Final Report

Review of IAIU Investigations of Suspected Child Abuse and Neglect in DYFS Out-of-Home Care Settings in New Jersey

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Executive Summary

The specific aim of this archival case review was to evaluate a representative sample of New Jersey Division of Youth and Family Services (DYFS) Institutional Abuse Investigation Unit (IAIU) files to determine the degree to which investigations of reports of child abuse and neglect in out-of-home care settings were investigated pursuant to professional standards, including New Jersey laws, policies, and standards. A simple random sample of 129 IAIU files out of a total of 1295 (10%) was drawn to represent the universe of available IAIU investigations of allegations of child abuse and neglect in out-of-home care between 1999 and 2002.

This simple random sample is assumed to be representative of the total population of available investigations during the study time period as each case had an equal chance of being selected and the sample was of sufficient size to represent the universe of available investigations. Using a simple random sampling method reduces the likelihood of bias or systematic error in the findings (Vogt, 1999). Thus, one can assume with a reasonable degree of confidence that these findings represent the same findings that would result if all the available IAIU investigations of child abuse and neglect in out-of-home care in New Jersey between 1999 and 2002 were reviewed.

An independent research team made up of child welfare experts at the University of Maryland, School of Social Work's Center for Families and the Institute for Human Services Policy reviewed and coded information related to the process and decisions described in these investigative files. Findings with the most important implications for the safety of children in out-of-home care are highlighted in this Executive Summary.

Characteristics of Children and Reports

The sample included reports of child abuse or neglect concerning 195 children in out-of-home care settings. These cases were relatively equally spread between the four New Jersey regions. The majority of the alleged victims were male (66.6%), African American (65.6%), with an average age of 9.6 years (age ranges from 3 months to 17 years). The majority of children were alleged to be maltreated in foster homes (67.2%), followed by residential (19%) and group home placements (8.3%). The greatest number of reports alleged neglect (56%), followed by physical abuse (50%), sexual abuse (9%), emotional abuse (2 %), and other concerns (0.8%).

Systemic IAIU Deficiencies That Affect the Risk and Safety of Children in DYFS Out-of-Home Care Settings

IAIU is required to investigate reports of abuse and neglect of children in DYFS out-of-home care and custody, and ensure the safety of those children. This review found a routine failure of IAIU to adequately investigate these reports or to ensure safety of children. As a result of IAIU's systemic deficiencies identified in this review, children in out-of-home care were and are in DYFS placements known to be abusive and neglectful, and no assurances can be given that any child in DYFS out-of-home care is safe. Based on the results of this review, immediate action must be taken to protect these children.

Professionally Unreasonable Decision-Making

One of the most dramatic findings from this study relates to the poor quality of IAIU decision-making. Based on the facts documented in the IAIU files, the IAIU findings decisions were found to be professionally unreasonable 25% of the time. The research team found numerous examples of cases that documented unjustified actions or omissions of the caregiver, which resulted in substantial harm or risk of harm to children, yet the IAIU investigation concluded with a finding of "not substantiated." Such IAIU case findings are inconsistent with the exercise of reasonable professional judgment, and put children at serious risk of ongoing harm in out-of-home care settings that are not closed to further DYFS placements.

For example, one case was unsubstantiated even though a foster mother admitted striking a child with a belt resulting in a 4 inch linear belt mark on the child's face. This foster mother had two prior substantiated incidents of abuse or neglect. There were equally serious examples of neglect to children that were classified as not substantiated, such as medically documented serious neglect of hygiene and nutrition that resulted in developmental delays, low weight, and pain and irritation to the child's skin.

Specific findings included:

- IAIU only substantiated 12% (15 cases) of alleged maltreatment in DYFS out-of-home placements, although 33% of the IAIU cases (40 cases) should have been substantiated if reasonable professional judgment had been exercised.
- Risk of harm to children was noted by IAIU in 40% of IAIU investigations, and IAIU actually recommended removal of victims from unsafe placements in 29% (35) of the cases, even though only 12% of all cases were substantiated.
- First-hand observations by DYFS workers of serious abuse and neglect in out-of-home placements were repeatedly discounted by IAIU.
- 58% of the cases that were "unsubstantiated" by IAIU should have been substantiated.
- 17% of the cases that were "unfounded" by IAIU should have been substantiated.

High Number of Prior Reports of Abuse and Neglect Against Caregivers

Another alarming finding relates to the number of caregivers for whom prior reports of abuse and neglect were documented. One foster parent had *five* prior *substantiated* abuse and neglect reports. No one who has a prior substantiated abuse and neglect report should be permitted to be a caretaker for children in DYFS custody. The decision by DYFS to leave children in homes with individuals who were known to abuse or neglect children seriously jeopardizes the safety of children in the care of the state and violates reasonable professional standards. The number of DYFS caregivers for which there is such a maltreatment history is shocking.

- Of those caregivers for whom a search of prior reports of abuse and neglect was documented (only 68% of the caregivers), 25% had prior reports of abuse and neglect (26 caregivers). This is an exceptionally high number for a group of caregivers who are entrusted to provide adequate care and protection to children in the care and custody of the state.
- The 26 caregivers with prior reports of abuse and neglect had a total of 45 prior reports, 21 (47%) of which were substantiated.
- Only 2 IAIU investigations (1.6%) included a current criminal records check on the caregivers suspected of abuse and neglect.

Failure to Consider Other Historical Information and Interview All Witnesses

IAIU was routinely noted to conduct overly legalistic and narrow investigations, frequently failing to adequately collect, integrate and critically analyze the available information with anything approaching reasonable professional judgment. As a result, risk to children in out-of-home care was not adequately assessed, leaving all children in out-of-home care at risk of dangerous DYFS placements. In addition, the routine failure to adequately document IAIU investigations found in this review is inconsistent with the exercise of professional judgment and further leads to inadequate decision-making, putting children at risk of being placed or left in unsafe out-of-home care settings. For example,

- 44% of IAIU reports failed to consider any historical information regarding the caregiver(s), placement, alleged victim(s), or other children in the placement as part of the investigation.
- 12% of the IAIU investigations failed to include interviews of some or all of the identified witnesses.
- 5% of the IAIU files failed to contain any documentation that the investigation had even been initiated.

Untimeliness of Investigations

Finally, investigations must be prompt to immediately assure child safety and to capture evidence before it evaporates or is compromised. Findings also need to be promptly reached and communicated to relevant parties so that corrective actions necessary to protect children will be taken. DYFS policy and professional standards require that IAIU conduct a face-to-face interview of the alleged child victim within designated response times, and that the IAIU report be completed within 60 days. The routine delays found put children at high risk of being placed or left in unsafe out-of-home care settings.

- 30% of the investigations document that the IAIU investigator failed to attempt to contact the alleged child victim within the IAIU designated response time for face-to-face contact with the child (i.e., immediate, 24 hours, 72 hours, or 10 days).
- 50% of the IAIU investigations were not completed within the required 60 days. The days between receipt of the referral by IAIU and completion of the findings report ranged from 5 days to 965 days (over 2.5 years).

Recommendations

1. **Immediately Reevaluate All Placement Settings With Prior Reports Of Child Abuse And Neglect To Ensure Child Safety.**
2. **Halt Practice Of Using Waivers To Keep Children In Foster Homes With Prior Substantiated Abuse Or Neglect Reports.**
3. **Overhaul Procedures And Guidance For Determining Findings Of Alleged Child Abuse And Neglect.**
4. **Identify And Remove Barriers To Responding To Reports Within Designated Response Times**.
5. **Use A Safety Evaluation Instrument To Assess Safety Of Children In Out-Of-Home Care Settings.**
6. **Implement Intensive Training For Investigators.**
7. **Ensure Adequate Supervisory Oversight.**
8. **Develop Teams To Improve Coordination**.

Final Report

Review of IAIU Investigations of Suspected Child Abuse and Neglect In DYFS Out-of-Home Care Settings in New Jersey

Background and Introduction

Pursuant to a request from Children's Rights, the University of Maryland School of Social Work's Center for Families and Institute for Human Services Policy conducted an independent research review in relation to a class action suit (Charlie and Nadine H., et. al. v. McGreevey) in the state of New Jersey.

Public child welfare agencies have a duty to protect children when they are removed from their biological families and placed in out-of-home care. In some circumstances, children in these placements are reported to have been the victims of suspected instances of child abuse or neglect. In these cases, child welfare agencies are required to promptly investigate suspected reports and make immediate arrangements to protect the involved children.

Since 1974, the Child Abuse Prevention and Treatment Act has required that states implement procedures for the investigation of suspected reports of abuse and neglect in out-of-home care. Limited research on the actual implementation of these procedures has been conducted.

Children's Rights filed a lawsuit against the Division of Youth and Family Services (DYFS) on behalf of children in the State of New Jersey in out-of-home care. This research review of investigations of alleged instances of abuse and neglect in out-of-home care concludes that DYFS is not protecting children who are reported to be abused or neglected while in care.

Aim of Study

The specific aim of this archival case review was to evaluate a representative sample of New Jersey DYFS Institutional Abuse Investigation Unit (IAIU) files to determine the degree to which investigations of reports of child abuse and neglect in out-of-home care were conducted pursuant to professional standards, including New Jersey laws, policies, and standards for investigating alleged reports of abuse or neglect in out-of-home placement.

These standards require that DYFS implement a system to: accept and screen referrals of abuse and neglect of children in out-of-home placements; investigate such referrals; immediately take actions necessary to ensure the safety of children named in a referral and others assessed to be at risk; assess the information obtained during the investigation; formulate findings and develop recommendations based upon the investigative information; and monitor actions taken by the home or facility to ensure the safety of the child.

Study Methods

This cross-sectional archival case review was designed to describe the characteristics of alleged reports of abuse and neglect in out-of-home care in New Jersey, describe the investigative response to those reports, and assess whether the decision-making related to required investigative procedures was performed with reasonable professional judgment.

