New Jersey Office of the Child Advocate

Protecting Children

A Review of Investigations of Institutional Child Abuse and Neglect
Acknowledgements

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The New Jersey Office of the Child Advocate is an independent state agency dedicated to promoting positive change in public policy and practice to improve the safety, health and well-being of New Jersey children, especially those with the greatest need.

To achieve this goal, the Child Advocate identifies important issues that require systemic change. The Child Advocate works closely with Legislators, government officials, community stakeholders and other advocates to craft innovative solutions to identified problems. The Child Advocate then monitors implementation of these reforms to make a real difference in the lives of New Jersey’s children and their families.

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Protecting Children:
A Review of Investigations of Institutional
Child Abuse and Neglect

Each year, thousands of children enter New Jersey’s foster care system, often leaving the only family they know and being placed in foster homes to safeguard them from abuse and neglect. Many others reside in institutional settings, such as group homes and other behavioral treatment facilities.

One of the state’s most critical responsibilities is to ensure the safety and well-being of these children, especially while in the care of the state. As part of its role in monitoring New Jersey’s child protection system, the Office of the Child Advocate conducted an in-depth review of 90 investigations of allegations of abuse and neglect involving 131 children living in out-of-home settings, including resource homes, group homes, residential treatment centers and juvenile detention centers. These investigations were initiated between January 2007 and June 2007.

The goal of this review is to provide an objective assessment of the thoroughness of these investigations and the soundness of the findings rendered by investigators. Based on this research, the Child Advocate makes recommendations to the Department of Children and Families (DCF) for ongoing improvement of the functioning of the Institutional Abuse Investigative Unit (IAIU), which investigates alleged abuse and neglect in out-of-home settings.

It must be noted, however, that the representative cross-sample of cases that were reviewed in this study covered the period from Jan. 1, 2007 through June 30, 2007. New Jersey’s child welfare system has continued undergoing significant change since that time. Focus groups and interviews with IAIU and DCF staff were conducted between May and June 2008 and thus reflect more recent observations by investigators and others in the child welfare system.

Specifically, the assessment was designed to answer the following questions:

- Is the institutional abuse investigatory practice thorough and consistent with DCF policy?

- Were the findings of the investigations consistent with New Jersey’s laws and DCF’s policy?

- Has the change from a 3-tier to a 2-tier findings system had any affect on the State’s ability to safeguard children in out-of-home placement? (New Jersey eliminated the “not substantiated” findings category in 2005, leaving two available findings: substantiated and unfounded).
Key Findings

Strengths

- The Child Advocate’s review team found the findings to be consistent with state law in 82 cases, or 91 percent of the 90 reviewed cases.

- Investigations met standards for timeliness or had justifiable reasons for delay, such as a criminal investigation, in 77 cases (85%).

- Of those instances in which in-person interviews with alleged child victims were appropriate, 97 percent of these children were interviewed. Thirty children could not be interviewed because of age, developmental level or other valid reasons.

- All 107 alleged perpetrators either received a face-to-face interview or a valid reason was documented to explain why this did not occur, such as the perpetrator was unknown or could not be located.

- There was documentation that the DYFS local office responsible for ongoing management of a child’s case was notified of the abuse/neglect allegation in 80 of the 85 relevant cases (94%).

- In 92 percent of the 90 cases, documentation confirmed that an initial supervisory conference was conducted.

Areas in Need of Improvement

- Information gathering was inconsistent. Investigators were most likely to seek information about the case from the DYFS local office. This occurred in 72 cases or 89 percent of relevant cases. They were least likely to interview all adult residents of a resource home. This was documented to have occurred in 25 cases, or 56 percent, of the 45 cases involving resource homes.

- Documentation confirmed that 27 (27%) of the alleged child victims were interviewed both privately and separately when appropriate, as required by DCF policy. For 62 children (61%), no documentation existed to confirm separate and private interviews were conducted. Thirty children could not be interviewed because of age, developmental level or other valid reasons.

- In four cases, the Child Advocate’s review team was unable to determine whether the findings met the standards of New Jersey law and policy because of a lack of information in the file.

- In 28 cases, although the investigation resulted in a finding that the alleged abuse or neglect was unfounded, corrective actions were recommended. This represents 32 percent of the 87 “unfounded” cases. Twenty-five of these plans addressed issues related to a child’s safety or well-being, suggesting that
investigators uncovered situations or behaviors that were of concern. Eleven of the 25 plans were never entered into the Department’s tracking system so it is unclear whether appropriate follow-up occurred.

**Incidents of Child Abuse and Neglect in the Sample**

- The Child Advocate’s Review Team concurred with each of the substantiated findings in the sample. However, the Child Advocate’s Review Team found that another four cases that were unfounded by IAIU rise to the level of substantiated findings under the legal definition of abuse or neglect.

- Using standards set forth in NJSA 9:6-8.21, the Child Advocate’s Review Team found that 7.7 percent of cases in the sample merited substantiation, which is greater than the percent of cases that were officially substantiated by IAIU during the study period.

**Overview**

The Department of Children and Families is completing investigations in a more timely manner. Historically, the Institutional Abuse Investigative Unit had a backlog of cases exceeding the required time limits for completing investigations. The Child Advocate’s review team found this is no longer the case, with 85 percent of cases meeting the timeframe or having justifiable reasons for delay.

New Jersey is under a federal court Modified Settlement Agreement to implement sweeping reforms to its child welfare system. The court appointed a monitor to measure the progress and success of those reforms.

Improving the timeliness of these investigations is a requirement of the modified settlement agreement. The Child Advocate’s finding with respect to the timeliness of investigations is consistent with the monitor’s findings and exceeds the standard established in the settlement agreement. The state’s progress in this area illustrates the ability to solve long-standing problems when appropriate resources and attention are applied. The Department should be commended for its progress on this front.

While the study found that investigations are conducted in a more timely fashion, the information gathering process was inconsistent. Although the review team agreed, in the vast majority of cases, that the findings were consistent with New Jersey law, those determinations were based on information available in the files. It is impossible to know whether different conclusions would have been reached had all relevant information been gathered in each case. A thorough investigation is critical in safeguarding children and must be conducted in every case. Otherwise, crucial information can be overlooked that could dictate a different course of action to determine whether a child is safe.

The Child Advocate’s study also identified concerns over the state’s shift to a 2-tiered findings system and the redefinition of the findings categories. In 2005, the state amended regulations to eliminate “not substantiated” as one of three findings that could
be made in an investigation into alleged abuse or neglect.¹ That finding had meant that available information provided “some indication that a child has been harmed or placed at risk of harm” but not to the level supporting the legal definition of “an abused or neglected child.”²

Prior to this definition shift in 2005, “unfounded” meant “there is no evidence of conduct that would pose risk to the child; there is no evidence that a parent, caregiver, temporary caregiver, institutional caregiver or child was involved; or the available information indicates that the actions of the parent, caregiver, temporary caregiver, institutional caregiver were necessary and reasonable and the incident was an accident.”³

Under the current 2-tier system, the “not substantiated” category was eliminated and the definition of “unfounded” was changed to mean “that there is not a preponderance of evidence that the child was harmed or placed at substantial risk of harm.”⁴

Both the case reviews and information gleaned in focus groups point to a concern regarding the 2-tiered findings system. Under the 3-tiered system, the “not substantiated with concerns” category indicated problems may exist, but those problems either did not rise to the legal definition of abuse or neglect or there was a lack of evidence to legally prove abuse or neglect had occurred.

