New Jersey Office of the Child Advocate
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Child Fatality Investigation Review
October 24, 2007

Scott M.
Melanie M.
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INTRODUCTION

The independent Office of the Child Advocate (OCA) was created by statute on September 26, 2003. Public Law 2005, c.155 enables the Office of the Child Advocate to investigate, review, monitor and evaluate State agency responses to allegations of child abuse or neglect in New Jersey and make recommendations for systemic and comprehensive reform.

Since its inception, the OCA has reviewed child fatalities due to abuse and neglect and has made recommendations resulting from fatality reviews to the Department of Children and Families, (DCF) Division of Youth and Family Services (DYFS) and other involved state systems.

Since December 2006, the Child Advocate has held a seat on the statewide Child Fatality and Near Fatality Review Board. Additionally, members of the OCA staff sit on each of the four Regional Fatality Review Teams.

Through these roles and other processes, the OCA will continue to independently review selected deaths of children who died while under the care of DYFS or who had a previously open DYFS case. Recommendations resulting from these reviews will continue to be made to involved state agencies.

In each review the OCA will focus on a few major questions:

- Was this a preventable death?
- Did the child welfare system fail in its mission to protect the child?
- Are there identified areas of concern in the provision of and access to necessary services that need improvement?
- Were there systems deficiencies or issues, such as case practice, lack of compliance with agency policies, poor record keeping or insufficient documentation, that contributed to this fatality?

By attempting to answer these questions, the OCA seeks to identify deficiencies in systems, which if corrected, could prevent these untimely deaths.

Each report will focus on issues that contributed to the child’s death and will provide recommendations and opportunities for systems improvements based on those concerns. An annual report summarizing concerns and recommendations will identify trends and significant systems areas in need of discussion and improvement.

Upon releasing its recommendations, the OCA will initiate further collaborative efforts with the DCF and other involved parties to create lasting change and improvement.
SUMMARY OF DEATHS

On May 25, 2006 at 10:40 a.m., the Cumberland County Prosecutor’s Office received a report of a murder-suicide in Millville, N.J. Scene investigation indicated that S.M., Sr. shot his two children, Scott M., Jr. and Melanie, and the mother of their children, W.B., while they slept. Scene investigation further revealed that S.M., Sr., then turned the gun on himself and took his own life.

Earlier that same day, S.M., failed to appear at his criminal trial for charges related to sexual assault of W.B.’s teenage daughter, A.B., and her friend. A.B. had testified in that trial the day before. Two acquaintances of S.M.’s, scheduled to testify as character witnesses for him, went to locate him when he did not appear for the hearing. Upon entering the family’s residence, they discovered S.M.’s dead body seated in the living room. The acquaintances left the residence and called 911. They did not know at the time of their discovery that three other deceased victims were also in the home.

In July 2004, S.M. was criminally charged with sexual abuse. S.M. was arrested and released on bail later that month. The court hearing stemming from these charges began the week of May 15, 2006.

In July 2004, DYFS substantiated the allegations that S.M. had sexually abused his step-daughter. In October 2004, W.B. arranged placement for A.B. with the paternal grandmother and moved A.B. out of the family’s home. A.B. was not living in the residence in the home at the time of the murder/suicide, and is alive today.

OFFICE OF THE CHILD ADVOCATE KEY FINDINGS

It is the opinion of the Office of the Child Advocate that:

• Scott M., Jr. and Melanie M.’s tragic deaths were possibly preventable.

• During the time that there was an active DYFS case with this family (between 7/14/04-5/26/06), there were numerous missed opportunities for DYFS and the courts to offer this family protection, services and intervention.
• **DYFS** was deficient in their case handling, evidenced by a failure to thoroughly assess the family, failure to recognize key inherent safety and risk factors, failure to conduct required visits with the family members and failure to adhere to agency policies for best practices to ensure child safety and well-being.

**FAMILY CONSTELLATIONS:**

**Birth Family:**

**Birth Mother:** W.B. (35 years old)

- Birth mother to A.B., Scott M., Jr., and Melanie M.

**Birth Father:** S.M., Sr. (40 years old)

- Birth Father of Scott M., Jr., and Melanie M.

**Birth father of A.B.:** D.H. (38 years old)

**Children:**

- Scott M., Jr. (12 years old), birth child of W.B. and S.M., Sr.