Sampling Plan, Inclusion and Exclusion Criteria

All available child abuse and neglect reports regarding children in out-of-home care received and investigated by the NJ DYFS Institutional Abuse Investigation Unit (IAIU) between January 1, 1999 and December 31, 2002 were eligible to be included for review.[1] Cases were excluded if: (1) the referral was screened out or resolved at intake by IAIU or (2) the report was received on November 1, 2002 or later (and therefore the investigation was not due for completion by December 31, 2002).

After applying the above exclusion criteria, data for 1295 cases were imported into an SPSS data file from an Excel spreadsheet. The simple random sample function in SPSS was used to randomly select 12% of the cases, resulting in a sample of 158 cases, for which investigative files were requested. Although the research plan called for reviewing 10% of the cases, a 12% sample was drawn to allow for pilot testing and to allow for case replacement if necessary. A second simple random sample of exactly 129 cases was drawn from the 158 using the simple random sample function in SPSS. This resulted in 129 cases (10% of the full sample) for review, and 29 cases that were designated to be used for training purposes. One case was later selected from the over-sample to replace a duplicate case in the sample. A case received at the end of 2001 and again in early 2002 was documented as one investigation. So as not to duplicate the data with the same case, the first case in the over-sample was selected to replace the duplicate case in the regular sample still resulting in 129 cases for review in this study.

Simple random samples are assumed to be representative of the total population of investigations completed during the study time period as each case had an equal chance of being selected. Using a simple random sampling method reduces the likelihood of bias or systematic error in the findings (Vogt, 1999). Where the universe of cases from which the sample is selected is over 1,000, 10% of the universe is presumed to be sufficient to assure representativeness (Rubin & Babbie, 1997). Thus, one can assume with a reasonable degree of confidence that the findings resulting from this study represent the same findings that would result if all available IAIU investigations of abuse and neglect in out-of-home care in New Jersey between 1999 and 2002 were reviewed.

[1] The State produced to Children's Rights the IAIU files for 1999-2002 relating to all children in DYFS out-of-home care custody as of a point in time in May 2002.

Data Collection and Coding Procedures

Following an analysis of New Jersey laws, policies, and procedures, a draft coding system was developed in Microsoft Access. This system was structured in six sections:

1. Coding information
2. Demographics
3. Report information
4. History and Prior reports
5. Investigation
6. Decision-making and Documentation

Coding procedures were developed to increase inter-rater reliability among the research review team (Appendix A). After drawing the 12% simple random sample as described above, 129 cases (or 10% of the original list) were randomly selected to be held for the research review. The remaining 29 cases (2% of the total list) were used for pilot coding and training purposes.

The core research team consisted of four primary reviewers with assistance from two additional case reviewers who helped to pilot test the coding system. During the pilot and training phase, the Principal Investigator made revisions to the coding system and added comments to the coding procedures on a daily basis until the team reached consensus on coding procedures. In addition, during the pilot period, each case coded by a team member was reviewed a second time by another coder. Meetings were conducted periodically to discuss coding decisions and to consult New Jersey policy. In addition, the Principal Investigator reviewed cases coded by each member of the team and developed feedback memos to the team to summarize case coding decisions.

The four primary coders: Diane DePanfilis, Gisele Ferretto, Deborah Linsenmeyer, and Heather Girvin have all worked in public child welfare agencies. Three of the team members have conducted investigations of alleged abuse or neglect in out-of-home care settings, and three have held supervisory and management positions in child welfare agencies. The fourth team member has had experience working in casework positions in child welfare and in a residential setting for children. Of the two remaining case reviewers, one has also had experience working in a residential child care position and the other has extensive clinical and management experience working with children placed in foster care due to abuse or neglect. (See Appendix B for brief bios of team members).

Once inter-rater agreement was achieved on each part of the system and after all training cases were coded, the team proceeded to read and code the regular sample of 129 cases (with one case replacement). The data base was placed on a secure server and the Principal Investigator continued to consult on all cases when a member of the coding team was uncertain about how to reconcile a coding question. In addition, the Principal Investigator directly reviewed and coded 41 or 32% of the 129 cases and conducted a second review of 33% of the 88 other cases in the review sample. Cases were selected for a second review if they were the first regular cases coded by a reviewer, the coder had not agreed with a key IAIU decision, or there was any question about the procedures for coding a specific case.

Definitions

Definitions and coding procedures were specified for each data element in the coding system (see Appendix A). This included using New Jersey definitions of physical abuse, sexual abuse, neglect, emotional abuse or neglect, and definitions for findings of substantiated, unsubstantiated, and unfounded. To identify sub-types of neglect and classify the severity of child abuse or neglect, researchers used guidance from New Jersey policy and supplemented with frameworks previously used by these researchers (DePanfilis, 2002; Magura and Moses, 1986; U.S DHHS, 1988; Zuravin and DePanfilis, 1996). Brief definitions of some of these key definitions follow. See Appendix A for all definitions.

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

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

Not substantiated. When the available information, as evaluated by the Division representative, provides some indication that a child was harmed or placed at risk of harm, but does not indicate that the child is an abused or neglected child as defined in N.J.A.C. 10:133-1.3. (N.J.A.C. 10:129A-3.3(a)).

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

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

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

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

Emotional abuse or neglect. Conduct by a child's parent or caretaker toward the child which contributes to, causes, allows, or permits: significant and or persistent emotional pain, harm, or impairment; and/or significant vulnerability to or risk of such pain, harm, or

impairment; and/or significant exacerbation of a child's existing emotional pain, or impairment. (II Field Operations Casework Policy and Procedures Manual, C.307, Emotional Abuse or Emotional Neglect, 2-27-97).

Confidentiality

Because case records contain personal information about children and out-of-home facilities, identifiers in case files existed. Given the purpose of this study, and the complexity of case records, the removal of all identifiers was not feasible. However, the privacy of children and families was protected in several ways. First, case material was coded directly in Microsoft Access data files without using paper coding forms. The Access data files did not contain any personal identification information such as case names, dates of birth, or other identification. The IAIU number was used to file hard copy case material and this number was used by case reviewers to record information in each of the six sections in the Access data system. Each case reviewer signed a confidentiality statement affirming an agreement to not disclose any identifiable case information to any person not part of the research team.

Copies of original archival case documents were kept in locked file cabinets in a secure research room in the University of Maryland School of Social Work Building at 525 West Redwood Street, Baltimore. The only parties who had access to a key to this room were researchers involved in conducting this study. The University of Maryland Institutional Research Board reviewed the procedures for this research and determined that the research was exempt from a full research protocol because all data was collected and recorded in case files before the beginning of this study and confidentiality procedures used in this study would prevent any individual cases from being identified in the results. (See Appendix C).

Data Analysis and Reporting

Descriptive analyses were initially conducted by running reports in Microsoft Access. These reports helped to describe the findings and finalize the data analysis procedures. Analyses were then conducted by converting the Access data file to SPSS and running descriptive statistics to report results.

Review Information

Results on sections (1) coding information; (2) case demographics; and (3) abuse and neglect report information are presented related to the 129 reports of alleged abuse or neglect. In the remaining sections, results on only 120 to 122 reports (depending on the data element) are presented as the investigative files were missing most or all information about the investigation. Documentation that any investigation was conducted was missing on seven reports or 5% of the sample. Since the sample was selected to represent the universe of investigations over a three-year period, this could mean that documentation of an investigation is missing for 64 out of the 1295 investigations of abuse or neglect in out-of-home care settings during this three year period. This, in and of itself, fails to meet professional practice standards, which require that investigations be promptly conducted and adequately documented.

Section 1: Coding Information

The sample of 129 IAIU investigative files relating to reports of child abuse or neglect concerning 195 children were reviewed between 2/12/2003 and 4/3/2003 by a University of Maryland School of Social Work Research Team affiliated with the Center for Families and the Institute for Human Services Policy. These 129 files were reviewed by five case reviewers outlined in Table 1. In addition, the Principal Investigator completed a second review of 33% of the files initially reviewed by other coders.

Table 1. Number of Cases Reviewed by Each Case Reviewer

Reviewer	# of Cases Reviewed	Percent
Diane DePanfilis	41	31.8
Deborah Linsenmeyer	40	31.0
Gisele Ferretto	35	27.1
Heather Girvin	11	8.5
Kimberly Haynes	2	1.6
Total	129	100.0

These cases were relatively equally spread between the four New Jersey regions ranging from 37 cases in the Metropolitan Region to 29 cases in the Northern Region. See Table 2.

Table 2. Number of Cases Reviewed in Each New Jersey Region

Region	Number in Each Region	Percent
Central	31	24.0
Metropolitan	37	28.7
Northern	29	22.5
Southern	32	24.8
Total	129	100.0

Section 2: Case Demographics

Ninety, or 69.8%, of the 129 reports involved one child, and only one report each involved five children and six children resulting in an average of 1.49 children per report. Table 3 presents these data.

Table 3. Number of Children per Report

Children	Number of Reports	Percent
1	90	69.8
2	24	18.6
3	9	7.0
4	4	3.1
5	1	0.8
6	1	0.8
Total	129	100.0

The majority of the 195 alleged victims were male (66.6%), African American (65.6%), with a mean age of 9.6 years (age ranges from 3 months to 17 years). Table 4 provides an overview of gender and ethnicity characteristics of alleged victims.

Table 4. Characteristics of Alleged Child Victims

Gender	Number (n=195)	Percent
Male	128	65.6
Female	67	34.4

Ethnicity Characteristics of Alleged Child Victims

Ethnicity	Number (N=189)[2]	Percent
African American	124	65.6
White	39	20.6
Hispanic	17	9
Interracial	4	2.1
Other	4	2.1
Native American	1	0.5

The majority of children were alleged to be maltreated in foster homes (67.2%), followed by residential (19%) and group home placements (8.3%). Placement settings at the time of the alleged incidents are listed in Table 5.

