. Copy of Hudson and Middlesex Counties' welfare records, including requests for Medicaid, of the O'Donnell family;
ix. Preliminary Report of the Middlesex County Medical Examiner;
x. Interviews with the DYFS Screener, Intake Worker and Intake Supervisor;
xi. Interviews with three Highland Park school officials;
xii. Interview with Middlesex County public welfare employee;
xiii. Policies and procedures regarding screening and handling of child welfare assessments, prepared by DHS dated December 29, 2004;

xiv. Copy of Medicaid Management Information System information outlining all Medicaid payments for service for Philip and Alice O'Donnell from February 1998 through September 2004;
xv. Copy of DYFS Call Log Sheet for all Screeners, February 17, 2005;
xvi. Interview, family pharmacist;
xvii. Interview, certain family and friends of Alice O'Donnell;
xviii. Interview, family physician.

II. REVIEW OF DYFS' INVOLVEMENT WITH THE FAMILY

Initial Referral: February 9, 2005

At 1:58 p.m. on February 9, 2005, the DYFS State Central Registry (SCR) received a call from a school official at Philip O'Donnell's Highland Park elementary school. The caller reported multiple concerns. She stated that "all school year, Philip (6-year-old) ha[d] been reporting, occasionally, that his mother [was] asleep on the floor and he could not wake her." The school official went on to explain that Ms. O'Donnell had not picked Philip up from school the previous day and the home had no telephone service. When Ms. O'Donnell had failed to retrieve Philip into the late afternoon the day before, a school employee escorted Philip home. Ms. O'Donnell reported to that employee that she had taken high blood pressure medication at 11:30 a.m. and had fallen asleep. The caller further alleged that Ms. O'Donnell told school employees that she had been depressed and that she had been diagnosed with mental health disorders. The school official added that there was a man who had been walking the child back and forth from school earlier in the year, whom Philip had recently been told by his mother was "evil" and the child was forbidden to see this friend of the family. Finally, the caller stated that Philip was sometimes unkempt, dirty and had body odor, and was absent an unusually high number of 15 days this year. She was concerned that he was again absent on the day of the referral. The school official later stated that it was her understanding that DYFS would respond to the O'Donnell household immediately.

The DYFS screener completed an intake summary of the reported information, noted that the mother was the only parent; that there were no other household members; the age of the child; the address of the home and the identity of the referent; and found no prior DYFS history on this family. Based on her initial assessment of the information gathered from the referent, the screener determined that the case should be handled as a child welfare assessment, rather than as a child protective services investigation. The screener indicated that her judgment regarding the coding of the case was based on a perceived absence of an allegation of child abuse or neglect and risk of harm. The screener determined that there was no immediate concern for this child and therefore coded the case as a "CWS," child welfare service response, with a response time of "within five (business) days." During an interview with the OCA, the screener indicated that she is permitted to make independent decisions about coding and response time and consults with her supervisor in these matters as she deems necessary.

The case was referred to the DYFS Edison DO, where the intake supervisor recorded the referral at 5:00 p.m. that evening and took no further action that day. The screening process began at approximately 2:00 p.m.; this represents a 3-hour time lag from the initial phone call to receipt of the referral. DHS/DYFS policy requires the SCR screener to transmit the report packet to the field office for assignment of the report within one (1) hour of answering a reporter's call to SCR.[24]

February 10, 2005

The Edison DO supervisor assigned the O'Donnell child welfare assessment to an intake worker in his unit at 9:00 a.m. The supervisor documented a discussion with the worker about the case on a "Supervisors Case Assignment Sheet – Pre-Case Conference." The supervisor's notes from the conference contain a synopsis of the case situation and expectations of tasks to be completed by the worker. The supervisor's synopsis restates the allegations and family information captured on the intake summary prepared at screening. The supervisor directed the worker to call the school that day to determine if Philip was present, and if so, interview the child and the referent that day at the school. The supervisor also provided direction to ascertain background information, including determining if the caregiver had a prior criminal or child abuse history, and instructed the worker to obtain collateral information on the family, identify any medications Ms. O'Donnell may have been taking and assess her mental health status. The worker was directed to assess the need for services "(school issue, value options and welfare)", develop a case plan and conference the situation with the supervisor again. The supervisor directed the worker to complete the "K-8" (statement of findings and conclusions) ASAP. There is no indication in the case record that the intake worker made any attempt to address the activities identified for completion on February 10, 2005; no call to the school to determine if Philip was present and no attempt to interview the child and the referent at the school.

Philip was present in school on February 10, 2005. The school official asked his teacher to probe to determine if DYFS had responded to the home yet. The teacher asked Philip if a stranger had come to their home yesterday to meet with his mother, and he indicated that he thought someone had. The teacher and school official therefore believed that DYFS had been out to the O'Donnell home on the previous day.

February 15, 2005

Despite the supervisor's directive, there was no action on this referral by the worker until February 15, 2005. The intake worker indicated that his ability to respond immediately to assess the O'Donnell family was impacted by a large caseload of 63 children. The supervisor, however, represented to the OCA that the worker had a caseload of 41 children at the time he was handling the O'Donnell case. The worker and the supervisor indicated that the significant discrepancy in caseload size was, in part, explained by error in the transmission of information between two data management systems now being used by DYFS. Reportedly, DYFS/SCR enters allegations of abuse or neglect screening

[24] DYFS Field Operations Casework Policy and Procedures Manual II B 213.2, revised July 1, 2004.

information quickly into a new NJ SPIRIT computer system. The NJ SPIRIT system converts incident reports automatically into SIS. There have been significant technical problems in the data transfer. The DYFS estimated that initially as many as 50% of the cases were not automatically transferring into SIS, necessitating manual input of the data by the production control unit in the screening unit. DYFS reported significant improvement in the data transfer but acknowledged continuing problems in this area.

The worker and supervisor in this case reported having to flag cases for SCR in order to have a production control unit enter them in manually. This would establish a case tracking code, which identifies open cases and permits DYFS reports to be completed as part of case management. Since the case must be entered and active on SIS for DYFS workers to complete tracking reports and forms, the worker described these cases lost in "the bridge" as difficult to manage. Furthermore, the utilization of these two systems, and the gaps between them, distort the actual DYFS caseloads by making them appear smaller than they are in instances such as this. The supervisor believed it doubtful that the dual data systems would fully account for the 22 child discrepancy in caseload size, but offered no alternative explanation.