- Melanie M. (6 years old), birth child of W.B. and S.M., Sr.

- A.B. (18 years old), birth child of W.B. and D.H.

**NARRATIVE SUMMARY OF DYFS HISTORY**

**Division of Youth and Family Services Involvement:**

The Cumberland County Local Office was responsible for this case from 7/14/04-5/26/06 until the case was closed. The exact dates of responsibility for some caseworkers and case supervisors are unclear from review of records.¹

**DYFS Case workers:** M.C. 7/14/04-9/20/04; T.M. 10/18/04 – unknown date; N.M. 12/21/04-5/26/06; C.O. 6/23/06-closure of case.

**DYFS Supervisors:** L.M. 7/14/04-9/30/04; D. O. 10/04-12/04; K.T. 12/6/04– 4/4/06; M.L. 4/6/06-closure of case. There also was some cross coverage by A.F. in 2005.

¹ Based on the DYFS Service Information System (SIS)
On July 14, 2004, DYFS received a referral from the Millville Police Department that S.M. had been arrested for sexual assault of A.B.’s friend and suspected assault of A.B. He would eventually be charged with six counts of aggravated sexual assault involving both girls.

Residing in the family home prior to the arrest were W.B., S.M., and their birth children, Scott Jr. and Melanie, and A.B. There was no previous DYFS involvement with this family.

The assigned worker began the DYFS investigation on July 14, 2004 and on July 15, 2004 interviewed W.B., A.B., Scott, Jr., Melanie, in their home. S.M. was not living in the home at that time as he was incarcerated due to the charges. Scott, Jr. denied being a victim of inappropriate touching/sexual abuse. Per the DYFS worker’s investigation notes, Melanie M. was difficult to interview because she was unable to stay focused. No further assessment was completed or recommended at this time. The Structured Decision-Making (SDM) Safety Assessment was completed based on S.M.’s absence from the home and no safety factors were identified. The Referral Response Report notations indicate that W.B.’s plans to protect the children and separate from S.M. were discussed on July 14, 2004, but a case plan was not fully developed and signed by the worker and W.B. until August 17, 2004. At the July 15 visit, W.B. appeared to the worker to be supportive of A.B. and agreed to work cooperatively with DYFS to protect her children and access services.

According to DYFS case notes, the worker attempted to interview S.M. in jail on July 16, 2004 but was unable to do so due to policies at the jail regarding interview schedules. Since the worker was unavailable on the next possible interview date, July 19, and it appears from the record that the worker did not arrange for coverage on that date, so the interview was rescheduled for July 26. However, S.M. was released from jail on July 23, 2004, due to a bail reduction, and the interview by DYFS of S.M. did not occur. There is no indication from the DYFS record that there was any notification by the Millville Police Department, the Cumberland County Department of Corrections, the Cumberland County Sheriff’s Office, or the Cumberland Co. Prosecutor’s Office to DYFS advising of S.M.’s release.

On August 4, 2004, DYFS referred A.B. for appropriate services and an appointment for services was scheduled for August 8, 2004. W.B. and A.B failed to keep that appointment. Also on that date, the worker completed an SDM Risk Assessment on W.B. and scored the family as low risk with a discretionary override, which elevated the Family Risk level to moderate.

On August 11, 2004, DYFS received a second referral on the family, regarding concerns that W.B. was under undue stress. This referral was coded as a Child Welfare Assessment. The same DYFS worker visited the family home on August 12, 2004 but, was unable to make contact until August 17, 2004 to follow up on the new referral.

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2 DYFS Policy- DYFS STRUCTURED DECISION-MAKING INITIATIVE; 4-15-2004; “Structured Decision-Making (SDM™) means -- A uniform process for Division-wide decision-making regarding critical aspects of agency intervention with a child and family from screening, through intake, to case management and case closure. Structured Decision-Making assessment tools are research and evidence-based. The system assists field staff to make critical decisions, based on the facts of a case, rather than relying solely on individual judgment by agency staff or others.”

3 A supervisor or worker can override a lower risk level if he/she identifies unique circumstances believed to warrant a higher risk level.