[2] Ethnicity was not documented for six alleged child victims

Table 5. Placement Setting At Time Of Alleged Incident

Placement setting	Number (N=195)	Percent
Foster home	131	67.2
Residential facility	37	19
Group home	16	8.3
Day school	5	2.6
After school program	4	2.1
Pre-finalized adoptive home	1	0.5
Camp	1	0.5
Total	195	100

Section 3: Abuse and Neglect Information

Information was recorded related to referral information including type of alleged maltreatment, referral sources, the number and type of alleged perpetrators, whether or not law enforcement was also contacted at the time of the report to IAIU, whether injuries to the child were alleged, and the designated response time.

The majority of original child maltreatment reports were made by residential administrators or staff, or DYFS staff. The largest referral source to the IAIU was DYFS staff. See Table 6.

The greatest number of reports alleged neglect (72, 56%) followed by physical abuse (64, 50%), sexual abuse (12, 9%), emotional abuse (3, 2%), and other (1, .8%). Most reports alleged only one type of maltreatment (82%). See Figure 1 for type of alleged maltreatment in the 129 reports sampled for this study.

Fifty-four reports alleged injury at intake, and investigations later documented injuries in 44 of these cases. Protracted significant injuries using New Jersey definitions for classifying injuries (DYFS, III.E.503.1, 1989), were documented in ten investigations.

> "An insignificant injury is superficial, singular in a location not involving other potential harm to the child and probably involving an extremity (limb). The accumulation of these elements such as multiple superficial marks moves the location of the factor towards the significant range".
>
> "A significant injury is more than superficial (needs treatment) and of some duration (protracted). Other considerations involve location of the injury (e.g., head injury opposed to an injury to a limb) and multiple injuries. A bruise lasting several days on a child's throat or neck could be considered significant whereas a "rug burn" on the child's elbow also lasting several days might not."

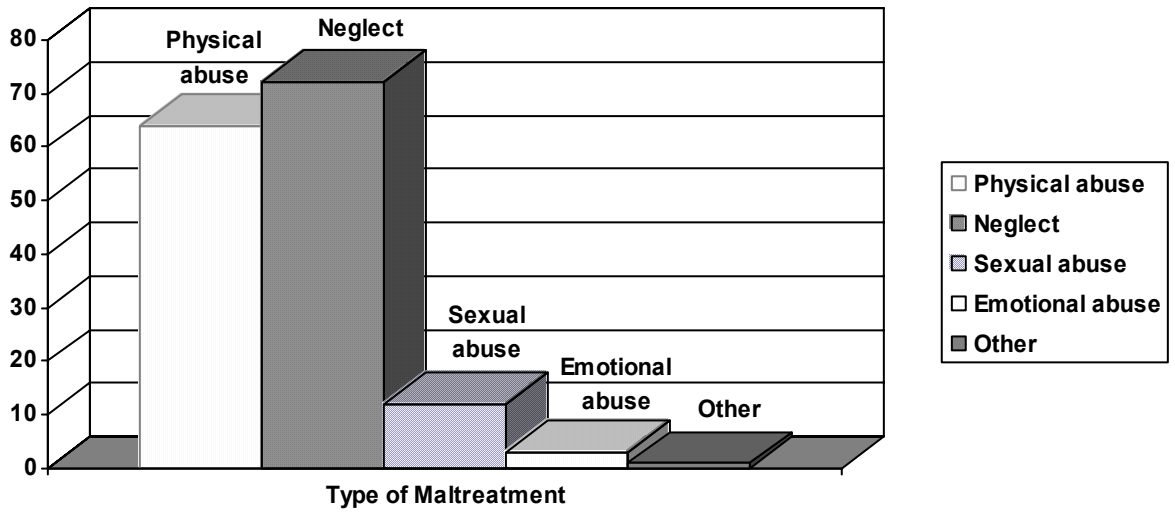
Table 6. Sources of Reports (n=129)
Original Sources of Reports

	Frequency	Percent
Legal	2	1.6
Parent	9	7.0
Relative	3	2.3
School	8	6.2
Self	6	4.7
Anonymous	8	6.2
Friend/Neighbor	2	1.6
Community/Group/Individual	10	7.8
Other agency	8	6.2
Health	9	7.0
DYFS	23	17.8
Police	6	4.7
Facility Administration	11	8.5
Facility Staff	23	17.8
Unknown or missing	1	0.8
Total	129	100.0

Sources Of Reports To IAIU

	Frequency	Percent
District Office	2	1.6
Regional Office	1	0.8
OCAC	30	23.3
Residential Facility	10	7.8
DYFS	66	51.2
Other, specify	20	15.5
Total	129	100.0

Figure 1. Type of Alleged Maltreatment



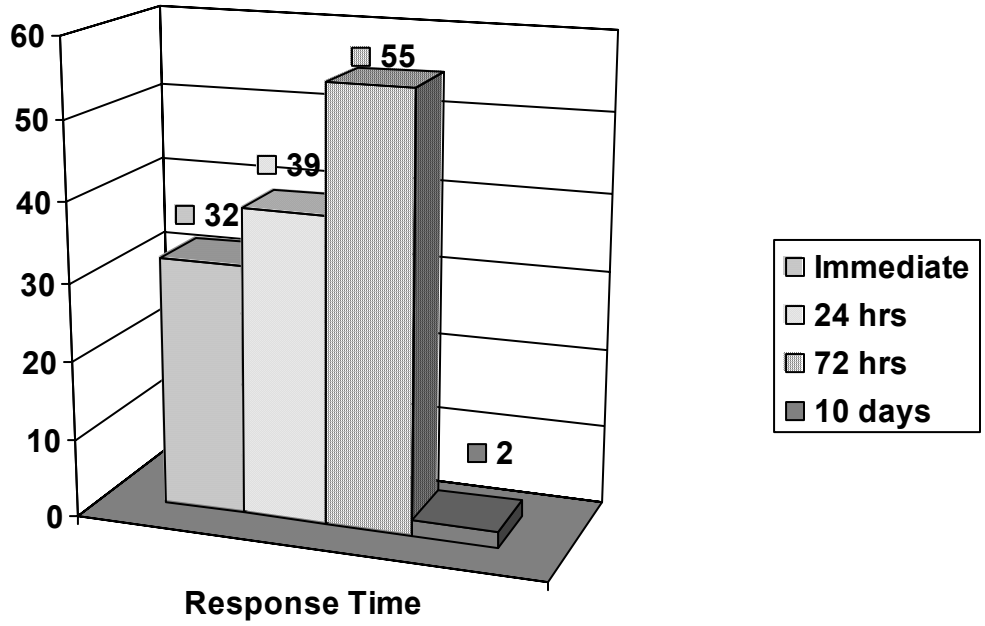
Most of the time only one perpetrator was reported as responsible for the alleged maltreatment (78%). Two perpetrators were identified in 29 reports and three perpetrators were identified in one report. Foster parents were the most frequent type of alleged perpetrators, followed by residential staff. See Table 7.

Table 7. Alleged Perpetrators (n=158)

	Frequency	Percent
Foster parent	100	63.3
Residential staff	45	28.5
Teacher or school staff	4	2.5
Other	9	5.7
Total	158	100

At Intake, injuries were noted by the referral source 40% of the time, law enforcement had also been notified 15% of the time, and the IAIU indicated that the case needed an immediate response in 25% of the 128 cases in which information was available. See Figure 2 for a depiction of the designated response times indicated by the IAIU at Intake. This illustrates that an immediate response was designated for 32 cases, a 24 hour response was designated for 39 cases, a 72 hour response was designated for 55 cases, and a ten day response was designated for 2 cases.

Figure 2. Designated Response Time at Intake



Since one of the factors used by the IAIU screening unit in designating a response time is the presence of an alleged injury, the relationship between an alleged injury and the designated response time at intake was further examined. For the 54 reports alleging an injury, IAIU designated an immediate response to 15 reports (27%), a 24 hour response for 21 cases (39%), and a 72 hour response in 18 cases (27%).

Most of the time, it appeared that the urgency decision was made appropriately by the screening worker and supervisor based on the probable safety of the child at the time of the report. For example, a 72 hour response might have been designated if the alleged incident occurred in a former placement setting or in a residential setting in which the alleged perpetrator would not have further contact with the child in the interim time period.

Systemic IAIU Deficiencies That Affect The Risk And Safety Of Children In DYFS Out-Of-Home Care Settings

IAIU Decision-Making and Documentation

IAIU findings were coded and the degree to which these decisions were consistent with reasonable professional judgment given the information documented in the investigative files was evaluated. IAIU investigations were assessed related to the case finding decisions, the prior history of abuse and neglect reports, the timeliness of investigations, and the recommendations related to the removal of children and other corrective actions.

A. Professionally Unreasonable Case Finding Decisions

Although risk was noted by IAIU in 40% of all reports investigated, IAIU substantiated only 15 cases (12.3%), determined a finding of not substantiated, with concerns noted, for 31 cases (25.4%), and unfounded the remaining 76 cases (62.3%). Significant differences in the substantiation rate were observed between regions with the Metropolitan region substantiating 24.3% of cases compared to the Southern region, which substantiated no cases. See Table 8 for a comparison of the findings of investigations by region.

Table 8. Comparison of Investigation Finding by Region *(n=122)

Finding		Substantiated	Not Substantiated	Unfounded	
REGION	Central	3	9	19	31
		9.7%	29.0%	61.3%	100.0%
	Metro	9	15	13	37
		24.3%	40.5%	35.1%	100.0%
	Northern	3	5	20	28
		10.7%	17.9%	71.4%	100.0%
	Southern	0	2	24	26
			7.7%	92.3%	100.0%
Total		15	31	76	122
		12.3%	25.4%	62.3%	100.0%

*Statistically significant differences between regions

After analyzing all information documented in each investigation, coders assessed whether there was sufficient information to conclude that children had experienced an injury, and had been maltreated in an out-of-home care setting.