On Tuesday, February 15, 2005, the case record reflects that the worker made an attempt to visit the O'Donnell family, but was unable to locate the home. The worker reported that "two streets that ran parallel had the same name" and due to the confusing nature to these streets, he was looking for the home on the wrong road. There was no further attempt to locate the home, such as consulting a map or asking for directions, nor was there any effort to see the child at school that day, or the next day.

Second Referral: February 17, 2005

According to the Highland Park school official**,** Ms. O'Donnell attended a parent support group at the school on the morning of February 17, 2005, for the first time, and was the only parent to attend that session. A school counselor facilitated this private session with the aid of another counselor for over an hour. Ms. O'Donnell reportedly revealed that she was depressed following the loss of both her life partner and her mother within a relatively recent and close period of time.[25] Ms. O'Donnell also reportedly disclosed feelings of anxiety and worries regarding the continued stability of her family due to her lack of income and continued unemployment. Ms. O'Donnell explained that she acquired counseling for Philip while they lived in Hudson County because she believed Philip had also been affected by the recent deaths. The school counselor indicated that she suggested that Ms. O'Donnell seek mental health supports for herself.

According to the school official, one of the most concerning issues raised during this parent support group was Ms. O'Donnell's allegation that her son may have been subjected recently to inappropriate sexual behavior by an adult family friend. Ms. O'Donnell reportedly alleged that she had allowed the friend to stay overnight on the couch in her apartment, and she awoke the next morning to find the person in bed with

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[25] Our investigation confirms that Ms. O'Donnell's life partner had died within the past year, but Ms. O'Donnell's mother is not deceased.

Philip. Both Philip and the friend were fully clothed, but she worried that there may have been inappropriate sexual contact. Ms. O'Donnell explained that she threw the person out of the house, threatened to call the police if they ever came near her or Philip again, and directed Philip not to see this person again.[26]

Ms. O'Donnell reportedly left the support group with a referral from the school to call Value Options to seek help to address her mental health needs. Value Options is part of the DHS child behavioral health system, and as such, does not provide support services to adults with mental health needs. Value Options does not function as an information and referral service for adult mental health services either, so the referral could not have – and did not - lead to services or aid.

After Ms. O'Donnell left, the school official had a heightened sense of worry for the family and placed another call to DYFS centralized screening. The school official reported to the OCA that she attempted to report the sexual abuse allegation through DYFS/SCR. She phoned the SCR hotline and told them she had "additional information on this case." According to the school official, the screener instructed her to call the Edison DO without engaging her in a discussion to ascertain the nature of the additional information she had to offer. The SCR call log on February 17, 2005, indicates that a school official called at 11:22 a.m. and, during a call of 30 seconds in duration, the school official was directed to call the DO where the case was being investigated. The SCR call log does not capture any level of detail, such as the name of the caller, child in concern or phone number so the OCA is unable to fully reconcile the information provided by the school official with the call log. However, this is the only school counselor in the log that day and it is consistent with the time of day the school official reportedly called the SCR. The school official reported that she then phoned the Edison DO where her call was transferred to the phone message system of the DYFS worker. The worker subsequently left a message with the school official indicating that he would be out to the school shortly to visit Philip and to speak with her.

The worker responded to the school and interviewed the school official, who reiterated her concerns as initially related to the screener on February 9, 2005. She described the schools' experience with the family to date, including the fact that Philip had repeatedly spoken about his inability to awaken his mother at home and his fears in this situation. The counselor also told the worker the information Ms. O'Donnell alleged earlier in the day regarding the family friend in Philip's bed lying next to her son, and she shared her concerns regarding Ms. O'Donnell's mental health status. During her conversation with the DYFS worker, the school official learned that there had not been a DYFS response to the home yet based on her February 9, 2005 call to DYFS.

The worker then interviewed Philip O'Donnell in the presence of the school official. The worker noted in one of the DYFS records, known as the referral response sheet (case summary), "Philip was not dirty or disheveled that day." Based on the worker's

[26] The family friend reported to OCA that Ms. O'Donnell manufactured the allegation after the man challenged her following a dispute regarding her unauthorized use of his vehicle. Certain family members of Ms. O'Donnell also expressed doubt about the veracity of the allegation.

recollection and case notes, the information Philip shared with the worker was consistent with what he had told school officials. Philip explained that his mother told him that her medicine makes her very sleepy. According to the worker, Philip reported a good relationship with his mother. When asked about the close family friend who had slept at his home, Philip explained that he was not permitted to see this person ever again, though he did not know why. During the OCA interview, the DYFS worker acknowledged that he did not probe to determine what may have happened because he did not interpret the information received from the school official as an allegation of sexual abuse. The case worker did not identify this child for a forensically appropriate/child sensitive interview by a trained interviewer, nor did he discuss the allegation with his supervisor to potentially upgrade the urgency of this case. Documentation in the case record bears no indication of concern regarding this information.

The intake worker did not meet with Philip's teacher, nor review Philip's school records during the course of the child welfare assessment. Lack of exploration in these two areas left the worker at a distinct disadvantage in coming to understand fully this family's situation. When the OCA spoke to the teacher following Philip's death, the teacher reported that Philip's explanation for his absences had not matched his mother's for the same days. The teacher had serious enough concerns prior to Philip's death regarding his numerous absences that she requested Philip's school records from Hudson County through the principal. OCA independently obtained the child's Hudson County school records, which document 35 absences in the previous school year.

Philip's school records provide valuable insight into the family's situation as well. Philip had been identified earlier in the year as needing academic supports to bring him to an age-appropriate readiness to learn. His teacher had facilitated the family's participation in a district-sponsored literacy program, which offered Philip and his mother the opportunity to work one-on-one with a reading coach, who came to their home or met them at the library. Ms. O'Donnell and Philip by all accounts welcomed this opportunity and had been engaged in the program for several months. The reading coach noted in Philip's school file that Ms. O'Donnell was sometimes grumpy, and repeatedly anxiety-ridden, weepy and depressed. During one session, Ms. O'Donnell reportedly excused herself because she was having a panic attack. On multiple occasions, the reading coach noted in the record that Ms. O'Donnell was sad and upset. On one occasion she noted that Philip's mother cried during the entire visit. The reading coach documented in Philip's file that Ms. O'Donnell once explained that she was unable to obtain her medication for seizures and a psychiatric condition because she could not afford them and was without health insurance.

By late January 2005, the reading coach conducted a parent survey with Ms. O'Donnell in which Ms. O'Donnell indicated very low self-esteem and feelings of being useless. The reading coach gave Ms. O'Donnell a recommendation for possible low-cost mental health support services. The reading coach spoke to the school official whose increased level of concern prompted her to call DYFS and air her discomfort, given her assessment of the mother's mental health status and its impact on Philip. The reading coach clearly found Ms. O'Donnell's perceived mental state to be noteworthy; however it remains

unclear if she recognized or understood the risks of child maltreatment associated with unmet mental health needs of a caregiver, or the appropriate steps to take to obtain help for the family.