The 2-tiered system eliminated this category. The new definition of “unfounded” is more expansive, encompassing both cases in which abuse or neglect could not be legally proven but concerns were identified that warranted corrective action and those cases that were essentially without merit.

The work of the investigators recognizes these two distinct types of unfounded cases. In nearly a third (32 percent) of the unfounded cases, investigators requested that caregivers or institutions take specific steps to address concerns uncovered during the investigation. This totaled 28 corrective action plans. Of those, 25 were directly related to a child’s safety or well-being.

In July 2008, the Department of Children and Families issued an updated policy regarding corrective actions plans for cases in which investigators concluded that the allegations were unfounded but with concerns.

For institutional settings, the facility administration must formulate a corrective action plan in response to the concerns identified by the Institutional Abuse Investigation Unit. These plans are reviewed and monitored by IAIU’s Corrective Action/Continuous Quality Assurance Unit.

For resource homes, the local office manager is responsible for writing the corrective action plan and submitting that plan to IAIU’s Corrective Action/CQA Unit, under the revised policy. This unit also is charged with monitoring corrective action plans for
resource homes to ensure appropriate follow-up. Additionally, DCF maintains that when such concerns involve facilities licensed by DCF, such as foster homes and residential treatment centers, the issues are addressed and remediated through the licensing process.

Regardless of the type of setting, information gleaned during the focus groups indicated that investigators and supervisors are uncomfortable labeling cases as “unfounded” when, in fact, concerns have been identified. They also indicated that a finding of “unfounded,” particularly when there are concerns, limits the development of a historical record of troubling behavior patterns that may prompt closer scrutiny of a program or out-of-home care provider. In addition, the finding of unfounded makes it more difficult to persuade providers to voluntarily comply with corrective action plans because the characterization does not readily communicate the fact that safety concerns may be present, despite the finding of unfounded.

Recent court rulings have limited IAIU’s authority to document and address concerns when there is an unfounded finding in a school district. This is arguably unrelated to the change from three tiers to two tiers and could have occurred under the previous findings system. In one recent ruling, the Appellate Division of Superior Court prohibited the Department from pursuing corrective action, ordering IAIU to “cease and desist its practice of requesting confirmation that a school district has taken or will take any corrective action when its investigation results or will result in a finding of ‘unfounded’. ”

Some enduring uncertainty about the unfounded category may be evidenced in a ruling issued on May 21, 2007, when the Appellate Division noted:

A finding of ‘unfounded’ means that no child abuse existed. N.J.A.C. 10:129-1.3. However, due to the definition of ‘substantiated,’ which clearly indicates that IAIU found evidence of abuse or neglect, there is no category title that allows for a recognition of the large gap between abuse and proper behavior. The Commissioner [of the Department of Children and Families] may want to reconsider the categories of findings which might be appropriate.

However, the Appellate Division failed to note that unfounded actually has a definition that is different from “no child abuse existed,” as the court asserted.

DCF officials contend that the current system provides an effective way to correct concerns and to track the history of providers, both through licensing and the IAIU Corrective Action/Continuous Quality Assurance Unit. They also note that the expungement law allows the “unfounded” findings to remain on an individual’s record for three years. If another allegation is made within that timeframe, the 3-year clock starts again and the individual must wait another three years for the earlier incident to be expunged. The 3-year period begins running anew even if the subsequent allegation
is also unfounded, thus providing an historical record of concerns regarding an individual. Officials also maintain that the 2-tier system has not adversely affected the Department’s ability to ensure child safety.

However, as delineated in Figure 1, it is clear that a 2-tiered finding system includes three types of investigative outcomes. What is unclear is if a 2-tiered system should use the term “unfounded” to refer to those findings that fall below the statutory level of abuse or neglect. It appears to be problematic to use the term ‘unfounded’ to refer to cases in which concerns are identified but the evidence of abuse or neglect is below the statutory level.

**Figure 1: Findings and Outcome Systems**

<table>
<thead>
<tr>
<th>Substantiated</th>
<th>Unfounded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preponderance of evidence meets the statutory level of abuse/neglect.</td>
<td>Preponderance of evidence falls below statutory level of abuse/neglect.</td>
</tr>
<tr>
<td>Incidents that are considered abuse and/or neglect.</td>
<td>Incidents that are not considered abuse and/or neglect but concerns exist.</td>
</tr>
<tr>
<td>Incidents that are not considered abuse and/or neglect and no concerns exist.</td>
<td></td>
</tr>
</tbody>
</table>

2- Tiers of Findings | 3-Categories of Outcomes

The common understanding of the meaning of “unfounded” is “without foundation; not based on fact,” and “groundless; unwarranted.” Therefore, regardless of how the term is outlined in DCF policy, its use is at odds with established norms and may be perceived as contradictory when accompanied by ‘concerns’ (i.e., how can an allegation that is without merit require a corrective action to address concerns). Granted, the definition of “unfounded” that is now in use is different than the definition that existed for many years, and altering such a fundamental component of the child welfare system can take time for veteran staff to accept and embrace.

This issue may require further examination and training of staff, as well as a look at the effectiveness of the Department’s monitoring of corrective action plans. It is critical that any safety and well-being issues identified through an institutional abuse
investigation are effectively categorized and addressed, even when they do not rise to the legal level of substantiated abuse or neglect.

**Method**

The questions developed to assess the cases in the sample were based on the investigatory and administrative policies of the Institutional Abuse Investigations Unit within DCF. Two data sources were used to compile the information contained in this report:

- A representative cross-sectional sample of 90 complete IAIU case files on investigations conducted from January 1, 2007 through June 30, 2007 as supplied to the Office of the Child Advocate by DCF.

- Focus groups and interviews with administrative, supervisory and investigation staff in the IAIU central office and four regional offices.

Only cases involving children in out-of-home placements, such as residential facilities, resource homes, group homes, shelters, in-patient psychiatric units, juvenile detention centers and facilities administered by the Juvenile Justice Commission were eligible for sample selection. Excluded settings were child care providers, schools, registered or unregistered day care settings, camps and bus companies. Using a confidence level set at 95 percent, the estimated standard error is ±4 percent. For more information on methodology, please refer to Appendix A.

The following tables provide a breakdown of the type of abuse/neglect alleged in each case and the relationship of the alleged perpetrator to the alleged child victim.

<table>
<thead>
<tr>
<th>Type of Allegation (n = 117)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Abuse</td>
<td>65</td>
<td>56</td>
</tr>
<tr>
<td>Neglect</td>
<td>40</td>
<td>34</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship of Alleged Perpetrator to Victim (n = 107)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Foster Parent</td>
<td>39</td>
<td>36</td>
</tr>
<tr>
<td>Institution staff</td>
<td>40</td>
<td>37</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: Each individual case can include more than one allegation and/or perpetrator. Therefore, these totals may exceed the total number of cases.