Based on facts documented in the IAIU files, the IAIU findings decisions were found to be professionally unreasonable 25% of the time. In comparison to the 15 cases (12.3%)

substantiated by IAIU investigators, 40 cases, or 33% of the investigations reviewed, should have been substantiated. Reviewers disagreed with the IAIU findings, finding them to be professionally unreasonable, 58% of the time when the IAIU finding was not substantiated, and 17% of the time when the IAIU finding was unfounded. All the IAIU findings of substantiated were professionally reasonable. See Table 9 for a breakdown of the differences in agreement for each type of finding.

Table 9. Comparison of Coder Agreement that IAIU Finding Reasonable*

		Disagree with Finding	Agree With Finding	Total
Finding	Substantiated	0	15	15
			100.0%	100.0%
	Not Substantiated	18	13	31
		58.1%	41.9%	100.0%
	Unfounded	13	63	76
		17.1%	82.9%	100.0%
Total		31	91	122
		25.4%	74.6%	100.0%

Statistically significant differences in the level of agreement by finding

Reviewers disagreed with the IAIU findings and found them professionally unreasonable when the documented caretaker actions or omissions and the consequences to children met definitions of child abuse or neglect in New Jersey, or the IAIU investigation was so inadequate that IAIU's finding could not be reasonably justified. Table 10 identifies examples of professionally unreasonable case findings of "not substantiated" by IAIU.

It is notable that the "factors/findings matrix" found in New Jersey policy (DYFS, 1989) improperly allows classification of situations which meet the definition of abuse or neglect in New Jersey law as "unsubstantiated" with concerns, instead of "substantiated." For example, actions by an out-of-home caregiver assessed as "unjustified" and "inappropriate," resulting in injury determined as "insignificant," would be classified as "unsubstantiated" with concerns. This is inconsistent with the New Jersey definition of physical abuse (ie. when a child is injured or at risk of physical injury due to a caretaker's action that was neither necessary nor justified, neither reasonable nor appropriate).

Table 10. Examples of Professionally Unreasonable Case Findings Classified as Not Substantiated by IAIU
▪ The foster mother admitted striking the child with a belt resulting in a 4 inch linear belt mark on the child's face. ▪ The child experienced injuries above the eye due to the grandmother hitting the child in the face with a hair brush. ▪ There was evidence of both physical abuse and neglect including the foster mother's boyfriend choking child around neck on 2 occasions, which resulted in cuts and scratches on the neck, and documentation that the foster mother's actions (locking the children outside on more than one occasion) were unjustified and inappropriate and placed the foster children at unnecessary risk of harm. ▪ The evidence indicated that the child was thrown by a staff member against the wall & then the staff member squeezed the child's private parts. The consequences of these inappropriate actions resulted in the child experiencing sore muscles and small scratches. ▪ The facts included medical documentation of serious neglect of hygiene and nutrition that resulted in developmental delays, low weight, and pain and irritation to skin. ▪ There was evidence that medical treatment was not provided as prescribed and hazardous conditions in the home contributed to injury to the child. ▪ The DYFS worker confirmed that unsanitary conditions in the home posed serious health risks to pre-school medically fragile children (e.g., pet droppings and hair). There was also documentation that the foster mother had not taken these medically fragile children for their immunizations. ▪ There was substantial evidence of the child being neglected in multiple ways over an extended period of time, including inattention to medical needs, urine smell in home, inappropriate supervision, alcohol overuse by foster mom while caring for child, no warm clothes for child in winter, and inadequate food in the household.

Table 11 provides examples of professionally unreasonable case findings of unfounded by IAIU.

Table 11. Examples of Professionally Unreasonable Case Findings Classified as Unfounded by IAIU
▪ The foster mother admitted to spanking the child on the buttocks against agency policy. Other children witnessed spankings and two reported implements being used: spoon, brush, and belt. ▪ The foster father admitted to tapping children on the head and spanking the children on a regular basis. His actions, which violated agency policy regarding corporal punishment, placed the children at risk of harm. ▪ Failure to give children in the home prescribed medication was a chronic problem in the home. Child observed to have bruise behind ear. Attempts to interview referral source & witness were not sufficient. Witness's credibility not assessed. ▪ Abuse could not be ruled out as the cause of the child's welts and scars on back. This incident was consistent with a prior report. ▪ The foster mother failed to administer medication as prescribed. ▪ A critical interview was never conducted with the grandson who was alleged to have "beat up" the foster child. ▪ The child was credible in making the report and had a documented injury but because the caregiver denied the incident and there were no witnesses to the incident, the facts suggested at least a "not substantiated" finding w/concerns.

Out of the 15 cases substantiated by IAIU, researchers found documented physical abuse in three cases, neglect in 15 cases, and sexual abuse in three cases. Based on the facts documented in the IAIU investigative files, however, physical abuse was present in a total of 21 cases, neglect in 29 cases, sexual abuse in three cases, and emotional abuse or neglect in 5 cases (a case could have multiple types of abuse and neglect).

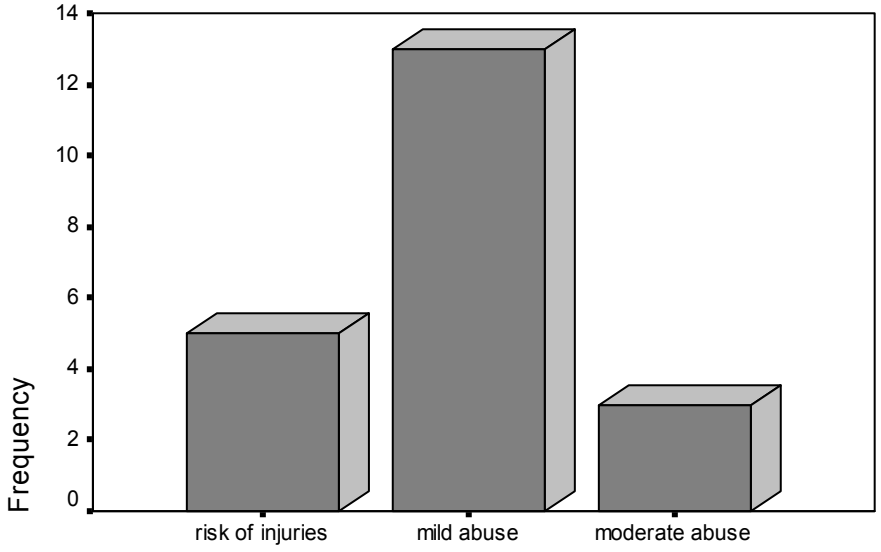
Physical Abuse

There were 64 reports of alleged physical abuse. IAIU substantiated three cases where researchers found documented physical abuse. Using New Jersey's definition of physical abuse, an additional 18 cases should have been substantiated for physical abuse because a child was physically injured or at risk of physical injury due to a caretaker's action or inaction that was neither necessary nor justified, neither reasonable nor appropriate. Of these, 14 were unsubstantiated by IAIU, and 4 were unfounded by IAIU. These findings were each inconsistent with the exercise of reasonable professional judgment.

Using a classification system previously used by the Principal Investigator (See Appendix A), 14% of these physical abuse cases were assessed as "moderate abuse," based on documentation of excessive force or inappropriate caregiver action that resulted in injuries that required medical care. Cases were classified with a "risk of injury" if information in the investigation file documented excessive force or inappropriate caregiver action that suggested a risk of injury but no injuries were sustained. Cases were classified as "mild consequences" if there was documentation of excessive caregiver force or inappropriate action resulting in superficial injuries that did not require medical care. See Figure 3 for a classification of the documented consequences to children in these instances of physical abuse in out-of-home care settings.

Figure 3. Severity of Physical Abuse

Of Children in Out-of-Home Care Settings (N=21)

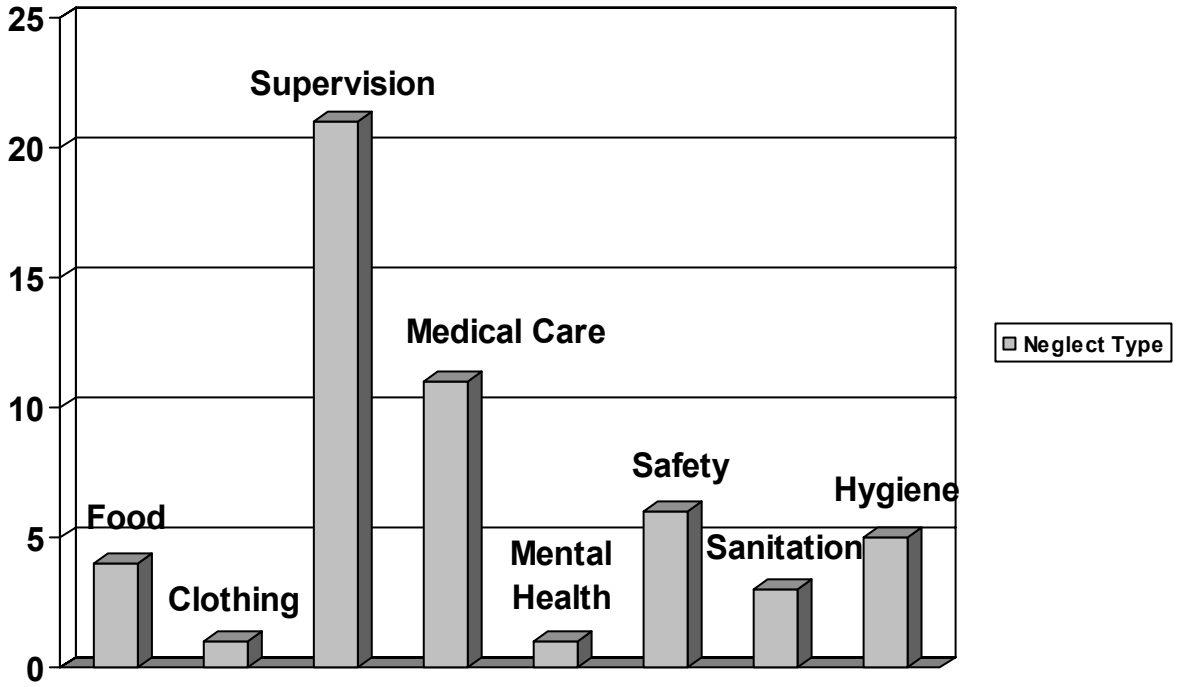


Neglect

There were 72 reports of alleged neglect. IAIU substantiated 15 cases where researchers found documented neglect. Using New Jersey's definition of neglect, an additional 14 cases should have been substantiated because a caretaker failed to provide for a child's basic needs. Of these, 8 were unsubstantiated by IAIU, and 6 were unfounded by IAIU. These findings were each inconsistent with the exercise of reasonable professional judgment.