After leaving the school on February 17, 2005, the DYFS worker located the O'Donnell residence and met with Ms. O'Donnell. Philip was also home at the time of the visit. Ms. O'Donnell offered explanations for her failure to pick up Philip from school and for occasions that Philip could not awaken her, attributing both to the effects of her medication. She identified her current medications to include several psychiatric drugs, reportedly prescribed for anxiety, depression, and seizures. There is no indication that the worker discussed the risks to Philip or the family associated with his inability to arouse his mother from sleep, the overall impact of her medication on her parenting of Philip or informal/formal supports available to assist Ms. O'Donnell with Philip's care until she was able to have her medications evaluated, and possibly adjusted to permit her to more effectively parent Philip independently.

Ms. O'Donnell reportedly indicated she was not seeing a therapist due to lack of health insurance. The worker noted that Ms. O'Donnell claimed to be coming out of her depression and said she was most concerned about getting employment or some assistance so that she would not be evicted, as she was served notice by her landlord recently for failure to pay rent. Ms. O'Donnell was also concerned about her ability to provide food for Philip. She told the worker that Middlesex County recently denied her application for welfare assistance. She asked the DYFS worker for help to prevent her and Philip from becoming homeless.

The worker asked Ms. O'Donnell about the allegation regarding a family friend whom she purportedly discovered in bed with Philip. Ms. O'Donnell related the account she had previously shared with the school official. She added that when she found the person in bed with Philip one morning, both were fully clothed, but Ms. O'Donnell reportedly said she "had a bad feeling about it." The worker documented the account in the child welfare assessment but took no further action. When interviewed by the OCA, the worker related that Ms. O'Donnell told him this story, but did not think it constituted an allegation of possible sexual abuse.

During the OCA interview with the supervisor, he indicated he had no knowledge of this information as shared by the school official, or subsequently as shared by Ms. O'Donnell, until he reviewed the child welfare assessment prepared by the worker after Philip's death. However, the supervisor concurred with the judgment of the worker that the information provided by the school official was not a sexual abuse allegation and did not warrant additional investigation.

The DYFS case record produced by DHS to the OCA did not contain any formal assessments made in the home during the initial visit – no safety assessment and no strengths/needs assessment. The OCA obtained a copy of a safety assessment directly from the worker during his OCA interview, almost a month after Philip's death. The DYFS case record included a "Case Plan in Home" form, dated February 17, 2005, which

was only partially completed, but was signed, by the worker and Ms. O'Donnell. This form states agreement by Ms. O'Donnell to keep Philip safe and meet his basic needs. It does not say how Ms. O'Donnell would do that, or how the state would help her. The form further establishes agreement that Ms. O'Donnell would call Value Options[27] for counseling. As previously indicated, this referral was pointless since Value Options does not provide adult mental health services or referrals for those services.

February 18, 2005

On February 18, 2005, the DYFS worker discussed his assessment of the O'Donnell family with his supervisor. The worker noted the "emotional issues" and admission of "psychiatric and psychological issues" of mother, the lack of financial stability in the home, denial of welfare, and apparent estrangement of Ms. O'Donnell and Philip from their family, as key areas of concern. The worker requested that DYFS provide Ms. O'Donnell with rental assistance. The supervisor directed the worker to get Ms. O'Donnell to "state what her plan is," to advise her to seek help from Value Options, to send out releases for collaterals, and to submit a request for a rental subsidy for the family, pending a "plan of action" obtained from Ms. O'Donnell.

The worker phoned Ms. O'Donnell and discussed the need for her to develop a plan for sustaining her family. The case record indicates that Ms. O'Donnell stated that she was seeking employment. The worker noted he inquired about her plan to pay her next month's rent and Ms. O'Donnell reportedly indicated that if DYFS could not help, a family member had offered to assist. The case record further reflects that during this call, the worker advised Ms. O'Donnell that he would submit a request for rental assistance on her behalf but that DYFS was not likely to help with the rent unless she had a better long term plan for income. The worker directed Ms. O'Donnell to go back to the Middlesex County welfare office to reapply. The worker did not assist Ms. O'Donnell in any way to secure financial stability for her family; the worker did not connect with the county welfare office to determine the reason the family was being denied assistance or to intervene on behalf of the family. Although the worker identified Ms. O'Donnell as overwhelmed with "emotional issues" and "psychiatric and psychological issues," the worker did not assist her in the application process by going with her to the welfare office or otherwise paving the way for her to be successful in gaining assistance from the welfare office.

Third Referral: February 22, 2005 – Child Fatality

At 11:30 a.m., on Tuesday, February 22, 2005, after a long holiday weekend, the DYFS SCR hotline received a call from the Middlesex County Prosecutor's Office reporting the death of Philip O'Donnell. The detective alleged that Ms. O'Donnell had overdosed her son and suffocated him with a pillow. The police had found Philip about 45 minutes earlier, and the detective's contact with the crime scene and the family led him to believe

[27] Here again Ms. O'Donnell received an inappropriate referral to Value Options. During this review, the OCA independently contacted Value Options on several occasions and confirmed that it does not provide adult mental health services or referral.

DYFS was involved prior to Philip's death. The detective asked that the assigned worker contact him prior to responding to the residence.

The DYFS worker indicated he was at a new worker training session when he was called by his supervisor and informed of Philip's death. The supervisor directed the worker to leave the training to go to the O'Donnell residence to see what information could be gathered about Philip's death. The supervisor and the worker each indicated, in separate interviews with OCA, that they jointly responded to the area of the home, but left without making personal contact with anyone or gathering additional information. The DYFS case notes contradict the worker's and supervisor's account of the visit's purpose. The case record notation implies this was a routine visit "in order to do follow up visit with Alice O'Donnell."

Following Philip's death, the worker prepared the child welfare assessment summary of the O'Donnell family and submitted it for review and approval by the supervisor later that day. The summary was dated and signed by the supervisor on the same day. Neither the worker nor the supervisor identified any red flags in the case. The recommendation, oddly, was that the case be transferred and opened for supervision to help with financial issues and supervise mother's mental health status, in that order. Since Philip was already deceased and DYFS staff knew the agency would not be supervising this family, the best that can be said of the flurry of documentation from February 22, 2005, is that it may reflect the plans of the worker and supervisor following their prior interaction with the family.

