OFFICE OF THE CHILD ADVOCATE

E X E C U T I V E S U M M A R Y

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

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Monitoring Institutional Abuse Investigations in New Jersey

Prepared by

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EXECUTIVE SUMMARY

The New Jersey Office of the Child Advocate (OCA) is an independent State child protection agency with the statutory authority to monitor and evaluate the activities and practices of the Institutional Abuse Investigation Unit (IAIU) within the New Jersey Department of Human Services (DHS). The IAIU, a statewide system, is designed to determine whether children in out-of-home care settings have been abused or neglected and to ensure their safety by ameliorating the risk of future harm. The IAIU is comprised of a Central Office and four regional investigative offices – Northern, Southern, Central and Metropolitan.

The IAIU is charged with investigating reports of suspected abuse and/or neglect of children in out-of-home care in New Jersey. An out-of-home care setting is defined as any facility, public or private, in-state or out-of-state, that provides children with out-of-home care, supervision or maintenance. Out-of-home care settings include but are not limited to, correctional facilities, detention facilities, treatment facilities, schools (public or private), residential schools, shelters, hospitals, camps or day care centers that are licensed or should be licensed, resource family homes and registered family day care homes.

THE AUDIT

In October 2004, the OCA contracted with the Center for Children and Families (CCF), an applied social science research training center affiliated with Rutgers, The State University of New Jersey, to assist with this cross-sectional archival case review. Together, the OCA and CCF audited cases from the IAIU that were referred and accepted for investigation from November 1, 2003 through May 31, 2004. The purpose of this audit was to evaluate the practices of IAIU. A second phase of this work will examine whether corrective actions recommended by the IAIU were implemented or monitored by other divisions within DHS.

For this audit, the OCA obtained a list of all 1,613 cases referred and accepted for field investigation by the IAIU during the designated review period. The study encompassed a systematic 10% sample (~161 cases). The 161 cases were reviewed by six members of the research team. Each case was randomly assigned to one of these six readers. Cases were read by a second reader if (1) the first reader requested that the case be reviewed by a second reader or (2) if the first reader disagreed with IAIU findings on the case. Forty (40) of the 161 cases were read by a second reviewer for either of these reasons. In addition, a second reader conducted an audit of 20 randomly-selected cases.

PROFILE OF THE SAMPLE CASES

More than three-fourths of the cases involved only one child, although there were three cases in which the alleged abuse involved five children. Among the 161 cases reviewed,

there were 224 children who were alleged victims of abuse and neglect. The average number of alleged victims per case was 1.39. In keeping with the mandate of the IAIU to investigate allegations of child abuse or neglect in varied types of out-of-home care settings, this study examined investigations beyond residential settings. At the time of the alleged maltreatment, the largest numbers of children were in resource family homes (33.4%). However, there were also significant numbers in public/private schools (24.5%), congregate care placements (15.6%), and child-care settings (13.3%).

The 161 cases involved 180 types of alleged maltreatment. Most of the cases had only one type of maltreatment alleged. Physical abuse was the most frequent type of alleged maltreatment (58.8%), followed by neglect (33.8%), sexual abuse (5%) and emotional abuse (2.2%). Among the 161 cases in the sample, IAIU investigators substantiated 10 (6.2%).

INTERVIEWING WITNESSES

Among the 161 cases, there were 145 cases in which it was clear that witnesses should be interviewed by the IAIU. There were 100 cases (68.9%) in which all witnesses were interviewed. In 10 cases (6.8%), no witnesses were interviewed and in 29 cases (20%), only some witnesses were interviewed.

In one case, an IAIU investigator thwarted an apparent cover-up by a school principal regarding a physically abusive aide who had slapped a child across the face. Hearing from sources that the principal had ordered faculty and staff to be uncooperative with the IAIU, the investigator set up after-hours and off-site meetings with all witnesses to the incident, verified that the abuse had occurred and confirmed the cover-up attempt by the principal. During the course of the investigation, the IAIU investigator discovered from faculty that the aide had a volcanic temper and was frequently abusive to children, but her close relationship to the principal had essentially paralyzed the rest of the staff. The investigator went to great lengths to document a pattern of abusive behavior toward children, ultimately leading to the aide's termination.

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

PROFESSIONAL DECISION MAKING

During this audit, IAIU investigators had several findings options available for each type of maltreatment alleged: substantiated, not substantiated (the "not substantiated" finding may be accompanied by child welfare concerns encompassing issues that do not place the immediate safety of the child at risk, but if left unaddressed may cause future harm to the specific child or another child), and unfounded. The Appendix B to the main report provides definitions and considerations for reaching each of the findings delineated.