The most frequent type of neglect was lack of adequate supervision followed by neglect of medical care. Types of neglect were classified based on a combination of New Jersey definitions and definitions previously used by the Principal Investigator (DePanfilis, 2002; Magura and Moses, 1986). Figure 4 profiles the types of neglect that were determined to be present in these 29 cases.

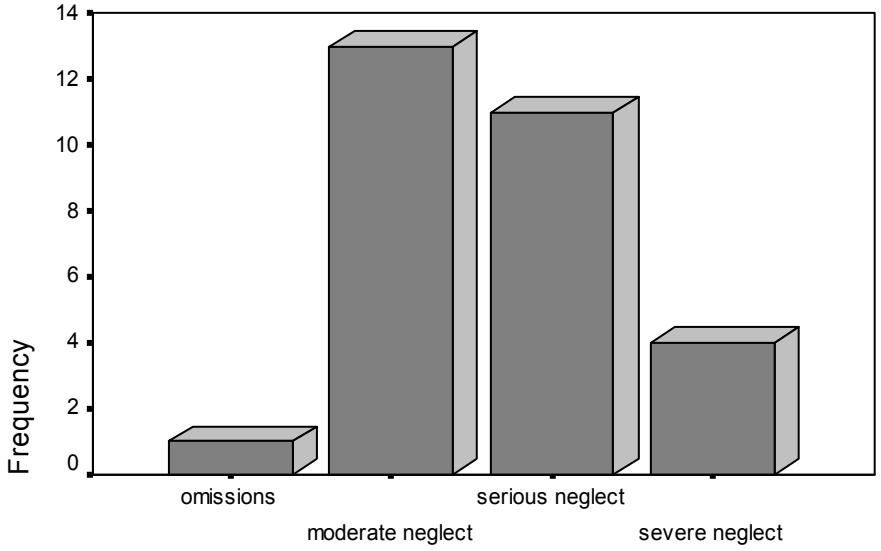
Figure 4. Types of Neglect to Children by Out-of-Home Caretakers (n=29)



Using the classification system previously identified, the consequences to these children as a result of neglect was documented. 52% of these 29 neglect cases were classified with serious or severe consequences to children. The case was classified as serious neglect if omissions in care led to consequences to the child and severe neglect if omissions in care led to serious negative consequences. The lowest rating was used if there were clear omissions of care as defined by one or more of the types in Figure 4 but that no negative consequences were documented and no specific risk of harm was indicated. The case was classified as moderate neglect if there were omissions in care and a clear risk of harm to the child was documented. Figure 5 depicts these results.

Figure 5. Severity of Neglect

To Children in Out-of-Home Care Settings (N=29)



An example of a situation that was rated as serious neglect involved documentation that the foster mother failed to administer prescribed medication to a 5 month old child and also failed to provide adequate food and nutrition to the five month old child and a 1 year old sibling as observed by the DYFS worker, the transportation worker, and the pediatrician. Even though the children were removed from the home due to identified risk by the DYFS and IAIU workers, and the foster care license was suspended due to inadequate care to medically fragile children, *the IAIU finding was unfounded*. This is a complete abdication by IAIU of its responsibility to substantiate corroborated serious neglect of children in DYFS out-of-home care.

An example of a case that was classified as severe neglect involved two girls ages 7 and 10 who were not supervised adequately by the foster mother, who was known to have an alcohol and drug problem, resulting in the girls being physically and sexually abused by an adult male who resided in the home. Although the IAIU investigator substantiated the report, and finally removed the children and closed the home, there had been four prior reports of abuse or neglect, two of which had been substantiated prior to this incident.

Emotional Abuse or Neglect

There were three reports of emotional abuse. IAIU substantiated three cases where researchers found documented emotional abuse. Using New Jersey's definition of emotional abuse or neglect, two additional cases should have been substantiated because conduct by a caretaker to a child contributed to, caused, allowed or permitted significant and or persistent emotional pain, harm, or impairment to the child. In addition, IAIU investigators did not often evaluate the degree to which conduct by a caretaker to a child contributed to, caused, allowed or permitted significant and or persistent emotional pain, harm, or impairment to children in their care, which was inconsistent with the exercise of reasonable professional judgment.

Sexual Abuse

There were twelve reports of sexual abuse. IAIU substantiated three cases where researchers found documented sexual abuse. These decisions were consistent with the exercise of reasonable professional judgment.

B. High Rate of Prior Abuse and Neglect Reports Against Caregivers

Because one of the best predictors of child maltreatment is a prior history of child maltreatment reports (DePanfilis and Zuravin, 1999a, 1999b), national standards establish that a complete assessment of alleged reports of child abuse and neglect and the potential risk to children include an analysis of patterns of abuse or neglect (CWLA, 1999, p. 40). Upon receipt of a report of alleged maltreatment in an out-of-home care setting, DYFS policies for Institutional Abuse and Neglect (1989) require that the screener check the DYFS Service Information System (SIS) for prior agency knowledge of the child and/or caregiver.

Information was coded with respect to whether the IAIU documented such a clearance check for prior reports, whether there were prior reports for alleged perpetrators and the substantiation status of any prior reports, whether there was documentation of a criminal history background check, and whether any additional prior history was considered as part of the investigation. Within these 129 reports, 159 alleged perpetrators were identified with 29 cases identifying two alleged perpetrators and one case identifying three alleged perpetrators.

For the 152 caregivers in the 122 cases with documented investigations, IAIU did not document a search of records of prior child abuse and neglect reports on 47 caregivers (31%). Of those 105 caregivers for whom a clearance check for prior reports was documented, prior reports of child abuse and neglect were identified for 26 caregivers (25%). In total, 45 prior reports were identified for these 26 caregivers and 21 prior reports were substantiated (47%). The number of prior child abuse and neglect reports for these caregivers ranged from 1 to 8 prior reports with the majority having one prior report. The number of prior child abuse and neglect substantiated reports ranged from 1 to 5 prior substantiated reports for this group of 13 caregivers with the majority of caregivers having one prior substantiated report. See Table 12.

Table 12. Prior Reports Of Child Abuse And Neglect Against Caregivers With Prior Report Clearances (N=105)

	Frequency	Percent
Prior reports		
Yes	26	24.76
No	79	75.2
Number of prior reports for caregivers with prior reports (N=26)		
1	18	69.2
2	4	15.4
3	1	3.8
4	2	7.7
8	1	3.8
Total # of prior child abuse and neglect reports	45	NA
Number of prior substantiated reports for caregivers with prior substantiated reports (N=13)		
1	8	61.5
2	4	30.8
5	1	7.7
Total # of prior substantiated reports	21	NA

The high rate of prior reports of abuse and neglect against caretakers who continue to care for children in DYFS out-of-home care is alarming. Children are being routinely left with caretakers even after substantiated abuse and neglect in out-of-home care settings by these caretakers. This practice violates reasonable professional standards and puts children at high risk of further harm.

New Jersey policy is consistent with national guidelines (CWLA, 1995), which require that criminal record checks be completed for all prospective foster parents and individuals employed in child caring institutions. Because new events can occur after receipt of a foster care license or after employment in a residential facility, it was expected that the IAIU investigative files would document new criminal background checks for all alleged perpetrators. However, only 2 (1.6%) out of the 122 documented IAIU investigations of reports of child abuse and neglect included documentation of current criminal record checks on the caregivers. This complete failure to gather such highly relevant information is an egregious violation of professional standards.

This is especially so given the State's apparent knowledge that a significant number of foster care parents have never been adequately screened, including criminal background checks, when their homes were opened for child placements. A 2002 email memo from the Bureau of Licensing to IAIU found in an investigation file related to a new report on a foster parent with two prior substantiated incidents of child maltreatment acknowledged that New Jersey District Offices is not always following procedures for approving and licensing foster homes. This memo (NJ 178767) states,

> "This home is one of many in the Southern Region . . . that was opened by a District Office without going through the required certification process. We are aware of this home but can not give it a certificate of approval because the District Office/Region Foster Home Unit has never provided us with documentation that this home ever met the requirements to be certified, specifically that criminal and child abuse checks were done, the foster parents completed the required pre-service training, the medical and other required references were received, etc. This is a problem with about 25 or so homes, mostly in the Southern Region. We have been requesting the necessary documentation but have not received it. In addition there are two substantiations of abuse/neglect on Ms. _____ and a waiver has not been done."