Upon learning of the death of Philip O'Donnell late in the day on February 22, 2005, we conducted an independent online search of the DYFS Service Information System (SIS) to determine if the family was known to DYFS. The OCA found no record of Ms. O'Donnell or Philip in SIS. The DYFS intake worker later advised us that he could not input his data on this case before February 22, 2005 because he was waiting for a tracking number which would register the allegation within the SIS.

February 23, 2005

OCA conducted a follow-up search for any information regarding Ms. O'Donnell or Philip in SIS and found information dating back to February 9, 2005. Based on the interviews OCA conducted with DYFS employees, it appears that the child welfare assessment summary was completed in the early evening on February 22, 2005 or early February 23, 2005, after the O'Donnell family was entered into SIS and a tracking number was established. It should be noted that this logging and tracking ability occurred 13 days after the initial call to SCR, and hours after DYFS knew the child was already deceased.

The DYFS case record indicates that the Prosecutor's Office advised DYFS that Ms. O'Donnell was charged in connection with her son's death and was being assessed for psychiatric hospitalization. The preliminary autopsy results note as the cause of death – acute poisoning - and as the manner of death - mechanical asphyxiation.

III. ADDITIONAL HISTORY ON THE FAMILY

DHS Division of Family Development - County Welfare/Medicaid Services

Ms. O'Donnell and Philip were also well known to the State's Department of Human Services Division of Family Development (DFD), the principal division in state government charged with operating and overseeing welfare and income support programs. Ms. O'Donnell's welfare history indicates that she first applied for assistance in January 1998 in Hudson County, where she received services through April of 2002. The record indicates that Ms. O'Donnell became employed and her case was closed. She reapplied for emergency assistance in February 2003 and received services through September 2004. She was sanctioned beginning in May 2004 for a reported failure to maintain job search, as required by Work First NJ; her financial assistance and food stamps were eliminated. Medicaid services remained available to Ms. O'Donnell and Philip through September 2004 through Hudson County, at which time Hudson County was notified by Middlesex County that the family had applied in Middlesex's welfare office for aid.

After the death of her life partner, and her "sanctioned" reduction in welfare support, Ms. O'Donnell was served an eviction notice from the Hudson County apartment for inability to pay rent. On July 28, 2004, Ms. O'Donnell was notified that her lease had been terminated and they had to vacate the premises. Ms. O'Donnell and Philip moved into the home of her sibling in Morris County, temporarily. Late that summer, they again moved to the home of another sibling in Middlesex County. In September 2004, Ms. O'Donnell managed to secure a one year lease for an apartment in Highland Park. On September 21, 2004, Ms. O'Donnell enrolled Philip in elementary school. Ms. O'Donnell received some assistance from family and friends in moving and purchasing groceries to sustain the family during this time.

In August 2004, Ms. O'Donnell applied for emergency assistance, welfare supports and Medicaid through a Middlesex County welfare office. Records indicate that Ms. O'Donnell made regular calls and visits to the Middlesex welfare office to inquire as to the status of her application and to provide additional information. On August 20, 2004, Ms. O'Donnell applied for social security disability benefits for herself and her son. The receipt for application for these benefits notes that the standard length of time to process an application is 150 days.

On August 26, 2004, Middlesex County was able to document the approved transfer of Ms. O'Donnell's case from Hudson County. On September 7, 2004, Ms. O'Donnell filed an application at the Middlesex County welfare office for a waiver of the welfare work requirement based on disability and noted mental illness next to disability on the form. She submitted a copy of a receipt confirming that she had applied for social security based on the same disability.

Also on August 26, 2004, the Middlesex County welfare office sent a letter to the Hudson County welfare office to notify them that Middlesex had deemed the O'Donnells eligible and would be "picking her up" effective September 1, 2004. But this did not occur. On October 5, 2004, the Middlesex welfare records note for the first time that Ms. O'Donnell had not provided proof of Middlesex County residency and had 30 days to provide documentation to verify Middlesex residence. On October 5, 2004, a secretary in the welfare office took a phone message from Ms. O'Donnell. Ms. O'Donnell called to alert the worker to her urgent need for Medicaid so that she could obtain medications for her physical and mental health conditions. On October 22, 2004, Ms. O'Donnell was notified she was rejected for all assistance, including welfare, food stamps, emergency assistance and Medicaid, due to her failure to provide proof of Middlesex county residency. Middlesex County welfare officials indicated that Ms. O'Donnell could have returned to the welfare office with a postmarked letter to her Highland Park address, or the documentation which she had provided to the school to establish residency for Philip's elementary school enrollment, and satisfied the outstanding issue. One month previously, she had provided the local school with a U.S. Postal Service change of address confirmation and a complete copy of her apartment lease agreement, which remained on file at the school, in order to meet proof of residency with the school district.

On September 30, 2004, Medicaid made disbursements for several psychotropic medications for Ms. O'Donnell for the last time, according to government records. These same records indicate Ms. O'Donnell had been treated for a diagnosis of "prolonged post traumatic stress disorder" with counseling and medication management since at least June 1998. Through interviews with pharmacists, family and friends, the OCA has learned that Ms. O'Donnell may have continued to access some of her medications through early 2005. However, records do not indicate that she was supervised by a psychiatrist after September 2004, and it is unclear whether she was receiving any medication monitoring or counseling during the period of October 2004 through the time of Philip's death in February 2005.

Records indicate that some friends paid for some of her medication refills, and she received free samples from a physician now and again. In summary, it is not clear that Ms. O'Donnell's mental health treatment, from September 2004 through February 2005, was consistent or appropriate.

IV. PERSONNEL AND CASELOAD INFORMATION

The OCA reviewed personnel files for the screener and intake supervisor and found them to be unremarkable. These staff had appropriate education and experience for their respective roles, and as best can be determined, had satisfactory employment history with DYFS.

The DYFS worker is a Family Service Specialist Trainee, who has been employed for nine months. Prior to his hire by DYFS, he held several positions, including food warehouse supervisor, aluminum siding installer/carpenter and pizza delivery person/shift

manager. The worker has a Bachelor's Degree in criminal justice and listed two internships in the criminal justice arena on his resume.

Upon hire by DYFS, the worker attended the standard one-month classroom-based new worker training. Upon completion of new worker training, he was assigned to the child protective service intake unit in the Edison DO.[28] The worker was hired in May 2004, moved into a permanent title in October 2004 and was on probation until January 5, 2005.