It is important to note that the assessment/evaluation tool used in this study posed questions on the handling of institutional abuse allegations based on the stated policies of the Department of Children and Families. All measurements discussed in this report
are based on whether DCF staff adhered to the relevant Department policy. As with all case studies, this examination relied on the documentation in the record. When no documentation existed to support an action had occurred, it was counted as though it had not occurred. So, in some instances, it is impossible to know with certainty whether the problem was case practice or lack of documentation. Either way, accurate documentation is critical to good case practice and the lack of documentation is, in and of itself, a problem.

**IAIU Functioning**

The Institutional Abuse Investigation Unit within the New Jersey Department of Children and Families is responsible for investigating reports of alleged abuse and/or neglect of children in out-of-home settings in New Jersey. These settings include any public or private facility that provides children with care and supervision, including schools, child care centers, family daycare homes, camps, in-patient psychiatric units, resource family homes, including foster care and relative/kinship care, shelters, group homes, residential treatment facilities, detention centers and juvenile correctional facilities.

In 2007, the unit responded to 3,201 allegations of abuse and neglect, according to DCF statistics. IAIU investigators are charged with conducting thorough investigations to determine if allegations are true and if further protective action is required to ensure children’s safety. The standard timeframe for initiating an IAIU investigation is within 24 hours, but a referral can be coded for immediate response in cases that warrant it.¹⁰ The IAIU supervisor has the authority to initiate an immediate field response.¹¹

**Discussion of Findings**

**Quality of Investigations**

The Child Advocate’s review team examined each step of the investigation to determine whether these inquiries were handled in a thorough manner. The review found that elements of the investigatory process tended to be handled thoroughly and professionally, but certain key areas need significant strengthening.

Areas of strength included timely completion of investigations, timely initial response to the allegation and a high percentage of in-person interviews of the alleged child victims and alleged perpetrators.

An area needing improvement was information gathering, including interviewing all relevant sources, the completion of assessment tools, supervision and documentation. While state policies mandate these actions, the review found that these critical steps are sometimes overlooked in practice.

Without a complete gathering of information, crucial information can be missed that could dictate a different course of action to ensure a child’s safety. This points to the need for continued and enhanced training and a vigilant quality assurance process to ensure policy translates into practice.
As indicated, the review team agreed with the investigators’ findings in the vast majority of cases. Importantly, those determinations were based on information available in the files. It is impossible to know whether different conclusions would have been reached had all relevant persons been interviewed and all appropriate sources of information been obtained in each case. As noted earlier, it is possible that investigative steps were taken but not documented. However, it cannot be stressed enough that strong documentation is critical to a good investigation. Clearly, a thorough investigation is a critical tool in safeguarding children. The chart below provides an overview of our findings with regards to thoroughness of investigations.

<table>
<thead>
<tr>
<th>Interview Process</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation completed within required time frame or justifiable delay</td>
<td>77 of 90 cases</td>
<td>85</td>
</tr>
<tr>
<td>Initial face-to-face contact with all alleged child victims in the case within the required time frame</td>
<td>77 of 90 cases</td>
<td>85</td>
</tr>
<tr>
<td>Alleged child interviewed in person</td>
<td>98 of 101 children</td>
<td>97</td>
</tr>
<tr>
<td>Each alleged child victim interviewed both separately and privately</td>
<td>27 of 97 children</td>
<td>28</td>
</tr>
<tr>
<td>Each child at risk of harm interviewed separately and privately</td>
<td>18 of 39 cases</td>
<td>46</td>
</tr>
<tr>
<td>Alleged perpetrator interviewed in person</td>
<td>100 of 100 perpetrators</td>
<td>100</td>
</tr>
<tr>
<td>Initial supervisory conference held</td>
<td>83 of 90 cases</td>
<td>92</td>
</tr>
</tbody>
</table>

**Note:** Total number of children and alleged perpetrators in respective rows reflect those individuals who could be interviewed (e.g., Children who could be interviewed based on age and developmental ability; Alleged perpetrators who could be interviewed because they were known and could be located)

**Timeliness of Investigations**

The timeliness of investigations is a key benchmark the state is required to meet as part of the federal settlement agreement. The Child Advocate’s study found that 77 investigations (85%) were either completed within the required 60 days or there were justifiable reasons for a delay beyond 60 days, such as a pending criminal investigation. The Institutional Abuse Investigation Unit has historically had a significant backlog of open investigations. In 2005, when the Child Advocate reviewed IAIU’s functioning, roughly one-third of investigations were completed within the required 60 days. This study documents a significant improvement and reflects the Department of Children and Families’ commitment to safety for children in placement and achieving the goals of the settlement agreement.

**Notification**

Initial notification is an important aspect of the investigatory process. Concerned parties need to be informed about allegations concerning a child. At the time of the Child Advocate’s review, DCF policy required the DYFS caseworker to notify the child’s parent or guardian about an allegation. Since the study did not examine the DYFS record, it is unknown how often this notification took place when the verifying information was not in the IAIU file. However, the study did find that IAIU documented
this notification in only 58 cases, or 64 percent, of all cases. With recent policy changes, the responsibility for notification of the parent or guardian now lies with the institutional abuse investigator. The Child Advocate would expect this policy change to strengthen documentation of initial notification of allegations.

**Initial Contact**

In 77 cases (85%), investigators initiated in-person contact with the alleged child victims within the required response time. This includes five cases in which they did not meet designated timeframes but documented sufficient justification for the delay.

**Interviews of Children**

Of the 131 alleged child victims in the sample, 30 were either too young to be interviewed or had developmental delays that prevented investigators from conducting a meaningful interview. Of the remaining 101 children, investigators interviewed 98 children in person (97%). In five cases, either the child or caregiver refused to grant an interview with investigators.

DCF policy also requires investigators to interview each child separately and privately. This means alleged child victims were alone (i.e. separate) with the investigator in a place where others could not overhear the conversation (i.e. private).

Documentation confirmed that 27 (27%) of alleged child victims were interviewed both privately and separately when appropriate, as required by DCF policy. For 62 children (61%), no documentation existed to confirm separate and private interviews were conducted. Thirty children could not be interviewed because of age, developmental level or other valid reasons.

<table>
<thead>
<tr>
<th>Separate and Private Interviews of Children</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable because of child's age, developmental level</td>
<td>30 of 131 children</td>
<td>23</td>
</tr>
<tr>
<td>Separate and private interview conducted when possible</td>
<td>27 of 101 children</td>
<td>27</td>
</tr>
<tr>
<td>No separate and private interview conducted</td>
<td>12 of 101 children</td>
<td>12</td>
</tr>
<tr>
<td>No documentation in record about location of interview</td>
<td>62 of 101 children</td>
<td>61</td>
</tr>
</tbody>
</table>

It is unclear whether investigators actually failed to conduct private and separate interviews or whether they simply did not record the location and circumstances of interviews.

The review found investigators’ methods for recording interviews varied widely. Some kept detailed records, while others provided brief overviews of their contacts with the victim, perpetrator and sources. This issue of documentation should be addressed with revised policy that clearly defines the information investigators must document,
especially with regard to the level of detail that must be recorded about who was interviewed, what was said and the location of the interview.

The Department should also examine whether investigators are, in fact, interviewing child victims separately and privately, as this is critical to obtaining accurate information by establishing a safe setting in which a child is more likely to be forthcoming about the alleged abuse or neglect.