C. Failure to Consider Other Historical Information and Interview all Witnesses

In addition to considering prior allegations regarding the caregivers, New Jersey policy requires that investigators pursue other historical information that is available to ensure a proper assessment about what happened and child safety. DYFS policy states (III.E.405.9 - DYFS, 1995):

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

It is alarming that in almost half of the investigations of these 122 reports (44%), IAIU investigators failed to consider any historical information about the caregiver, facility, alleged victims, or other children as part of the investigation. To be valid, IAIU investigations must go beyond considering isolated incidents and consider the context and history of the placement, the caregiver(s), and the alleged victims. This egregious failure is an abdication of DYFS's responsibilities to protect children in its care.

Some examples of relevant historical information that was considered by IAIU investigators are identified in Table 13.

Table 13. Examples Of Historical Information Considered In Investigations
▪ History of concerns documented by workers in case records of other children ▪ School records which documented observations of children over time (related to neglect allegations) ▪ Records of therapists about the capacity of specific children to lie ▪ Child's case plan which had identified needed services for a medically fragile child who was alleged to have been neglected ▪ Past incident reports in a residential facility which identified prior concerns about lack of supervision ▪ Consultation with foster care workers regarding history of any concerns in the placement setting, review of foster home re-evaluation reports and memos related to past concerns, review of home studies and records of prior corrective action, and review of foster home records of prior suspensions ▪ Consultation with licensing inspectors regarding history of licensing violations ▪ Consultation with residential administrators regarding alleged perpetrator's employment history ▪ Review of past police reports of similar incidents related to a facility ▪ Review of facility policies and procedures for supervision of youth

In these investigations, investigators demonstrated how gathering additional information increased the quality of the decision-making and often led to increased safety for children.

New Jersey policy also requires that those who may have information about the reports of child abuse and neglect be interviewed as part of the investigation. In the case of a foster home, for example, there should be documentation that all residents in and persons frequenting the home were interviewed. In addition, witnesses and collaterals should be interviewed as appropriate based on the specific nature of the allegations. Information in investigation files indicated that between 8 and 18% of the time, *all* others who may have had significant information about the alleged incident were *not* interviewed. 12% of the IAIU investigations failed to include interviews of some or all of the identified witnesses. See Table 14 for specific results.

Table 14. Interviews with Other Parties

All persons frequenting the home were interviewed

	Frequency	Percent
No	8	7.4
Yes	100	92.6
Total	108	100.0

All witnesses were interviewed

	Frequency	Percent
No	4	3.4
Yes	102	87.9
Some	10	8.6
Total	116	100.0

All collaterals were interviewed

	Frequency	Percent
No	3	2.5
Yes	106	87.6
Some	12	9.9
Total	121	100.0

All others were interviewed

	Frequency	Percent
No	22	18.0
Yes	100	82.0
Total	122	100.0

Examples of individuals who were not interviewed but should have been interviewed because they had important information that would have been relevant to the investigation are provided in Table 15.

Table 15. Examples Of Individuals Who Had Information About The Alleged Incident But Were Not Interviewed As Part Of The Investigation

EXAMPLES OF OTHER PERSONS IN THE HOME WHO WERE NOT INTERVIEWED

- Three others in household who knew about incident
- Daughter of foster mother who assumed child care responsibilities
- Family members who witnessed the incident
- Foster mother's grandson who was alleged to have beaten the victim (allegation was due to lack of supervision by foster mother which endangered child)

EXAMPLES OF WITNESSES WHO WERE NOT INTERVIEWED

- Adults caring for child during the event
- Babysitter who witnessed the alleged conditions
- Biological child of foster parent who was present during the incident
- Neighbors specifically mentioned in referral who witnessed the incident
- Referral source & witness
- Store personnel who witnessed incident
- One of the child residents who witnessed event

EXAMPLES OF COLLATERALS WHO WERE NOT INTERVIEWED

- Emergency Department physician who suspected abuse
- 8-year-old child's teacher who observed conditions
- Physician who completed an evaluation of the child's condition
- Emergency Department physician to clarify findings (sprain, bruise)
- Headstart staff and pediatrician who knew child over time and had information about situation
- Medical provider (child received stitches)
- Nurse who examined child
- Staff members who made report and had concerns about facility policies which they believed placed children at risk
- Treatment professionals caring for child

EXAMPLES OF OTHERS WHO WERE NOT INTERVIEWED

- Social workers
- Supervisors
- Administrators

As these examples illustrate, there were serious gaps in the thoroughness of IAIU investigations as persons who had information about alleged incidents were not always interviewed as part of the investigation. Thus there was a significant gap between what DYFS policy requires in its investigative protocol (victims, alleged perpetrators, witnesses, collaterals, administrators, social workers, supervisors, additional information) (DYFS, 1995) and what actually was documented in investigative files. This is also a breach of professional standards.

Furthermore, even when interviews were documented with all persons who were believed to have information about an alleged incident, the investigative files frequently did not provide sufficient documentation to draw the conclusion that all aspects of the alleged incident were adequately explored.

A significant finding regarding the documentation of child interviews was that frequently it was difficult to assess whether or not all aspects of the alleged maltreatment were explored with the child and whether sufficient time was provided for the child to feel comfortable telling what happened. Interviews with children alleged as maltreated take considerable time (Berliner, 2000; DePanfilis and Salus, 1992; Jones Harden, 2000; Kolko, 2000; MacFarlane, 2000). The superficial documentation for some of these

interviews in contravention of professional standards suggested that IAIU investigators may have seen the child for a short period of time and may not have adequately explored all aspects of the out-of-home care situation that was of concern.

New Jersey policy and professional standards also require that the child be interviewed face-to-face and privately. Of the 122 completed investigations, investigative files documented that the investigator had a face-to-face interview with all alleged victims in 120 cases (98% of investigations). In one case, a telephone interview (instead of a face to face interview) was conducted with a child who was placed in Pennsylvania at the time of the report and in the other case, there was no documentation of whether the interview was conducted face-to-face. While in 111 out of 122 cases (91%), the files specifically documented that interviews with alleged victims were conducted privately, in at least two instances the child was interviewed in the presence of the alleged perpetrator, which was a violation of professional standards, and in three cases, whether or not the child was interviewed privately was unable to be determined due to missing documentation.[3]

IAIU investigation files also frequently failed to adequately document whether the interview with alleged perpetrators fully explored the nature, extent, and details about the alleged maltreatment, in violation of New Jersey policy and professional standards. It was not unusual for the investigator to document that an interview occurred on a specific date and that the caregiver denied the allegation without providing any details about the specific explanations that may have been given about the alleged incident. Documentation of these investigations was often insufficient to assess whether the DYFS protocol for interviewing perpetrators was actually implemented.

Finally, it was notable that in multiple investigations IAIU investigators did not appear to give credibility to witness statements by DYFS caseworkers when they reported serious observable neglect or abuse. If a foster parent denied allegations, the observations by DYFS workers who had been in the home on multiple occasions seemed to be discounted or ignored. That IAIU gives credibility to alleged perpetrators over DYFS caseworkers who actually observed maltreatment and who are presumably trained to identify abuse and neglect of children under their supervision is nothing short of outrageous. It is indicative of IAIU's overly legalistic and narrow investigations, and frequent failure to adequately integrate and critically analyze the available information with anything approaching reasonable professional judgment. As a result, risk to children in out-of-home care was not adequately assessed, leaving all children in out-of-home care potentially at risk of dangerous DYFS placements.

D. Untimeliness of Investigations

Information was coded with respect to the timeliness of IAIU investigations. New Jersey policy (DYFS, 1996) outlines the circumstances that require an immediate, 24 -72 hour, or 72 hour to ten-day response. IAIU screening staff and supervisors designate this response time. However, 30% of first attempted contacts by IAIU investigators with the alleged child victim were *not* within the designated response time using calendar days, and 22% of first attempted contacts were *not* within the designated response time using work days. See Table 16.

[3] In some cases, the child was also reported to have been too young, disabled, or too fearful to be interviewed alone.

Table 16. Attempted Contact With Child Within Designated Response Time (N=120)

	Frequency	Percent
Within Designated Response Time		
No	36	30
Yes	84	70
Within Designated Response Time (work days)		
No	26	22
Yes	94	78

Having properly determined the urgency of the response based on such factors as the seriousness of the alleged maltreatment, the age and vulnerability of the child, the availability of others in the setting who can protect the child, and the expected cooperation of the alleged perpetrator and others who must be interviewed as part of the investigation (DePanfilis and Salus, 1992; Wells, 2000), IAIU must then respond promptly to adequately protect children. Delays in initiating contact with the child were found across all designated response times, and amounted to a breach of professional standards that increased risk to children in these cases. The cases originally designated as requiring a 72 hour response were the most likely to have an untimely IAIU response. In these investigations, IAIU did not attempt to contact 62% of the children within the designated response time.

In one case, a lapse of 119 days before an alleged child victim was interviewed by IAIU involved an allegation regarding four children in out-of-home care who had been attending an after school program and one child was unable to be located for an interview for an extended period of time. Missing information in the investigative file made it impossible to determine why the investigator was unable to locate the child since he appeared to still be placed in an out-of-home care setting.

In several cases, the DYFS worker actually responded to the reported abuse and neglect before the IAIU investigator and improperly interviewed the children in front of the alleged perpetrators. This practice is an egregious breach of professional standards that can obviously increase risk to children and can decrease the possibility of finding the facts about what happened.

There were also serious delays in the documentation of final IAIU investigative reports. First, from the total sample of 129 investigation files, seven had no documentation that the investigation had been initiated even though the inclusion criteria required that a reported allegation of abuse or neglect had been received at least sixty days prior to sample selection. In an additional case, all that was available in the file was a letter stating the finding but the findings report was missing.

For the 121 cases in which a findings report was available, the days between receipt of the referral by IAIU and completion of the findings report ranged from 5 days to 965 days. The average number of days until completion of the investigation was 109 days. Only 50% of the investigative reports were completed within the 60 days required by DYFS policy

and professional standards. The end result was that some investigations were pending for lengthy periods of time, with findings reports and letters communicating the findings to DYFS units supervising out-of-home care placements such as the Regional Foster Care Units and the Bureau of Licensing issued months or years late. There were also significant delays between investigator and supervisor signatures. The number of days between investigator and supervisor signatures ranged from 0 days to 120 days with an average of 12 days.