V. FINDINGS AND CONCERNS

At the outset, we note that none of our concerns even remotely suggest that had any government entity acted differently, Philip would be alive today, or that Ms. O'Donnell's alleged conduct was the rational and inevitable result of government failings. Neither is true. Further, we underscore that the OCA did not conduct an investigation of the fatal incident to determine either criminal culpability or the veracity of Ms. O'Donnell's claims of mental health issues, as that prerogative rests in the sole purview of law enforcement authorities. As such, the concern noted relating to the reported mental health status of Ms. O'Donnell is presented solely to demonstrate how the child welfare system interacted with a person claiming to have those mental health issues, regardless of their truth or falsity, and to inform systemic reform going forward. The response of DYFS in this case raises concerns about policies and operations that have significant implications for thousands of children who rely on the system to work effectively. Following are detailed concerns regarding screening and case handling.

A. Screening

1. The "Allegations Based System," implemented by DYFS last year, uses the child's immediate safety or immediate risk of harm to the child as the threshold to trigger child protective services investigations. DYFS Policy directs hotline screeners to "focus and direct information from the call to gather information to determine whether a child is presently unsafe or at substantial risk of harm." The DYFS Field Operations Casework Policy and Procedures Manual II B 301 indicates that the Allegation Based System now employs 32 discrete categories of child abuse or neglect. DYFS abuse or neglect investigations and responses are now "strictly limited to the 32 allegations listed in the system." Each discrete category is defined and has a specific set of actions/responses that guide the investigation or assessment based on the nature of the allegation.

[28] An intake worker is responsible for investigations of allegations of child abuse and neglect. This role is best filled by experienced employees due to the depth and complexity of independent decision-making and assessment required in the field. The DYFS intake worker in this case was given a brief opportunity to shadow other staff and began managing a caseload under the supervision of the intake supervisor. The worker and the supervisor held that the worker was adequately prepared for his role and responsibilities in the intake unit.

The Allegations Based System, which identifies specific categories of harm and imminent risk to children, was modeled in large part on a similar system in Illinois. It is increasingly clear that the implementation of the Allegations Based System in July 2004 before DYFS had undertaken sufficient training reform and before it had connected its workforce with significant new services for families has not strengthened the safety net for children. The worries expressed to DYFS by the school official in this case justify both a thorough child protection investigation to ensure Philip's safety and a robust social work response to address the family's dire economic and health needs. The child welfare assessment in this case was neither: its pace and practice was suboptimal, at best. DYFS' agreement with Ms. O'Donnell to keep Philip safe, without actively addressing the family's poverty, pending eviction, lack of health insurance and her mental illness, was without meaning because it failed to address the issues most critical to the stability of the family. The fact that both the DYFS intake supervisor and intake worker urged upon Ms. O'Donnell a pointless referral to Value Options for adult mental health services suggests fundamental gaps in training, as well.

2. The initial referral on February 9, 2005, regarding Philip O'Donnell should have been screened as substantial risk of harm, based on the report of his mother's inability to care for him, his age, and the fact that he had not been seen that day at school.[29] The initial call on February 9, 2005, contained enough information to be coded as "Allegation #74, Inadequate Supervision," which is defined as a report where the "child has been placed in a situation or circumstances which are **likely** to require judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities would reasonably dictate. Examples include, but are not limited to: being present but unable to supervise because of the caregiver's condition (including a parent who cannot adequately supervise the child because of his/her medical condition)."[30] In addition to taking the report about the child in the care of an inadequate or inappropriate caregiver, the screener is directed by policy to note both child factors (including but not limited to the child's age and developmental stage, physical condition and mental abilities) and certain caregiver factors (such as the caregivers accessibility, capability, physical condition and cognitive or emotional condition). Further, the screener is directed to note the frequency of this occurrence, time of day, and the availability of other adults. DYFS policy notes, "this harm is always NEGLECT."

[29] In a DHS DYFS Inter-Office Memo dated February 22, 2005, the Acting Administrator of SCR reminded staff of common themes discussed in case practice seminars (continuous quality improvement sessions), including the critical nature of factoring in the age of the child in assessing the appropriate response (child protection investigation or child welfare assessment) and the need to obtain more information from the reporter in order to properly screen calls. "What may be of a minor concern to a teenager could be a major safety concern for an infant or toddler."

[30] DYFS Policy II B 1511, Definition of Allegation of Harm #74, Sections 3001-3003.

3. The practice of operating what is commonly referred to as a dual, or differential, response is increasingly common in child protection systems. All states have a child abuse and neglect response, in which they investigate families involuntarily, based on various state child protection laws. Involuntary intervention often includes the removal of children from the home or the imposition of supervision and regulation on the family. When allegations do not rise to the level of abuse or neglect, many states provide a response to families and children in need of services that involves voluntary engagement, based on the principle that the non-coercive provision of services can strengthen families and prevent family dissolution and harm to children. Families voluntarily engaged may accept assistance more readily, but the intervention of the child welfare worker is clearly limited and is contingent on parental assent.

   In a differential response system, the screener's decision regarding the nature of the allegations and required response is critical to assuring appropriate intervention with the family, whether voluntary or involuntary. In the O'Donnell case, the OCA determined that the SCR screener erroneously coded the report for a child welfare assessment, missing indicators of potential child neglect. Instead of initiating a neglect investigation within 24 hours, the effect of this decision was to sanction a less immediate agency response to the child's household within 5 business days and a less probative review of the family's situation.[31]

4. The determination of whether or not an allegation rises to the level of abuse or neglect is based on whether the screener interprets the information as posing a high risk to the child. Many of those cases which do not rise to this level according to the screener are designated for a child welfare assessment. To be successful, these assessments require workforce training and new services, as outlined above.

5. The Child Welfare Reform Plan directs that investigations and assessments be conducted by separate staff in order to avoid the prioritization of investigations and the marginalization of assigned assessments. This reform has not yet been realized in the field statewide, but appears imminent. In the interim, until this bifurcation of responsibility is actualized statewide, the present iteration of the differential response system leaves some DYFS case managers with the responsibility to conduct child protection investigations as well as child welfare assessments. The need to triage responses is common, and it is reasonable to expect that a case manager grappling with the competing demands of an intake caseload would prioritize the child protection investigation over the child welfare assessment. This approach leaves the child who is the subject of the child welfare assessment potentially at risk when competing for attention with a child who is the subject of allegations warranting a more immediate protection

[31] For example, children who are the subject of a child welfare assessment do not have to be interviewed by DYFS privately.

investigation. It is imperative that workers receive adequate training and supervision on forensic investigations and the detection of abuse or neglect before they undertake child welfare assessments.