Of the 161 cases, 131 investigations included a finding. In these instances where a finding was rendered by the IAIU, the readers found the overall IAIU findings decisions to be professionally reasonable in almost 78% of the cases. A similar audit of the IAIU conducted nearly two years ago by Dr. Diane DePanfilis of the University of Maryland School of Social Work found IAIU findings decisions to be professionally reasonable 75% of the time.[1] In eight of the 131 (6.1%) investigations where a finding was rendered by the IAIU, the readers found insufficient documentation to determine agreement or disagreement with the finding. It is possible that had the appropriate documentation existed within these 8 files, the readers may have found overall IAIU findings decisions to be professionally reasonable in as many as 84% of the cases where a finding was made.

THE SUBSTANTIATED CASES

In the present audit, 10 of the 161 allegations of abuse or neglect were substantiated by the IAIU. The number of substantiated cases by region varied considerably, with the Northern Region having the highest percentage (10.8%) and the Southern Region having the lowest percentage (2.2%).[2] The OCA and CCF readers for this audit agreed with the substantiated decisions 100% of the time.

THE UNSUBSTANTIATED CASES

In the present audit, 48 cases were determined to be not substantiated. Forty-four (44) of the 48 unsubstantiated investigations, or 91.6%, were "not substantiated with concerns." Of these 44 cases, the readers disagreed with the IAIU in 11 (25%) investigations, finding the decision professionally unreasonable and determining that the allegations should have been substantiated. In the DePanfilis audit, readers disagreed with 58.1% of the not substantiated findings.

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

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

Some examples of professionally unreasonable case findings classified as "Not Substantiated" by the IAIU include the following: (1) The IAIU investigator and employees of the DYFS Adoption Resource Center concluded that there were continuous incidents in which the pre-adoptive father beat the foster children with a belt and the pre-adoptive father admitted it. The investigators determined that the pre-adoptive mother also beat the children. The couple had been repeatedly warned by DYFS and IAIU to refrain from slapping the children. Despite the pre-adoptive father's own admission to beating his foster child with a belt, IAIU did not substantiate abuse. (2) The IAIU investigator concluded inadequate staffing and vague supervision policies at a secure correctional facility allowed one youth to stab another with a pencil in the head while unmonitored in a basement. (3) The IAIU investigator determined that a juvenile detention officer cut a 14-year-old boy on the throat with her finger or key, opening a one-half inch wound. Although the investigator determined that use of physical force was unnecessary and inappropriate, abuse was not substantiated. (4) The IAIU investigator determined a teacher grabbed a 12-year-old boy causing the child's neck to redden and sting. The investigator concluded the actions were inappropriate, unnecessary and unjustified but did not substantiate abuse.

THE UNFOUNDED CASES

Within the sample of 161 cases, IAIU investigators determined 73 cases were unfounded. The OCA and CCF readers for this audit found 10 cases, amounting to 13.6% of the IAIU's unfounded findings, to be professionally unreasonable. The DePanfillis readers disagreed with 17.1% of the unfounded findings nearly two years ago.

An example of a professionally unreasonable case finding classified as "Unfounded" by the IAIU is the following: (1) The IAIU investigation revealed that a residential treatment center did not timely respond to an eye injury suffered by the child victim. The child was injured during a basketball game and repeatedly asked to see a nurse or doctor. The facility staff delayed sending the child to a doctor for several days and then delayed obtaining prescribed medicine for a torn retina that ultimately required surgery. The facility's log entry regarding the child's need for eye surgery was not credible as the entry was made only after the incident was under investigation by IAIU.

INTERVIEWING COLLATERALS

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

interviewed and in 61 cases (40.9%) only some of the appropriate collaterals were interviewed.

TIMELINESS OF INTERVIEWS WITH CHILDREN

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

Information was coded with respect to the timeliness of IAIU interviews with the alleged child victim. During the period covered by this review, New Jersey policy outlined the circumstances that require an immediate, 24-hour, 72-hour or 10-day response time.

The audit readers evaluated the extent to which IAIU investigators met with the alleged child victim as prescribed by the IAIU screening staff and supervisors. When reviewing investigator compliance with the designated response time in terms of hours, the readers found that the IAIU failed to conduct a face-to-face interview with the identified child victim within the designated response time in 81, or slightly more than half (50.3%) of the cases.

The IAIU conducted face-to-face interviews with the identified child victim within the designated response time in 74 (46%) of the cases. Data was missing in six cases.