These findings are consistent with DYFS's own tracking of "Incomplete Abuse/Neglect Reports," which in a report run on March 1, 2003, documented 142 IAIU reports incomplete over two months from the referral of abuse and neglect (NJ254564-627). Clearly the available tracking system has not been used to remedy a serious ongoing problem with the number of investigations that are not completed within the required 60 days. In the meantime, children are at high risk of being placed or left in dangerous out-of-home care placements.

In 33 of the cases an interim report had been filed prior to the final report, 98% of the time prior to 60 days following the receipt of the initial referral of abuse or neglect. However, in light of the many IAIU investigation deficiencies, a brief interim report was found in most instances to be inadequate to inform the necessary parties as to the scope of the risk to the children involved. Also, since the letters communicating the findings to necessary parties were not issued until after a final findings report was completed, these delays still indicate that DYFS units supervising out-of-home care placements are not adequately informed about situations that present risks for children in out-of-home care settings.

E. Failure to Recommend Child Removals and Other Necessary Corrective Actions

Documentation in investigation files indicated that children were removed due to alleged incidents of abuse and neglect in 35 cases (29%). In addition, there were indications that after removal from placement settings for other reasons, children made allegations about a prior placement. If removed prior to the report of abuse and neglect being made, those instances are not included in the total number of children removed. In an additional five investigations, IAIU's failure to recommend removing the children involved in these incidents was a violation of professional standards and put children at further risk of harm. Table 17 identifies examples of cases where children were not removed from their out-of-home care placements and IAIU did not recommend their removal.

Table 17. Examples Of Cases Where IAIU Failed To Recommend That Children Be Removed Due To The Incident
▪ This was a serious physical abuse incident where foster mother admitted to striking the child with a belt across the face and had 2 prior substantiated abuse or neglect reports. The child was left in the home by DYFS and the foster mother intended to adopt him.
▪ This was the third time this foster parent had used physical punishment and been reported. She had been given corrective action previously because of non-compliance with the corporal punishment policy but her behavior had not changed Even though she again agreed to discontinue use of the belt and there was no injury related to this incident, the ongoing risk of harm to the child is high.
▪ The child newest to the home who was the first to disclose information about the "whoopings" was moved but two other children were left in the home. One of these children was identified as a victim in this referral and the third child was a 5-month-old who is especially vulnerable. The investigator addressed concerns about physical punishment with the foster mother, but the foster mother discounted these concerns. The risk of harm to the remaining children is too high to leave them in this home.
▪ The foster mother admitted to spanking the child on the butt and hands & described her as "spoiled". Other children witnessed spankings and two reported implements being used: spoon, brush, and belt. The child's body was never examined without clothing. The pediatrician was not consulted about suspicions. The record indicates that the family planned to move to another state and adopt the child. This child is at risk for abuse in this home.

IAIU recommended that foster home licenses be suspended or revoked (beyond the initial investigative period) in 29 cases (23%). Based on a review of the records, the license should have been suspended or revoked in an additional 12 cases Table 18 identifies examples of cases where IAIU failed to recommend suspension or revocation of a foster care license, in violation of reasonable professional judgment.

Table 18. Examples Of Cases Where IAIU Failed To Recommend That Foster Care Licenses Be Suspended Or Revoked
▪ Five prior substantiated reports plus this incident suggest that this home should not be kept open.
▪ Abuse report, which is consistent with prior abuse reports (foster parents using a belt resulting in welts on child's back), indicates children are not safe in this home.
▪ Not the first incident and the foster mother admits to using corporal punishment on a regular basis. The home was only temporarily suspended with recommended counseling for the foster mother but there is no detail about how the foster mother was "counseled" and what will she do differently when the child misbehaves.
▪ Two special needs children (ages 8 and 9) were left unsupervised for an unknown length of time resulting in injuries to one child. A higher level of care should be expected from "therapeutic" foster parents. More training is indicated before any additional placements.
▪ The foster mother admitted striking the child with a belt resulting in 4 inch linear belt mark on face. The decision to restrict the home to current placements is unacceptable. The home should have been closed due to safety concerns for the children who remain in this home.
▪ Excessive physical punishment was used after two prior incidents and prior remedial training. There is nothing to suggest that children will be safe in this home in the future.
▪ The basic hygiene and nutritional needs of 2 year old children were neglected and these children also failed to receive adequate nurturing and stimulation as they were living in a household with 9 children, 6 of whom were under the age of 5. The lack of adequate care and stimulation during infancy could result in long-term consequences for the involved children. The home should have been closed because of the seriousness of neglect in this household.

Corrective action was recommended in 83 of the IAIU cases reviewed (68%). Reviewers disagreed with the corrective action recommendation in 17% of the 122 cases reviewed, either because no corrective action was recommended by the IAIU or because the corrective action was insufficient to address the problems identified. Examples of instances when the corrective action recommendations were insufficient to protect children in those placements from further harm are provided in Table 19.

Table 19. Examples Of Deficient IAIU Recommendations For Corrective Action

- After minimal corrective action, the home was approved for 2 more medically fragile children in spite of serious concerns about inadequate nutrition and medical care provided to 5 month old and one year old children in this case. The corrective action was insufficient to address the seriousness of the concerns.
- The supervision problems resulting in four injuries in 5 months and the foster parent's lack of understanding of the child's Attention Deficit Disorder could lead to future injuries. This foster home should have been reevaluated for appropriateness as a placement for special needs children and measures to reduce the child's accidents should have been put in place.
- Foster mother with 5 prior substantiated abuse incidents plus this incident was counseled regarding the use of physical discipline and told to go to parenting class. This was insufficient to insure future safety of children with someone with her history.
- Investigation/corrective actions addressed several issues: the need to cap the number of children in the home, the foster mother's obligation to report other adults staying with her, concerns about "marginal" condition of the home, but the file did not identify what action was put in place to remedy these conditions. Documentation of corrective actions was incomplete.
- Recommendation for "administrative counseling" should be more specifically related to the level of supervision needed by "special needs" children in this home.
- Telling the foster mother to not use corporal punishment and offering parenting training will not deal with the core issue that this foster mother believes that hitting children with belts is okay.

In addition, if a foster home was being closed for other reasons (e.g., the foster parents said they wanted to resign or were moving out of state), there seemed to be a trend to conduct a less than thorough investigation. This is dangerous and professionally unreasonable because, without documenting the seriousness of any abuse or neglect that may have occurred, the investigation record will be discounted and could even be expunged. The foster parents could then be free to continue as foster parents or reapply again without an adequate assessment of these prior maltreatment concerns being considered.

Finally, it is alarming that even when IAIU recommends corrective action it appears that in many cases, no corrective action plan is ever put in place. DYFS-generated reports tracking outstanding and overdue corrective action plans subsequent to an IAIU report as of March 6, 2003, indicate that 234 requested corrective action plans are currently outstanding for foster homes and residential facilities in New Jersey (NJ254628-641). Of those, 137 date back to 2002, and 50 to 2001. If even the corrective actions that IAIU does request are not implemented, the likelihood of further abuse and neglect to children in those placements is unacceptably high.

Additional Systemic Deficiencies Identified By IAIU That Affect The Risk And Safety Of Children In Out-Of-Home Care

In addition to investigating individual reports of child abuse or neglect in out-of-home care settings, the IAIU has a responsibility to identify administrative or systemic problems that

may come to light in the course of an IAIU investigation. For example, IAIU policies (DYFS, 1995, III.E.406.5) suggest that investigators offer recommendations regarding policies and other administrative procedures, e.g., changing staffing patterns, modifying training programs, etc. that go beyond the specific incident. IAIU identified systemic problems in 31 cases (25%). Examples of systemic deficiencies that were identified by IAIU as needing administrative solutions included:

- Children are being placed in homes above the number of children for which the homes are approved.

  This decreases the capacity of foster parents to adequately supervise children, can increase stress of parenting, can cause conflicts between children who may be in a household, and reduces the possibility that the individual needs of children will be adequately met.

- Personnel action not taken against a worker who observed serious problematic conditions in violation of DYFS policy for foster homes but had not acted to report the problems.

  Without an independent investigation, there is less likelihood that abuse and neglect will be documented and children will be protected. Enforcing the standards of the agency is essential for preventing future incidents of child abuse and neglect.

- Residential facility failing to report a previously known allegation of child sexual abuse.

  When problems are identified in the context of a case, it offers the opportunity to educate facilities about the reasons for reporting and increases the likelihood that children will be protected if future incidents are identified.

- Need for training residential staff on the level of supervision required in policy.

  This action is a proactive and preventive approach that may lead to practices that will increase safety for children.

- Facility policy on supervision and security needs to be rewritten to include detailed inspections of rooms every half-hour throughout the night. Additional training may be required for staff.

  Similar to other actions identified above, changes in policies that are reinforced through training may lead to increased safety for children.

- Contracted agency responsible for supervising foster homes had not followed up on corrective action in multiple foster homes.

  Corrective action is only relevant if a system for follow-up is in place. Ensuring that supervising agencies meet their responsibilities for enforcing corrective action is essential to prevent future incidents of child abuse or neglect.

Conclusions and Recommendations

The Institutional Abuse Investigation Unit (IAIU) of the Division of Youth and Family Services (DYFS) is required to: accept and screen referrals of abuse and neglect of children in out-of-home facilities; investigate such referrals; immediately take actions necessary to ensure the safety of children named in a referral and others assessed to be

at risk; assess the information obtained during the investigation; formulate findings and develop recommendations based upon the investigative information; and monitor actions taken by the facility to ensure the safety of the child. This review of a random sample of IAIU investigations from 1999 through 2002 identified strengths and limitations in the degree to which the IAIU has fulfilled this mandate and concludes that there are significant systemic deficiencies that breach professional standards and put children in out-of-home care at unnecessary risk of serious harm.