In this case, Philip did not die before DYFS responded to the O'Donnell home. The outcome could be different for another child the next time an allegation of risk to safety is treated as it was in this case. We sound this alarm to underscore our ongoing concerns about DYFS' screening practices which must provide a safety net for children at risk of abuse or neglect.

This case represents repeated failures to recognize a report of inappropriate sexual contact/sexual abuse, regardless whether the allegation was founded. As previously noted in this report, the school official reported to OCA an attempt to make an allegation of possible sexual abuse to the SCR and was quickly directed to call the Edison DO without fully airing her concern with the screener. This represents a failed opportunity for DYFS to identify and respond appropriately to an allegation of sexual abuse.

The DYFS screening call log reflects a call from a school official around this time was coded "I & R" (information and referral) and no other data was collected or recorded. The screener aborted the opportunity to capture a report regarding possible sexual abuse, make a determination regarding the nature of the information offered and initiate a child protection investigation on Philip's behalf.[32] In the presence of fuller information related to the sexual abuse allegation, DYFS' handling of the O'Donnell family should then have been elevated to a child abuse/neglect investigation, rather than a child welfare assessment. National studies reveal that the failure to recognize and/or report allegations of child sexual abuse is a significant missed opportunity in prevention. According to Victor Vieth of the National Center for the Prosecution of Child Abuse, "[a] 1990 study found that only 40 percent of maltreatment cases and 35 percent of the most serious cases known to professionals mandated to report were in fact reported or otherwise getting into the child protection system (CPS). A study published one decade later found that 65 percent of social workers, 53 percent of physicians and 58 percent of physician assistants were not reporting all cases of suspected abuse."[33]

B. Case Handling

[32] DYFS Interoffice Memo dated February 22, 2005 indicates that many screeners need to "obtain more information from reporter."

[33] Vieth, Victor I. "Unto the Third Generation: A Call to End Child Abuse in the United States Within 120 Years," Journal Of Aggression, Maltreatment & Trauma, 2004, *citing* David Finkelhor, *Is Child Abuse Overreported?,* Pub. Welfare, Winter 1990 at 25, *and* Steven Delaronde, et al, *Opinions Among Mandated Reporters Toward Child Maltreatment Reporting Policies*, 24 Child Abuse and Neglect 901, 905 (2000)..

1. Untreated adult mental illness and child abuse/neglect are frequently correlated. The Child Welfare Reform Plan acknowledges the need to better prepare DYFS workers to access services for parents, including addiction treatment and recovery, income assistance, mental health treatment and domestic violence counseling. DYFS did not recognize the depth of Ms. O'Donnell's problem and was apparently unaware of Middlesex County's many community- and hospital-based services that could have assisted Ms. O'Donnell with obtaining medications as a long time mental health consumer on an emergent basis.

   DHS houses all of the divisions that could have strengthened the O'Donnell family at a time of struggle, including the Division of Family Development (income assistance); the Division of Mental Health and Hospitals (treatment and recovery assistance); DYFS (child welfare services); the Division of Medical Assistance and Health Services (health insurance). The response of the Department to this family does not evidence a meaningful integration of inter-related government agencies working in concert to strengthen families and save children.

   The tragedy of this case is that mental health care and services finally became available to Ms. O'Donnell only as a result of Philip's death. This is the same care that had remained elusive to her while Philip was alive and dependent on her well-being for his nurture. Ms. O'Donnell's futile effort to obtain assistance during the past year highlights the urgent need for reform of both the mental health system and the child welfare system. Child welfare reform at the grassroots level requires real services be made available to families in need. The record shows that the untreated mental health of Ms. O'Donnell may have been a factor in the events leading to Philip's death.[34] The school records, welfare files, and Medicaid documents demonstrate that Ms. O'Donnell had long indicated a history of mental illness and an interest in accessing treatment. The collective OCA investigative file also indicates that between October 2004 and February 2005, Ms. O'Donnell exhibited behavior to suggest her mental health may not have been stable. Many people who engaged the family took note of her apparent condition but none saw it as their role to take the lead in ensuring this mother was connected to timely assessment and treatment.

2. The school reading coach documented Ms. O'Donnell's instability, but the coach was not successful in connecting her with care and treatment. School officials observed Ms. O'Donnell for months and increasingly suspected significant mental health issues, but could not connect her, an uninsured parent, with necessary mental health services. The Middlesex County welfare office had reason to believe that Ms. O'Donnell had ongoing mental health needs, but did not provide referral or services, nor, in the end, health insurance. The DYFS intake worker completed the child welfare assessment by first focusing

[34] This investigation did not include adequate data to determine whether the mental health status of Ms. O'Donnell was a contributing factor in the death of her son Philip.

on Ms. O'Donnell's self presented financial problems, and then taking Ms. O'Donnell's word that as to her mental health, she was "doing better." The worker, who had very limited training and experience, felt competent to make a determination about Ms. O'Donnell's mental health status, as did the supervisor. Neither the worker nor his supervisor could accurately identify the medications Ms. O'Donnell reported to take for her mental health condition, and neither suggested that further mental health evaluation was needed to fully assess and ensure the safety and care of Philip in his mother's care. Several parties, including DYFS, inappropriately referred Ms. O'Donnell to Value Options, the State's child behavioral health system administrator.

While Ms. O'Donnell was denied Medicaid assistance in her new home county of Middlesex for lack of residency proof, the Highland Park school file for her son contained all the necessary documents. The same documentation on file which allowed Philip to attend school and participate in the free lunch program could have easily supported Ms. O'Donnell's Medicaid application and, therefore, her access to medication and medical care. The welfare and Medicaid systems continue to create enormous paperwork burdens to individuals struggling to meet basic needs, and to the agencies themselves. The integrated ability for systems to share vital information could save lives and spare suffering. Where the only missing information on a welfare application is address verification, and the local agency is aware the applicant has reported a dire need for medications and income supports for a child, as in this case, a home visit by the public agency – or verification of residence through utility or school checks could resolve the matter readily.

3. The worker and the supervisor did not recognize an additional allegation of possible sexual abuse. The DYFS case record does not contain a new allegation of sexual abuse, despite the school official relaying the allegation to the intake worker. The record only notes the mother's later version of the story involving the family friend, ostensibly told to the worker directly, in which Ms. O'Donnell is said not to have concern of potential sexual abuse. It is unclear why the worker did not obtain and record the same detailed information OCA gained from interviews with the school officials, who reported that Ms. O'Donnell alleged the man to be a pedophile, and suspected inappropriate contact to have occurred. Obviously, any allegation of sexual abuse should be taken seriously. In this instance, minimally, the worker should have flagged this case for a child-victim sensitive interview and a coordinated response with the county prosecutor. The failure to investigate and enter information into the State's tracking system represents a breakdown in case handling, with the grave consequence that a potential perpetrator of sexual abuse went unreported to SIS/NJ SPIRIT. Good case handling would have required an investigation regardless of Ms. O'Donnell's recantation. The Child Welfare Reform Plan calls for the creation of standardized statewide approaches to the handling of child sexual abuse, and eventually the creation of child advocacy center protocols, in keeping with national best practice, statewide.