**Interviews of Perpetrators**
In every case in which the alleged perpetrator was known and could be located, the alleged perpetrator was initially interviewed in person. Only seven of the 107 alleged perpetrators, or 6.5 percent, were not interviewed in person. In six of these cases, the perpetrators were unknown and in one case the individual could not be located.

**Supervisory Contact**
Effective supervisory oversight is a critical factor for ensuring thorough investigations. At the time of the case review, DCF policy required a supervisor to have an initial supervisory conference. In the vast majority of cases – 83 cases (92%) – an initial supervisory conference was documented. As a result of previous audits, DCF administrators had recommended a change in policy to require a minimum of three supervisory conferences during the course of the investigation. Because of that recommendation, the audit measured the practice of holding three or more consultations.

Documentation confirmed that in more than half of the cases, there were three or more consultations, although this was not mandatory at the time, which is an encouraging sign of the system’s progress. As of July 2008, the policy was officially updated to require the IAIU supervisor to hold an initial supervisory conference with the assigned investigator and conduct weekly conferences for the duration of the investigation. This is a positive step that will likely have a measurable impact on strengthening supervisory oversight of these investigations.

**Safety Assessments**
When allegations involve children who are placed in resource homes, a standard safety assessment is used to aid investigators in determining whether those children are safe. Similarly, safety assessments are also conducted as part of investigations into alleged abuse and neglect involving children who are living in their own homes. This tool is a critical aspect of an investigation. This study uncovered some concerns with the way assessment tools were used to determine the safety of children in resource homes.

In the sample, 57 cases involved resource homes where investigators should have used the safety assessment tool. In 48 of the cases (84%), safety assessments were conducted and in 12 instances, safety factors were identified by the investigator.
The Child Advocate’s review team was asked to describe the quality and thoroughness of the safety assessments conducted in resource home settings based on certain criteria derived from relevant DCF policy. The review team was asked to assess whether the safety assessments met practice standards.

<table>
<thead>
<tr>
<th>Quality and Thoroughness of the Safety Assessment in Resource Home Setting (n = 57 cases)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets practice standards</td>
<td>26</td>
<td>46</td>
</tr>
<tr>
<td>Does not meet some practice standards</td>
<td>18</td>
<td>31</td>
</tr>
<tr>
<td>Does not meet most practice standards</td>
<td>13</td>
<td>23</td>
</tr>
</tbody>
</table>

The criteria the review team used included:

- A child’s safety in a resource home setting is formally assessed by fully completing the safety assessment;
- Assessment accurately reflected information documented in file, including interviews with the child;
- Concerns are noted on the form in the appropriate section;
- Investigator … [considered] that child may strongly desire to go home and not return/remain at the facility, which may affect how child responds to the investigator.

In nine of the 48 cases in which assessments were conducted, Special Response Unit (SPRU) investigators were responsible for the investigation and so they completed the safety assessments. The SPRU unit handles evening and weekend investigations of alleged child abuse and neglect in both DYFS and IAIU matters. In all nine SPRU investigations, the SPRU workers assessed safety, which is positive. However, workers used the assessment form designed for in-home DYFS cases, not the correct form for out-of-home placements as required by policy. The correct safety assessment form addresses the unique circumstance of children in out-of-home placement, including additional questions assessing the caregiver’s ability to protect the child, other individuals who reside in or frequent the home, indicators of possible substance abuse in the setting and willingness of others in home to care for children in placement.

In 14 cases, there was no documentation in the file that safety factors were discussed or observed, although investigators completed the assessment tool. In order to accurately use this tool to assess safety, the investigators must engage in an in-depth conversation, coupled with keen observation of physical indicators. Then investigators must document these conversations and observations in the record. In eight cases, the files did not contain a safety assessment.
In one case, a safety factor was identified, but it was not reviewed by the supervisor until five days later. When any safety factor has been identified, DCF policy requires that worker to contact their supervisor immediately from the field. In another case, the child said he was afraid of a caregiver, but the safety assessment does not document his fear.

**Information Gathering**

DCF policy requires investigators to seek information from relevant sources, including various agencies within the Department and individuals who may have knowledge of the alleged incident. The requirements vary, depending on whether a child is in a resource home or a congregate care setting, such as a group home or residential treatment center. The Child Advocate’s review team identified which information sources would be appropriate in the various settings and then measured whether those sources were consulted.

The review found that investigators were most likely to seek information about the case from the DYFS local office responsible for ongoing management of a child’s case. This occurred in 72 of 81 relevant cases, or about 89 percent. They were least likely to contact the DYFS Resource Family Unit for information, conducting these collateral checks in 40 of 50 relevant cases, or about 80 percent of the time. These units are responsible for facilitating resource home placements and provide essential support to and oversight of resource homes. The Office of Licensing was contacted for information in 64 of 83 cases, or 77 percent, of relevant cases in which policy would require licensing to be contacted. This office is responsible for ensuring that homes and facilities meet the state’s safety and health standards.

With regard to interviewing individuals who may have knowledge of the case, investigators were most likely to interview each child residing in a resource home, as required by DCF policy. This occurred in 41 cases, or 82 percent, of the relevant cases. They were least likely to interview all adult residents of resource homes. Documentation indicated that this occurred in 25 cases, or 56 percent, of relevant cases. In 25 cases (76%), investigators interviewed all congregate care staff who may have had knowledge of the incident.

The review also found that people who saw and/or heard the incident were interviewed in 51 cases, or 70 percent of the cases in which there were witnesses to an incident.

Failure to interview or solicit information from all relevant and appropriate sources compromises the quality of the investigation and could affect the soundness of the finding.
Investigator interviewed relevant source:

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Family Unit</td>
<td>40 of 50</td>
<td>80</td>
</tr>
<tr>
<td>DYFS Local Office</td>
<td>72 of 81</td>
<td>89</td>
</tr>
<tr>
<td>Office of Licensing</td>
<td>64 of 83</td>
<td>77</td>
</tr>
<tr>
<td>People who saw/heard incident</td>
<td>51 of 73</td>
<td>70</td>
</tr>
<tr>
<td>Each adult resident in resource home</td>
<td>25 of 45</td>
<td>56</td>
</tr>
<tr>
<td>Each child resident in resource home</td>
<td>41 of 50</td>
<td>82</td>
</tr>
<tr>
<td>All relevant staff in congregate care settings</td>
<td>25 of 33</td>
<td>76</td>
</tr>
<tr>
<td>Relevant contacts outside DCF in congregate care setting</td>
<td>22 of 29</td>
<td>76</td>
</tr>
</tbody>
</table>

Investigative Findings

As part of the evaluation, the Child Advocate’s Review Team used the same legal standard that governs IAIU to determine whether each case in the sample met the criteria for a finding of unfounded or substantiated (N.J.A.C. 10:129-1.3). The review team agreed with DCF’s findings in 91 percent of cases in the sample. Among those, the Child Advocate’s Review Team concurred with each of the three substantiated findings in the sample. However, the Child Advocate’s Review Team found that four of the cases with “unfounded” findings rise to the level of substantiated findings under the legal definition of abuse or neglect.