Strengths

Reviewers found some examples of excellent and thorough investigations, including prompt contact with alleged victims and alleged perpetrators, thorough and well-documented interviews with all parties, and timely and professionally reasonable conclusions and decisions in order to ensure the safety of involved children. In over half of the investigations, investigators were noted to consider important historical information as part of the complete assessment of the allegations in the report. This finding indicates that some investigators were able to competently carry out their responsibilities to ensure the safety of children entrusted to the care of the state.

Required interviews with alleged victims and alleged perpetrators occurred in over 98% of the cases reviewed. Required interviews with other relevant parties were assessed as complete between 82% and 92% of the time. This performance suggests that investigators usually knew who should be interviewed in order to thoroughly investigate a report and implemented interviews as required most of the time.

Documentation suggested that investigators notified law enforcement of findings in 20% of the cases and the case reviewers concurred with this decision in all cases. Reviewers also agreed that most children who needed medical care related to the incident had received care.

Finally, investigative files included documentation that notification of the finding was sent as required to supervising agencies, the DYFS regional offices, and the Bureau of Licensing in most investigations (between 93% and 98% of the time).

Systemic Deficiencies in the Quality of Investigations that Affect the Risk and Safety of Children in Out-of-Home Care Settings

The most alarming deficiency identified in these investigations was related to the deficient analysis of the facts gathered leading to professionally unreasonable IAIU findings. IAIU investigators substantiated only 15 out of 122 cases, yet case facts collected by IAIU revealed that the findings were not professionally reasonable 58% of the time for cases classified as “not substantiated with concerns,” and 17% of the time for cases with a case finding of “unfounded.” For example, one case was not substantiated even though a foster mother admitted striking a child with a belt resulting in a 4 inch linear belt mark on her face. In another case a child received injuries above his eye due to the caregiver hitting the child with a hair brush. There were equally serious examples of neglect to children that were not substantiated such as medical documentation of serious neglect of hygiene and nutrition which resulted in developmental delays, low weight, and pain and irritation to the child’s skin, or in another case where sanitary conditions in the home posed health risks to pre-school and medically fragile children who were found likely to ingest pet droppings and hair.

Arriving at a case finding of not substantiated or unfounded when serious abuse or neglect has occurred is a significant failure to exercise reasonable professional judgment, which can only increase risk to the safety of children. The case finding decision affects decisions related to removing children from unsafe placements, suspension or revocation of foster care licenses, and other corrective actions. IAIU investigators actually recommended removing children from unsafe households more than twice as often as they substantiated reports of child abuse or neglect, suggesting that investigators realized that the safety risks for children required removal, but for some reason did not verify those concerns by substantiating clear cases of child abuse or neglect, as reasonable professional standards dictate they must. While this may temporarily keep individual children safe, this practice leads to increasing risk and safety concerns for other children in DYFS custody who could still be placed in these out-of-home care settings.

Equally shocking was the fact that records indicated that twenty-five percent of the alleged perpetrators identified in this sample had prior reports of child abuse or neglect. In total, 45 prior reports were identified for 26 caregivers. 21 of these prior reports were previously substantiated. The number of prior reports ranged from 1 to 8 reports and 1 to 5 substantiated reports. Deciding to place children in homes with prior substantiated reports of child abuse and neglect is a complete failure to exercise professional judgment, especially since it appears that investigators only substantiate abuse and neglect in rare, very serious maltreatment situations. The end result of this practice means that the state has removed children from biological families, usually due to abuse or neglect, and placed them in homes where caregivers have been known to seriously abuse or neglect other children. Since the IAIU so rarely substantiates reports of child abuse and neglect in out-of-home care situations, it is also likely that children in homes with prior unsubstantiated reports are also placed in seriously unsafe situations in violation of professional standards.

IAIU was routinely noted to conduct overly legalistic and narrow investigations, frequently failing to adequately collect, integrate, and critically analyze the available information with anything approaching reasonable professional judgment. As a result, risk to children in out-of-home care was not adequately assessed, potentially leaving all children in out-of-home care at risk of dangerous DYFS placements. The routine failure to adequately document IAIU investigations found in this review is also inconsistent with the exercise of professional judgment and further leads to inadequate decision-making, putting children at risk of being placed or left in unsafe out-of-home care settings.

Most of the time, homes were not closed and corrective action seemed superficial to address such long term practices by some caregivers as using instruments such as belts, sticks, and curtain rods to physically punish children. These children were physically abused by use of excessive force during physical punishment in spite of the state's no corporal punishment policy for out-of-home care settings. Not verifying the seriousness of these actions or omissions by substantiating them when they met the definitions for abuse or neglect has resulted in further abuse and neglect and serious detrimental consequences for children in these out-of-home care settings.

As a result of the deficiencies identified in this review of a representative sample of IAIU investigations from 1999 through 2002, no assurances can be given that children in DYFS out-of-home placement are safe from abuse and neglect.

Recommendations

Some of the findings of this report simply describe what happened to these children in out-of-home care and may suggest the need for further study to examine the reasons that the quality of some investigations may have been hampered, e.g., caseload size or

inadequate training of investigators. Other findings suggest the need for immediate changes to the policies and procedures employed by DYFS to fulfill its mandate to investigate reports of child abuse and neglect in out-of-home care settings and to make decisions that will increase safety for children the state is charged to protect. Most importantly, immediate action must be taken to assure the safety and well-being of all children in placements with prior reports of abuse and neglect. Eight specific recommendations follow:

1. **Immediately Reevaluate All Placement Settings with Prior Reports of Child Abuse and Neglect to Ensure Child Safety.** Given the number of cases in which children were placed in out-of-home care settings with prior reports of child abuse and neglect, the state should reevaluate all homes with prior reports of child abuse and neglect to determine whether children are currently unsafe in these homes. In particular, homes with prior substantiated or prior unsubstantiated with concerns findings must be examined immediately.

2. **Halt Practice of Using Waivers to Keep Children in Foster Homes with Prior Substantiated Abuse or Neglect Reports.** The state should determine it is unsafe for children to keep foster homes open after a foster parent has a substantiated report of abuse or neglect.

3. **Overhaul Procedures and Guidance for Determining Findings of Alleged Child Abuse and Neglect.** The state should examine the guidance they provide to investigators about how child abuse and neglect findings decisions are made and overhaul IAIU practices and procedures in this area. It is assumed that directions in procedures and/or training (either directly or indirectly) have suggested that investigators not substantiate cases even when the facts of a case meet the definitions of child abuse and neglect in New Jersey law. Use of the "factors/findings matrix" found in New Jersey policy (DYFS, 1989) apparently allows classification of situations that meet the definition of abuse or neglect in New Jersey law as "unsubstantiated with concerns" instead of "substantiated." This practice has clearly created unsafe situations for children as evidenced by the large number of children who were subject to new reports of child abuse or neglect in homes where caregivers had prior unsubstantiated reports and should be eliminated.

4. **Identify and Remove Barriers to Responding to Reports Within Designated Response Times**. DYFS should examine what barriers prevent investigators from responding to reports of abuse or neglect in out of home care settings within the response times designated by screening workers and supervisors. There are always concerns for a child's safety if an agency fails to respond to reports of child abuse and neglect in a timely manner (DePanfilis, 1997). However, the concerns are even greater in situations when children are placed in out-of-home care settings.

5. **Use a Safety Evaluation Instrument to Assess Safety of Children in Out-of-Home Care Settings.** In the last investigations reviewed in 2002, reviewers noted the introduction of a new safety assessment instrument that provided a structured method for assessing safety concerns in out-of-home care settings. The decision-making in the two cases where this instrument was used seemed to be notably improved compared to other cases reviewed. It is recommended that DYFS assess the safety of all children in out-of-home care settings using a safety evaluation instrument to help them evaluate the information they gather about the care of children in out-of-home care settings.

6. **Implement Intensive Training for Investigators.** There was considerable variability in the quality of the investigations reviewed. Some of this variability could be because of different expertise and skill of the investigators. As stated by the National Association of Public Child Welfare Administrators (NAPCWA, 1999), agencies are responsible for ensuring that its staff has the specialized knowledge and skills to provide quality services. In this case, the quality services required are timely and thorough investigations that ensure children are safe. It is recommended that the state carefully examine the qualifications and training of investigators and consider increasing training on interviewing, thoroughness of investigations (protocol for gathering sufficient information), analysis of gathered information, and decision-making.

7. **Ensure Adequate Supervisory Oversight.** Regardless of the level of experience, investigators need guidance, an objective perspective on cases, and assistance with decision-making (DePanfilis and Salus, 1992). The review identified potential problems in the supervisory involvement in these investigations. In some cases, significant gaps occurred between when the investigator and supervisor signed the final report. In other cases, where investigative file information was superficial and when the information indicated that different decisions should have been made to increase safety for children, the supervisor signed off on investigations that did not reflect the exercise of reasonable professional judgment. DYFS should carefully examine the role that supervisors play in the investigation of out-of-home care child abuse and neglect reports and implement procedures to improve the quality of supervision in these cases.

8. **Develop Teams to Improve Coordination**. Due to the complexities of child maltreatment reports in out-of-home care settings, multiple professionals are often involved (e.g., law enforcement, licensing agency, supervising agency) and therefore special protocols should be established in order to enhance the quality of decisions that increase safety for children (CWLA, 1999). Cross training of these professionals and the development of interagency agreements and teams can improve the quality of investigations and coordinate the follow-up of recommendations for personnel action, corrective action, revocations of licenses, etc. (Nunno and Motz, 1988).

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