4. The child welfare assessment, as conducted up to the point of Philip's death, was shallow and narrowly focused. The worker left the school without interviewing the reading coach who had spent the past few months in the home, or requesting all the school files on the child. By failing to interview the reading coach or review her files as a collateral contact, the worker missed well-documented concerns regarding the mental health status and lack of medication for Ms. O'Donnell. The worker did not interview Philip's teacher, who had many occasions to interact with Ms. O'Donnell and who had the most contact with Philip. The teacher revealed to OCA worries about the instability of Philip's home, Philip's ability to cover for his mother's illnesses and the teacher's concerns about the tenuous nature of Ms. O'Donnell's mental health status. The teacher also reported that Ms. O'Donnell's reasoning for Philip's absences frequently did not match his explanation for the same day. The worker left the school without completing a request for records or obtaining records.

5. As a result of several child fatalities last year, DYFS policy[35] changed and directed workers to obtain collateral information in conversation with informants, such as teachers and pediatricians. This was done because important information about a child's situation was being lost to the formalities of narrowly constructed questions and stilted written answers. The OCA review of this case indicates that the practice of faxing requests to collaterals from the DO still occurs, months after it was abandoned by policy directive. The policy was changed last year by Assistant Commissioner Edward Cotton based in part on assessments of previous child fatalities, and it must be implemented consistently to improve case practice. As with any new policy change, this is a matter of training and supervision.

   The "Case Plan in Home" was only partially completed and omitted information that could have been beneficial for planning with the family and obtaining financial assistance and medical coverage for the family from the county welfare board. In addition, the portion of the plan that documents the "Needs and/or Changes Expected" of the family contains a predetermined listing of services as a menu of options for the family. This localized practice is inconsistent with policy that supports individualized planning with the family based on an assessment of strengths and needs. That this narrow menu of services may represent the full continuum of options considered or available for families in this community is the surest sign this case offers that child welfare reform has yet to have a meaningful impact on community service capacity. This is not necessarily surprising since the reform was only eight months old at the time of these events, and growing services to strengthen families is a massive undertaking. That said, DYFS staff misunderstood even what service

[35] DYFS New Manual II R 801, Forensic Investigations requires collateral contacts to be in-person or by telephone. The policy indicates that "[i]t is not acceptable to mail a collateral contact form to a school, doctor, or other source."

Value Options provides. The best that can be said is this is an instance where the child welfare system did not respond well to the challenges posed by adult mental illness in the context of child safety work. An important foundational training goal for DYFS staff should be operational knowledge about the scope and capability of service options in their communities to assure that families are referred to resources they need.

6. The Child Welfare Reform Plan emphasizes hiring experienced and appropriately prepared workers, reforming training for the workforce, and implementing reasonable and appropriate caseloads. In the review of this case, none of these critical issues evidence reform. Here, a new worker with little relevant experience was hired into an investigative position and assigned a large intake caseload quickly.

7. OCA is concerned about DYFS' lack of consistency in using complete identifying information each time a case is entered into SIS. The use of a caregiver's last name as the only identifier on DYFS documentation and tracking systems is a frequent occurrence. In this case, the family last name was misspelled on some of the documenting reports, which could have led to an error in connection with future interaction by child welfare staff about the history of the family. The new data system in development should be designed to account for and overcome worker error.

RECOMMENDATIONS

As previously indicated, DHS has already taken steps to address some of the concerns that have been elevated in this report. 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 following recommendations:

1. Allegations Based System

DHS should make public the audit of its SCR system undertaken by Hornby Zeller Associates, Inc. and prepare a corrective action plan for SCR attendant to the deficiencies noted throughout OCA's report, and incorporated here in their entirety by reference.

2. Child Welfare Assessments

The OCA recommends that DHS do the following:

a. Modify the timeframes of response for child welfare assessments to range between immediate and 72 hours, depending on the nature of the report. Currently, the designated response time can be as long as 5 business days, which represent an inordinate delay between referral and initial face-to-face contact with a child. The OCA observes that 72 hours is a reasonable standard consistent with many other child welfare dual response systems.

b. Retain an independent consultant to audit a statistically relevant, random sample of child welfare assessments from the second quarter of this year to determine how many of these child welfare assessments led to the opening of a DHS supervision case because of safety or risk issues, to establish whether changes need to be made at screening, or in assessment protocols and practice, to ensure the safety of children at risk of abuse or neglect.

c. Since child welfare assessments are not an effective prevention intervention when DYFS does not have adequate access to services for families – housing assistance, mental health, and substance abuse treatment in particular, DHS must ensure clear linkages for frontline DYFS workers to services for families. This is an area that needs to be highly supervised and supported in the local offices and should build on existing information systems.

2. State Centralized Screening

The OCA found that emerging agency policy governing practice at centralized screening (SCR) lacks sufficient guidance in some keys areas. Based on these child fatality reviews and OCA's ongoing work in our Bureau of Citizen Complaints, we are concerned that the screening unit does not uniformly elicit sufficient information about the nature of the

allegations and general family dynamics where the information is known to the referent, and at times miscodes allegations as being less serious than is appropriate. The OCA recommends that DHS/DYFS ensure that DYFS policy and procedure requires or includes the following tenets to ensure the safety of children:

a. Screeners should have improved policy training and decision support tools regarding when to initiate a child protective services investigation versus a child welfare assessment. Supervisors should be actively involved in this decision as well as the assignment of the appropriate time frame for field response. Explicit guidance to staff at all levels to err on the side of safety for the child, even in the absence of a discrete child abuse or neglect allegation category, with supervisory approval, should be encouraged.

b. Information and Referral (I & R) policy should be clarified to ensure that potential reports are thoroughly screened, and not quickly diverted to the District Office. Screeners should be trained to ask sufficiently probative questions to garner a true sense of the referent's concern to assure each new allegation is properly screened, documented and directed. The existing DYFS I & R policy directs SCR to forward the I & R to the Worker/Supervisor in the DO, if the information concerns a family with an active case or investigation. The directive should clarify that screeners must determine first and foremost whether a new allegation is being made. This policy further requires screeners to assist callers to establish contact with the assigned DYFS field staff, to document the contact on an intake summary and to transmit the intake summary to the appropriate field office. Continuous quality improvement measures are required to assure consistent adherence to this policy requirement.

c. DHS should replicate the audit of SCR conducted by Hornby Zeller Associates, Inc. on a semi-annual basis until there is greater certainty that DYFS has in place an adequate screening safety net.