In four other cases, the review team deemed that insufficient information existed in the case record to determine whether the finding was consistent with state law and policy. These eight cases were subject to a second review by Office of the Child Advocate staff members to verify the accuracy of these findings.

Findings (n = 90 cases)

<table>
<thead>
<tr>
<th>Findings</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed findings consistent with state law</td>
<td>82</td>
<td>91</td>
</tr>
<tr>
<td>Disagreed findings consistent with state law</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Insufficient documentation to determine whether findings consistent with state law</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: Percentages do not sum to 100 due to rounding (E.g., 4 / 90 = 4.44%) 

In the sample, DCF investigators substantiated three cases. In the Child Advocate’s determination, however, using standards set forth at N/JSA 9:6-8.21, 7.7 percent of cases in the sample merited substantiation, a greater percentage of cases than were officially substantiated by IAIU during the study period. The Child Advocate’s review team found that the evidence in the four cases detailed below support a finding of substantiated.

Case #1 - Relative Resource Home

In one case, there had been two reports regarding children placed in a foster home. The first referral alleged drug use by the foster parent. The second referral was called into the child abuse hotline after a caseworker visited the home to assess it for kinship legal guardianship, a permanency option available to children living with relatives. The worker observed deplorable living conditions in the home. On the same day, the children were removed from the home by court order. Despite this court action, the
IAIU investigator deemed both allegations, which were combined into one investigation, to be unfounded. The children were never returned to the home.

The Child Advocate’s review team determined that the facts in this case met the statutory definition of abuse or neglect under N.J.S.A. 9:6-8.21. Based on the Child Advocate’s subsequent internal review of this case, it was determined that the evidence would have supported a substantiated finding under N.J.S.A. 9:6-8.21.c.(4)(a) because the caregiver, failed “to exercise a minimum degree of care in supplying the child with adequate food, clothing [and] shelter...though financially able to do so...”

Case #2 – Residential Treatment Facility
A 17-year-old resident of a treatment center reportedly had his head pushed into a wall multiple times by staff during a restraint. His injuries included bruises and swelling to his head.

Prior to this incident, the staff member had been instructed on de-escalation skills and ways to guide youth in a different direction when they become agitated. Residents who were interviewed regarding the alleged incident said the staff member had instigated the alleged victim and escalated the situation to the point of physical contact between the staff member and the youth.

The Child Advocate’s review team determined that the facts in this case met the statutory definition of abuse under N.J.S.A. 9:6-8.21.c.(1). Based on the Child Advocate’s subsequent internal review of this case, it was determined that the evidence would have supported a substantiated finding. This finding would have been appropriate under both N.J.S.A. 9:6-8.21.c.(1) because the evidence indicated the staff member “inflicted upon such child physical injury by other than accidental means which created a substantial risk of ... protracted impairment of physical or emotional health.”
Furthermore, the evidence supported a finding of abuse under N.J.S.A. 9:6-8.21.c.(6) because “excessive physical restraint” was used “under circumstances which do not indicate that the child’s behavior is harmful to himself, others or property.”

Case #3 - Group Home
A 17-year-old resident of a group home was inappropriately discharged from the group home despite their responsibility to plan for a safe, appropriate placement for the boy. The facility staff tried to reach the boy’s family and his DYFS caseworker but were unable to make transportation arrangements with family members. Despite this, staff left the youth at a Newark train station with enough money to purchase a ticket to Camden where his family lived.

The group home administrators neither called to confirm that the youth had safely reached his destination nor informed all appropriate parties about the discharge. When contacted by screeners at the child abuse hotline, the program administration falsely claimed the youth had run away and that they had reported him missing to the police. No such report had been filed.
The Child Advocate’s review team determined that the facts in this case met the statutory definition of abandonment under N.J.S.A. 9:6-8.21.c.(4)(a). Based on the Child Advocate’s subsequent internal review of this case, it was determined that the evidence would have supported a substantiated finding under N.J.S.A. 9:6-8.21.c.(4)(a) because the group home had failed “to exercise a minimum degree of care in supplying the child with adequate food, clothing [and] shelter...though financially able to do so…”

**Case #4 - Group Home**
A 17-year-old girl living in a group home had an asthma attack one evening. The girl suffered from chronic asthma and could not locate her inhaler or medication. When she tried to dial 911, she found the phones were not working and no staff members were in the home. She had to leave the home and seek help from a nearby group home for boys. The allegation of neglect was deemed to be unfounded.

The Child Advocate’s review team determined that the facts in this case met the statutory definition of abuse and neglect under N.J.S.A. 9:6-8.21.c.(4)(a). Based on the Child Advocate’s subsequent internal review of this case, it was determined that the evidence would have supported a substantiated finding of neglect under N.J.S.A. 9:6-8.21.c.(4)(a) because there was no staff member available to assist the child in obtaining access to “adequate … medical care” and therefore the child was at “imminent danger of becoming impaired.”

**Substantiation**
The study did find that investigators reached appropriate findings under New Jersey law and policy in 91 percent of cases. However, when child safety is at stake, it is imperative that sound findings are reached in every single case. In addition, the rate at which New Jersey substantiates institutional abuse and neglect has fallen since 2005. Many factors can affect the rates at which allegations of institutional abuse and neglect are substantiated under New Jersey’s legal standard for child abuse and neglect.

While this study was unable to document exact reasons for that decline, it did identify that the quality of investigations was lacking in certain key areas. Without a thorough investigation, it is impossible to determine whether a report of child abuse and neglect should be substantiated. While some elements of the interview process are being handled appropriately, a key element – the collection of information – was found to be incomplete in several important areas. This included the failure to interview and document everyone who saw or heard the incident in 30 percent of cases and failure to interview and document all adult members of resource homes in 44 percent of relevant cases.

In focus groups, investigators said IAIU training still falls short of the desired instruction in the various procedures, techniques, legal concerns and interviewing skills needed to conduct a thorough investigation. The Department of Children and Families must continue to strengthen training of those involved in the investigative process,
while reinforcing the importance of the new model for case handling (case practice model) that is being implemented as part of the broader child welfare reforms. These include honing skills to engage children and families.

**Quality Assurance**

Quality assurance is a powerful tool that child welfare agencies can utilize to provide feedback to staff and to ensure that children in placement are receiving the highest standard of care and services. The Child Welfare League of America has stated that “continuous quality improvement requires ongoing evaluation of [an] agency’s out-of-home care system for children who have been abused or neglected, including analysis of information regarding incidents of maltreatment in out-of-home care to identify trends and agency strategies for preventing harm and attending to appropriate nurturance for children in out-of-home care.”

To meet the requirements of the Settlement Agreement, DCF is developing a proposal for a department-wide quality assurance plan by the end of December 2008. It is important to note that DCF conducts monthly meetings with representatives of department units to examine concerning emergent trends in settings investigated by IAIU. It is critical that all groups participate in this process on a consistent basis. For example, DCF has made significant progress in developing additional resource family homes and should be commended for this effort. As more resource family homes are developed, Central Office and Local Office resource family units can use the information identified from trending statewide and local patterns in IAIU complaints to perform a myriad of quality assurance functions. These include using this information to identify resource family training needs, areas where resource parents may need additional supports or education, and using the information to identify the skills of resource staff in developing, safe, appropriate and high-quality homes.