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

CONSULTING THE CHILD ABUSE REGISTRY

DYFS maintains a central Child Abuse Registry of the findings of each report of child abuse or neglect with respect to each alleged perpetrator. The DHS policy requires the completion of a Child Abuse Registry Inquiry (CARI) check during the course of each investigation to determine if the alleged perpetrator has previous history of child maltreatment. The CARI check is generally completed and the findings recorded during screening. The CARI check is important during the investigation to view the current allegations against the perpetrator in the context of his/her past recorded behavior since the best predictor of child abuse and neglect is a prior record of such abuse. The professional readers searched all 161 case files for evidence of a completed CARI check. There was no evidence of a completed CARI check in the file for 108 of the 199 alleged perpetrators (53.2%).

The readers determined that of 91 alleged perpetrators for whom IAIU conducted a CARI check, 22 (24.1%) had a prior allegation. Of the 22 alleged perpetrators with a prior allegation, 13 had one such report, and eight alleged perpetrators had two or more such reports. Six of those reports for four perpetrators had been substantiated, raising questions about how these adults were permitted to continue contact with children and whether adequate follow-through on requests for corrective action by the IAIU existed. The OCA intends to audit the follow-up to IAIU requests for corrective action in the next phase of monitoring.

TIMELINESS OF THE INVESTIGATIONS

IAIU policy requires that investigations be completed within 60 days of the IAIU referral. Of the 161 cases included in this review, 51 cases (31.7%) were completed within the 60 day limit. An additional 66 cases were completed in 61 or more days. Forty-four cases, or 27.3%, all of which should have been completed, remained open investigations at the time of this review.

It is noteworthy that IAIU investigators rendered a finding in 131 cases, but there was supervisor sign-off in only 117 of these cases. Failure to complete investigations in a timely manner potentially leaves children at risk of harm, and has been demonstrated to create staffing difficulties in congregate care settings where the alleged perpetrator is barred from contact with the children pending the outcome of the investigation.

Of the 44 incomplete investigations, the shortest case remained open for 110 days and the longest incomplete investigation was open for 278 days. The average amount of days was 173.3 days.[3]

THE INVESTIGATION BACKLOG

In July 2003, the IAIU prepared a corrective action plan[4] that addressed issues raised by the DePanfilis study. Specifically, the corrective action plan was targeted to address a significant number of overdue, incomplete investigations and corrective action plans dating back to 2001.

The IAIU corrective action plan identified staffing shortages as a contributor to IAIU inefficiencies to be remedied by hiring administrative assistants and investigators by September 2003. The DHS progress report on the corrective action plan indicates that by October 2003 only minimal gains had been realized relative to hiring the additional staff. However, the implementation of the IAIU corrective action plan provided a measure of success in alleviating the existing backlog of investigations. In July 2003, the DHS plan adopted a more aggressive time frame for completing investigations (45 days) and indicated that the IAIU had 629 incomplete investigations that were open more than 45

[3] As of September 14, 2004.

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

days; 197 of these investigations were from 2001/2002. By October 1, 2003, the overdue investigations backlog had decreased to 215, with 45 remaining from 2001/2002. The established time frame to complete all overdue investigations was December 31, 2003.

The IAIU apparently experienced a significant increase in referrals beginning on or about October 27, 2003, due in-part to publicity surrounding the Jackson child abuse and neglect case. No additional investigators were assigned to IAIU during this review period, and the backlog of overdue investigations began to soar.

As of November 30, 2004, the IAIU had a total active caseload of 1127 investigations, with 838 investigations open beyond the 60 days for completion permitted by policy. Adjusting for consistency with the previous 45-day time frame for completion of investigations, there were 956 investigations that were past due as of November 30, 2004. This represents a 445% increase in investigations not completed timely, from October 1, 2003 to November 30, 2004. The increase in this backlog within the past year is a finding of great concern.

CONCLUSIONS

Professional Judgment

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

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

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

Timeliness of Investigation

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

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

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

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

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

RECOMMENDATIONS

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

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

2. The absence of a documented CARI check for the majority of the alleged perpetrators is a grave concern. According to the DHS, the new centralized screening protocols require the screener to complete a CARI check before proceeding any further with the case. The DHS should establish protocols to assure that each alleged perpetrator subsequently identified during the course of the investigation is the subject of a documented CARI check. The continuous quality improvement measures should assure that a CARI check is conducted on each (100%) alleged perpetrator, that investigators recognize the importance of the history of the alleged perpetrator, and that information gathered from routine CARI checks is integrated into the overall assessment of the alleged perpetrator and his/her role in the presenting incident.

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

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

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

e. Supervisory guidance regarding the progression of interviews and review/approval of interview content to assure appropriate follow up questions are asked and information gathered is verified.

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

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

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

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

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