3. Systems Integration and Education

These cases elevate the need for the various agencies in DHS to better coordinate service delivery. The cases in this report demonstrate that it may be commonplace for a family to be receiving, or eligible to receive, services from the each of several DHS agencies – DYFS, Division of Family Development, Division of Addiction Services, Division of Medical Assistance and Hospital Services, Division of Child Behavioral Health and the Division of Prevention and Community Partnerships – and have service plans that are incongruent and fail to address one or more eligible needs of the family. In addition, multiple agents from each of these agencies may have competing requirements for the time and personal resources of individuals who are already emotionally strained.

a. The OCA recommends that DHS establish mechanisms to streamline application and service delivery for families eligible for services from multiple agencies. Presumptive eligibility and linking information systems to prevent

overly burdensome paper systems are critically necessary reforms. The current pilot to link free lunch program and Medicaid/FamilyCare eligibility should be expanded statewide as a start, and include eligible adults.

b. The cases in this review elevate the need for DHS child welfare reform to include integration of community partners, such as schools, law enforcement and community providers. Community education and training must be a priority: Social workers, counselors, psychologists, physicians, educators, and police in these cases were not well versed in how to understand and navigate the new entities in the child welfare system, including how to make a report of child abuse or neglect in a manner that assured a timely field response. Educated reporters would be better able to make clear, concise reports that would activate the appropriate level of response from DYFS; abuse/neglect investigation versus, child welfare assessment, or information and referral. A well-informed public can strengthen the safety net for children. Training and consistent standards for reporting in the education community are imperative as that is where children spend most of their time. DHS and the Department of Education should work collaboratively to establish guidelines regarding how schools engage the child welfare system, what to expect, where to go if the State's response is inadequate, who in the school is designated to report allegations of abuse or neglect and contingency plans in the absence of the primary designee that are consistent statewide.

4. Access to Services

a. Adult Mental Health Services: Some states that have strengthened afflicted families have created targeted programs for families involved in the child welfare system that not only ensure access and continuity of adult mental health care, but also ongoing supports and services to teach parents how to navigate the system. OCA recommends DHS provide accessible and targeted adult mental health services for families identified by the child welfare system. OCA recommends DYFS workers be educated about available mental health resources and be equipped with adequate access to treatment, recovery and wellness services for mentally ill caregivers. This is a critical area, and should be included as a significant component of the DYFS training curriculum.

b. Family Reunification Services: Services required to prevent placement or to effectuate the reunification plan should not be delayed or denied based on the parent's inability to secure and pay for services. DYFS workers must be educated about the use of contract services and creative use of financial resources available to the DYFS District Offices (PRS emergency fund, FLEX funds) to provide services to families. As the implementation of Family Team Meetings for case planning is put into practice statewide, the District Office Resource Development Specialist should be an integral part of the team to support workers in identifying services available to meet identified needs and to assist in the referral process as needed and appropriate.

c. Medical Care for Children in Placement – There was a lapse in medical care for the children in two of the reviewed cases. The lack of coordination of medical services for at-risk children continues to be an exigency which will benefit from DHS' immediate attention and action.

5. General Casehandling, Supervision and Documentation

a. The OCA is committed to identifying the lessons learned from each child fatality review to strengthen the child welfare system's response to children and families. To that end, the OCA interviewed key DYFS staff involved with each of the three children in this report. We asked each employee to consider any lessons learned from their involvement in the case and offer any insight into what they may have done differently, not necessarily to prevent the death of the child, but to be more impactful in the lives of the families under supervision. Each employee generally lacked insight and believed there was nothing they would have done differently. This lack of insight is at odds with a reform plan that promises to serve children very differently than was evident in these cases. The OCA recommends the following to encourage learning among DYFS staff from their work with children and families:

   i. DHS/DYFS should conduct a debriefing and assessment case conference with the relevant DYFS staff, including but not limited to the investigator, permanency worker and supervisor of the case, in each of the foregoing cases.

   ii. Internal Child Death Reports (DYFS Form 21-09) should be used as an in-service training tool at the District Office level, during one-on-one supervisory conference, unit meetings or staff meetings, to foster the development of insight and recommendations from the field for systems improvement. Current policy on the Child Death Policy - Purpose of Reports and Reviews and Case Conferencing of Child Deaths[36] should be revised as needed to support this practice.

   iii. Case assessments conducted by external bodies, such as the OCA and the Child Fatality and Near Fatality Review Board, should be shared with all staff to expand their view of the work.

b. High quality supervision is an essential support for competent screening, thorough investigations and assessments, and meaningful intervention with families to promote safety, permanence and well-being of children. The supervisor is a joint decision-maker with the case manager, a mentor for continued professional growth and development, and a coach of innovative intervention strategies targeted to strengthen and empower families while ameliorating the risk of future child maltreatment. In addition, the supervisor

[36] Field Operations Casework Policies and Procedures Manual, IIA 2700 (2701 and 2705 respectively).

provides the first round of quality assurance regarding case handling, adherence to existing agency policy, seeding emerging agency policy and supporting reform efforts. DHS should establish requirements to assure ongoing professional development and support for the cadre of supervisors to ensure they are knowledgeable of related best practices.

c. Documentation of screening, investigative and ongoing case management activity must be recorded contemporaneously in a clear and concise manner to maintain a completely cogent picture of the family at all times, and safeguard the integrity of the DYFS case record.

6. Proper Handling of Child Sexual Abuse Allegations

The Child Welfare Reform Plan calls for the creation of standardized statewide approaches to the handling of child sexual abuse, and eventually the creation of child advocacy center protocols, in keeping with national best practices, statewide. One of the best methods for preventing sexual abuse of children is identification of perpetrators in existing cases and use of proper multidisciplinary investigative and intervention techniques to enhance opportunities for successful prosecution of perpetrators. Proper case management on the front lines is critical to thwarting sex offenders who prey on children. The OCA recommends DHS include in its training academy intensive training in child sexual abuse, including but not limited to screening, recognition of indicators, child-sensitive forensic interviewing, investigation, and provision of related services.

7. Caseloads

DHS' Auditor should independently verify through random selection audits the actual caseloads of DYFS workers to determine whether DYFS' reported data conforms to the real experience of workers in the field.