In addition to using statewide patterns and trends to enhance resource family related services and activities, vigilant monitoring and robust quality assurance processes must also be put in place to ensure that investigators are adhering to policy, especially in the areas of interviewing all relevant witnesses and collaterals. A critical next step is to ensure all systemic issues identified through this process are formally addressed through training, policy changes, facility oversight, contracting and licensing, as appropriate.

**Central Review Process**

In 2006, the Department of Children and Families added a new element to its review process for those cases in which the investigator determined that abuse and/or neglect should be substantiated. DCF has indicated that this review is conducted to ensure that the investigation was thorough and the finding appropriate. The new element added to this process is to discuss the case with a Deputy Attorney General (DAG), the Department’s legal representative in the courts. This review is undertaken by IAIU administrators in the Department’s central office.
If, during a review, administrators find a lack of evidence to support the finding of abuse or neglect, they can direct the investigator to gather more information. If after additional investigation, there is still not the preponderance of evidence necessary to substantiate a claim of abuse or neglect, then the recommendation to substantiate can be rejected, leading to a finding of unfounded.

This process can only potentially result in fewer substantiated findings since the Department does not undertake a similar review of unfounded cases in which concerns are noted. For example, four cases in this sample lacked the necessary information to make a determination of whether the findings were appropriate. These cases would not have been subject to an additional review.

While it may be appropriate for the Department to review the original regional office’s findings decisions, the Department should institute a similar review of unfounded cases in which investigators identified significant concerns.

**Child Abuse Registry**
Concerns over the child abuse registry also emerged during the course of the Child Advocate’s research. Substantiated perpetrators of child abuse or neglect are listed in this statewide registry. While access to the registry is strictly limited by state law, inclusion in the registry effectively prevents substantiated perpetrators from becoming licensed child care workers, foster parents and working in residential treatment centers for children. These severe consequences last a lifetime. This is appropriate in some cases, but under current practice the severity of the consequences are the same regardless of the severity of the offense.

In focus groups, investigators expressed concerns over these serious consequences, regardless of the nature of the allegation, and said this sometimes becomes a factor in their decision-making process. They said they were sensitive to the fact that a substantiation would have severe consequences for any child care staff or foster parent as they would be listed on the registry. This is an issue that has been raised by many advocates and one that clearly requires a thoughtful response.

The Child Advocate will conduct initial research on this issue for the purpose of initiating a conversation with stakeholders about whether the laws and regulations governing New Jersey’s registry are in need of revision. The Child Advocate will work to involve DCF and other stakeholders in this effort.

**Cases with Concerns, Corrective Action Plans**
In 32 percent of reports of abuse/neglect that are unfounded, the investigators documented concerns significant enough to prompt the recommendation of “corrective action plans.” This translates to 28 “unfounded” cases that had a corrective action plan attached. The Child Advocate reviewed the concerns raised in these recommendations and found that in 25 cases the issues were related to the safety and well-being of children. In three cases, the concerns were related to administrative issues.
Following are some examples of issues that the corrective action plans attempted to address:

- A resource parent may have used corporal punishment on a child in placement, in violation of Division policy. The child had a scratch under his right eye and the child alleged that his foster father hit him.

- Concerns that a resource parent was failing to safely supervise children at a swimming pool and other supervision issues

- Concerns over a child’s hygiene and weight loss

- A resource parent delayed seeking medical care for three days after her child in placement had significantly burned her hands

- Concerns that staff at a residential program failed to have a youth examined by the facility nurse after the resident had engaged in self-cutting behavior

- A resource home that was in disarray and unkempt. One child in placement was removed from the home the day after the initial allegation; another was removed 13 days later.

Equally concerning was that 11 out of 28 corrective action plans were never entered into the institutional abuse corrective action monitoring system and therefore were never tracked for subsequent compliance. Consequently, it is unclear whether the steps called for in these plans were ever implemented. The corrective action process, including the notification and tracking of cases from the IAIU units to the Central Office, the subsequent data entry and monitoring the implementation of these plans needs to be supported by a thorough electronic tracking system.

Findings System

In focus groups, investigators, supervisors and administrators widely expressed the opinion that the 2-tiered findings system, instituted in 2005, is problematic. These four focus groups included 16 IAIU investigators, six supervisors and four administrators from all regions of the state.

Many of the focus group participants said the 2-tiered system does not account for the “gray area,” in which actions were “inappropriate and unjustified” but did not rise to the statutory level of abuse/neglect.
“It’s not a black/white issue…[the third category] really helped when something significant happened but it didn’t rise to the level of abuse/neglect. Sometimes there are issues,” one IAIU Investigator said.

There are “so many issues that don’t fit into all or nothing categories,” an IAIU administrator said.

Some participants also said the 2-tier system makes it more difficult to capture a pattern that could signal problems with a specific caregiver or staff member. They said it was easier to prove a pattern with a history of “not substantiated” findings, as opposed to a string of “unfoundeds.” Cases often include a series of earlier incidents that may have presented concerns but did not quite rise to the level of abuse or neglect. Under current law, however, unfounded cases must be expunged from the individual’s record after three years. DCF, as noted above, has taken steps to ensure that information about unfounded cases are maintained beyond the 3-year limit if there is a subsequent allegation within three years.

Participants also said the finding of “unfounded” makes it difficult to impose corrective action plans on caregivers or staff members who may need remedial action.

“It is hard to send a report that says ‘unfounded with concerns.’ It almost doesn’t make sense,” said one IAIU supervisor. Another supervisor called the change to the 2-tiered system “an absolute and utter mistake.”

When the state moved from a 3- to 2-tiered findings system, the initial expectation was that the number of substantiations would increase because investigations would become more rigorous. An early version of the proposed regulation, which was later amended, stated:

“Further, by eliminating the category of not substantiated and clarifying the burden of proof as ‘preponderance of the evidence’ in the Divisions (sic) investigation findings, it is likely that more investigations will meet the threshold for substantiation, thus increasing child safety.”

In the 2005 published rule proposals, DCF anticipated that the rule changes would result in “increased safety of children and the renewed confidence in New Jersey’s child welfare system to successfully meet its promise to protect the most vulnerable members of its population,” and that “children will benefit directly from the increased clarity about what constitutes abuse or neglect.” These changes to the findings system were accompanied by substantial changes in investigation policies and procedures, including adoption of a new system for defining those circumstances in which an abuse and/or neglect investigation is required based on the type of allegation called into screening.

It is clear that in 2005, DCF instituted changes to the child welfare system with the goal of providing better service children and families. While much progress has been made,
the Child Advocate review indicates that revisiting the issue of the findings system as it relates to investigative outcomes may be most timely and appropriate.

**Summary**

The Department of Children and Families has made significant strides in completing investigations of institutional abuse and neglect in a more timely manner. In addition, the Child Advocate found the Department’s findings to be consistent with state law in 91 percent of cases.

This audit also found, however, that while some parts of the investigation are handled appropriately, the Department needs to be more rigorous in the collection, documentation and interpretation of information. In four cases, the Child Advocate’s team was unable to make a finding determination. In another four cases, although abuse and neglect was unfounded the Child Advocate’s team felt the evidence supported a substantiated finding.

The study also found that a significant number of cases, while not rising to the legal level of child abuse and neglect, still had troubling issues involving child safety. This prompted investigators and supervisors to express concern over the 2-tiered findings system and the confusing label of “unfounded.” This issue requires deeper examination to ensure that any concerns uncovered during the course of these investigations are adequately addressed and remediated to ensure that children are safe.

**Recommendations**

**Address Issues Concerning the Two-Tier System.** This study found that using the term “unfounded” in a 2-tiered system to refer to all cases is problematic. DCF should amend regulations to explicitly describe the range of cases that fall within the “unfounded” category. This range spans those in which there is no evidence of child abuse or neglect to those in which there is inadequate evidence of child abuse or neglect but significant concerns about child safety or other issues that warrant a corrective action plan. Clearer delineation of the types of findings that fall within this category could address misgivings by investigators and others about the “unfounded” category.

**Examine the Child Abuse Registry.**

This study identified concerns by investigators over the serious consequences that result from a substantiated finding and inclusion on the child abuse registry, regardless of the nature of the allegation. Some staff indicated this was sometimes a factor in their decision-making process.

The Child Advocate believes the structure of the child abuse registry needs to be examined to determine whether it should be changed to allow classification for different types of offenses and more closely align the gravity of the consequences with the severity of the substantiated abuse or neglect. This examination should also determine whether all substantiated allegations should remain on the registry forever, or whether
procedures should be considered in some cases to allow an individual to work toward being removed from the registry.

The Child Advocate recognizes any study of this issue would require a significant amount of effort on behalf of DCF, as it continues to devote considerable resources to meeting the terms of the federal court settlement agreement. The Child Advocate will conduct initial research on this issue for the purpose of initiating a conversation with stakeholders and DCF about whether the laws and regulations governing New Jersey’s registry are in need of revision. The Child Advocate will work to involve DCF and other stakeholders in this effort.

**Improve Corrective Action Monitoring.** The Department should institute clear measures for ensuring that all cases involving recommendations and corrective actions are appropriately identified and tracked by IAIU Central Office and that safety concerns are addressed in a timely and appropriate manner.

**Expand Supervisory Review.**
DCF should institute a review process of “unfounded” cases in which significant concerns are uncovered to ensure appropriate findings and follow-up. This should be similar to the review process for cases in which investigators initially arrive at a conclusion that an allegation should be substantiated.

**Quality Assurance.** In accordance with the modified settlement agreement, the Department of Children and Families is developing a quality assurance process. This process must include vigilant monitoring of the institutional abuse investigation process, including the gathering of information, the completion of safety assessments and notification of appropriate parties, including parents. The development of the quality assurance system should include input from the Office of the Child Advocate.

While IAIU has instituted a process for discussing quality improvement issues with other offices (e.g., Office of Licensing, Resource Family Unit), it is important that all groups participate on a consistent basis.

**Strengthen Training for Investigators.** The Department of Children and Families must provide more training in the various procedures, techniques, legal concerns and interviewing skills required to conduct thorough investigations that will not only accurately identify abusive situations, but will also withstand legal challenge. The Department of Children and Families must continue to strengthen training of those involved in the investigative process, while reinforcing the importance of the new approach to case handling (Case Practice Model). The Department should also consider linking information obtained from an internal quality assurance process to data trending to develop training policies and other system enhancements.

**Strengthen Documentation Policy.** Lack of consistency in documentation was apparent in many of the case records. Diligent evidence gathering and thorough documentation is
critical to ensuring quality investigations that will withstand legal challenge. This issue should be addressed with a revised policy that clearly defines the information investigators must document, especially with regard to the level of detail that must be recorded about who was interviewed and what was said. The Department must also monitor implementation of this new policy to ensure investigators are adhering to it.
Endnotes

1 37 N.J.R. 5004(b)

2 N.J.A.C. 10:129A-3.3 [Amended in 2005]

3 Ibid.

4 Current N.J.A.C. 10:129A-3.3


10 State of New Jersey, Department of Children Family Services, Division of Family Services (2008), Support Operations Manual (Volume III), Institutional Abuse and Neglect (Chapter E); Section 400 - Part 401; Timeliness of Response for Initial Response

11 State of New Jersey, Department of Children Family Services, Division of Family Services (2008), Field Operations Casework Policy and Practice Manual (Volume II), Chapter B., Section 1400, Part 1400.10; Timeliness of Response Determined by Field

12 Ryan, Kevin, Davidson, Mary, et. al, State of New Jersey, Office of Child Advocate; Rutgers University, Center for Children and Families, State of New Jersey (2005); Monitoring Report: The Department of Human Services Institutional Abuse Investigations Unit


15 37 N.J.R. 2132 (a) (2005) [Rule Proposals, Vol. 37, No.12; June 20, 2005]

16 37 N.J.R. 2132(a) (2005)

17 37 N.J.R. 5005(b) (2005)
Appendix A

Method
The case review was based on a representative cross-sectional sample of IAIU cases from January 1, 2007 through June 30, 2007. The sampling unit for our study was the full IAIU case record. A single IAIU case record may involve multiple children; therefore, the total number of children involved in our study exceeds the number of IAIU cases sampled. On occasion, the sampling unit (IAIU case) and the unit of analysis (IAIU case, child victim) are different within the study.

During the first six months of 2007, 1,730 referrals were accepted for investigation through central screening (SCR) at New Jersey’s Department of Children and Families (DCF). Only those cases that involved out-of-home state-effectuated placement by the Division of Youth and Family Services (DYFS) were considered eligible for the random sample of cases. Therefore, the only cases eligible for selection were those that involved state-directed placement to the Division of Developmental Disabilities (DDD) facilities, group homes, shelters, inpatient psychiatric units, juvenile detention centers or Juvenile Justice Commission-administered facilities, residential treatment facilities, resource homes and contracted foster homes. In total, 894 cases were eligible representing 1,281 children. Excluded placement settings were babysitters, schools, registered or unregistered day care facilities, camps and transportation companies.

While the proportion of facility types represented in the sample was similar to the proportion of facility types observed in the total sample, incidents of abuse were rarely reported in Department of Human Services, Division of Developmental Disabilities (DDD) facilities in the first half of 2007. While this category was eligible for the sample, the negligible number of incidents resulted in their exclusion for reasons of low probability of selection in the random sample. DDD facilities represented less than 0.1 percent of all cases that met the eligibility criteria for inclusion.

The 894 cases eligible by setting were reduced due to unstable IAIU case assignment numbers, subsequent coding downgrades, out-of-state placements settings or cases in which investigations were conducted by the Office of the Public Defender due to conflict of interest. Related-information records, in which case information was documented under a single IAIU case number on different days—or a single incident where each instance of new information was called into SCR on different days and subsequently recorded under separate IAIU case numbers—were consolidated under a single case record for the purpose of the sample. All related records for such cases were then requested from the Department of Children and Families. Removing records for all of the reasons cited above reduced the total sampling frame to 886 full cases. From those, a 10 percent systematic random sample \( (n = 90) \) and a 2 percent oversample \( (n = 18) \) were taken for a total selection of 108 IAIU case records.
Estimation of the sample’s standard error assumed a proportion of 98-to-2 (Unfounded-to-Substantiated) in the observed findings. Using a confidence level set at 95 percent, the estimated standard error within the sample is approximately ±4%.

The 18-case oversample, which was systematically selected from the 108 files, supplied cases for reader training, replacements for downgraded cases and replacements for records rendered unusable due to incomplete or illegible documentation. Prior to case review, six cases were removed from the oversample for reader training.

**Case Review Method**

The file review team was composed of two OCA staff members, one staff member of the federal court-appointed Monitor (The Center for the Study of Social Policy), one retired former DYFS Local Office manager and two retired former DCF child welfare trainers. Prior to the actual file review activities, each team member attended a one-day training session. During that session, DCF staff from IAIU Administration provided training on IAIU policies, procedures and the investigation process in addition to providing written materials, such as an IAIU Reference Guide and a sample IAIU file. The team was also trained by staff from Rutgers University, School of Social Work, Institute for Families, and OCA on the data collection tool to be used in the file reviews.

The file review phase of this assessment extended from May 7, 2007 to May 23, 2007. Of these six team members, one OCA staff member served as Project Manager and reviewed two cases in the sample, while the other five team members reviewed the remaining 88 files. The Project Manager also led quality control measure activities, including second reviews of 13 cases as well as data verification of selected items for the entire sample.

The file review involved the reading and review of each of the 90 complete IAIU investigation files in the sample followed by the completion of a data collection tool instrument. For each of the IAIU investigation files, a team member read and reviewed the entire contents of the file. The data collection instrument provided readers with a standard format for collection of information on written documentation in the file to assess whether decisions were made in accordance with law and policy and to evaluate the thoroughness and quality of the procedures and processes involved in an IAIU investigation. Appendix B is a copy of the data collection instrument. The data were analyzed using Excel and SPSS¹.

A tiered review process was applied to 17 cases. In six of these cases, the review team had disagreed with investigators’ findings. Upon subsequent review, Child Advocate staff determined that in two of those six cases the investigators’ findings were consistent with New Jersey Statute.

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¹ SPSS was formerly known as the Statistical Package for the Social Sciences.
In 11 cases, review team members found they could not determine if findings were consistent with New Jersey Statute due to a lack of information in the file. The Child Advocate’s subsequent review found that adequate information existed in seven of those cases to determine that the findings were consistent with state law and that four of those 11 cases did lack adequate information to determine whether the findings were consistent with New Jersey’s law and policies. This extra review was conducted to ensure the accuracy of the study’s findings.
Appendix B


For purposes of this act:

"Abused child" means a child under the age of 18 years whose parent, guardian, or other person having his custody and control:

a. Inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ;

b. Creates or allows to be created a substantial or ongoing risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted loss or impairment of the function of any bodily organ; or

c. Commits or allows to be committed an act of sexual abuse against the child;

d. Or a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian, or such other person having his custody and control, to exercise a minimum degree of care (1) in supplying the child with adequate food, clothing, shelter, education, medical or surgical care though financially able to do so or though offered financial or other reasonable means to do so, or (2) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or substantial risk thereof, including the infliction of excessive corporal punishment or using excessive physical restraint under circumstances which do not indicate that the child's behavior is harmful to himself, others or property; or by any other act of a similarly serious nature requiring the aid of the court;

e. Or a child who has been willfully abandoned by his parent or guardian, or such other person having his custody and control;

f. Or a child who is in an institution as defined in section 1 of P.L.1974, c. 119 (C. 9:6-8.21) and (1) has been so placed inappropriately for a continued period of time with the knowledge that the placement has resulted and may continue to result in harm to the child's mental or physical well-being or (2) has been willfully isolated from ordinary social contact under circumstances which indicate emotional or social deprivation.

A child shall not be considered abused pursuant to subsection f. of this section if the acts or omissions described therein occur in a day school as defined in section 1 of P.L.1974, c. 119 (C. 9:6-8.21).

1. As used in this act, unless the specific context indicates otherwise:
   a. "Parent or guardian" means any natural parent, adoptive parent, resource family parent, stepparent, paramour of a parent or any person, who has assumed responsibility for the care, custody or control of a child or upon whom there is a legal duty for such care. Parent or guardian includes a teacher, employee or volunteer, whether compensated or uncompensated, of an institution who is responsible for the child's welfare and any other staff person of an institution regardless of whether or not the person is responsible for the care or supervision of the child. Parent or guardian also includes a teaching staff member or other employee, whether compensated or uncompensated, of a day school as defined in section 1 of P.L.1974, c.119 (C.9:6-8.21).
   b. "Child" means any child alleged to have been abused or neglected.
   c. "Abused or neglected child" means a child less than 18 years of age whose parent or guardian, as herein defined, (1) inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ; (2) creates or allows to be created a substantial or ongoing risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted loss or impairment of the function of any bodily organ; (3) commits or allows to be committed an act of sexual abuse against the child; (4) or a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian, as herein defined, to exercise a minimum degree of care (a) in supplying the child with adequate food, clothing, shelter, education, medical or surgical care though financially able to do so or though offered financial or other reasonable means to do so, or (b) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or substantial risk thereof, including the infliction of excessive corporal punishment; or by any other acts of a similarly serious nature requiring the aid of the court; (5) or a child who has been willfully abandoned by his parent or guardian, as herein defined; (6) or a child upon whom excessive physical restraint has been used under circumstances which do not indicate that the child's behavior is harmful to himself, others or property; (7) or a child who is in an institution and (a) has been placed there inappropriately for a continued period of time with the knowledge that the placement has resulted or may continue to result in harm to the child's mental or physical well-being or (b) who has been willfully isolated from ordinary social contact under circumstances which indicate emotional or social deprivation.
A child shall not be considered abused or neglected pursuant to paragraph (7) of subsection c. of this section if the acts or omissions described therein occur in a day school as defined in this section.

No child who in good faith is under treatment by spiritual means alone through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall for this reason alone be considered to be abused or neglected.

d. “Law guardian” means an attorney admitted to the practice of law in this State, regularly employed by the Office of the Public Defender or appointed by the court, and designated under this act to represent minors in alleged cases of child abuse or neglect and in termination of parental rights proceedings.

e. “Attorney” means an attorney admitted to the practice of law in this State who shall be privately retained; or, in the instance of an indigent parent or guardian, an attorney from the Office of the Public Defender or an attorney appointed by the court who shall be appointed in order to avoid conflict between the interests of the child and the parent or guardian in regard to representation.

f. “Division” means the Division of Youth and Family Services in the Department of Children and Families unless otherwise specified.

g. “Institution” means a public or private facility in the State which provides children with out of home care, supervision or maintenance. Institution includes, but is not limited to, a correctional facility, detention facility, treatment facility, day care center, residential school, shelter and hospital.

h. “Day school” means a public or private school which provides general or special educational services to day students in grades kindergarten through 12. Day school does not include a residential facility, whether public or private, which provides care on a 24-hour basis.

L.1974, c.119, s.1; amended 1977, c.209, s.1; 1987, c.341, s.6; 1994, c.58, s.39; 1999, c.53, s.55; 2004, c.130, s.27; 2005, c.169, s.1; 2006, c.47, s.47.