4 Child Welfare Assessments pertain to issues involving non-abuse and neglect.
Documentation from the August 17 visit with W.B. indicates that she was beginning to reconsider the situation and wanted to keep S.M. in her life. She understood services were available and would need to be completed successfully before S.M. could return to the home. She reaffirmed her understanding that S.M. could not have contact with A.B., and stated that she was only allowing “monitored” phone contact between S.M. and his birth children, Scott, Jr. and Melanie. The Case Plan, dated August 17, was agreed upon and signed by W.B. and the worker. It indicated that: “(1) W.B. was to ensure that the children had no contact with S.M. until all services were complete and Division deems safe; (2) W.B. was to ensure that A.B. participate in evaluation and follow-up therapy; (3) W.B. was to ensure children’s needs were met; (4) W.B. was to meet her children’s needs for a safe home with all medical and educational needs met.”

The Statement of Conclusions written on the Referral Response Report that followed the August 17 visit indicates that the Child Welfare Assessment was complete. It was noted that the case was to remain open based on the substantiation of the initial allegation of sexual abuse. Also on August 17, 2004, the worker obtained two addresses for S. M.’s residences and went to both locations. No one was home at either address. The worker left cards requesting contact.

On August 23, 2004, DYFS was advised that W.B. cancelled A.B.’s appointment for services and re-scheduled for August 30.

On August 25, 2004, police contacted DYFS to express concerns that A.B. was being pressured by her mother to drop the charges against S.M. DYFS staff visited the home that day and while A.B. denied she was being pressured by her mother, she did confirm that her mother told her that she would like ‘things to work out.”

On August 30, 2004, A.B. and her mother attended the appointment for A.B.

The Referral Response Report supplied to OCA by DYFS regarding the first allegation of sexual abuse includes two final notations and a summary. The summary includes the following information:

“RED FLAG ISSUES: at this time W.B. seems to want to have S.M. reunite with the family after he completes services and has expressed interest in dropping the charges. The Division has not been able to make contact with S.M. to assess his willingness to complete services.”

It is noteworthy that the worker specifically used the words,” RED FLAG ISSUES” in upper case in the report. A handwritten addition beneath the summary dated September 1, 2004 states that S.M. called the worker on that day and stated he was unwilling to discuss any aspect of the case at that time. The notation further states that DYFS would substantiate abuse.

Based on records submitted to the OCA, there is no evidence that DYFS visited the home between August 17 and October 6, 2004.

On October 6, 2004, two workers visited the home and W.B. advised them that S.M. had moved back in with her and the two younger children. She stated that A.B had been living at the home of her paternal grandmother since October 3, 2004 and had no contact with S.M. prior to that. The DYFS Contact Sheet from the visit does not indicate that either of the workers...
expressed concern about S.M.’s return to the home or that his return clearly violated the Case Plan. No action was taken to remove either of the children from the home.

On October 7, a detective from the Cumberland County Prosecutor’s Office contacted the worker to ask whether DYFS was aware that S.M. moved back into the home and that A.B. was living with the paternal grandmother. The worker advised him she was aware of that information.

It was not until October 18, 2004 that two DYFS workers met with A.B. at her school at the request of her assigned worker. A.B stated that she was “fine” at her grandmother’s.

On November 18, 2004, the paternal grandmother contacted the worker to request an appointment so they could discuss the case. That visit took place that same day in the grandmother’s home and the worker did a Safety Assessment. The grandmother advised that her son, A.B.’s biological father, D.H., was seeking custody of A.B. The DYFS worker confirmed that A.B. was in agreement with that plan.

A December 20, 2004 Supervisor’s Note outlines serious case practice deficiencies. The note cites that despite the Case Plan, S.M. had returned to the home without any indication that he had completed services or that DYFS had assessed whether or not it was safe for him to return. The note states that “only one service has been set up, that being for A.B.”

The supervisor advised staff to: “(1) make contact with the family by December 21, 2004; (2) reassess safety needs; (3) reaffirm that S.M. could not be in the home until he had a psychological or evaluation to determine risk to the children and any recommendations for services; (4) conference case for litigation; (5) interview children about good touch/bad touch; (6) complete school and medical collaterals on children; (7) speak to detective concerning whether S.M. is allowed to be with the children (8) evaluate any possible No-Contact Order with his biological children and assess whether the couple was in violation of that order; (9) re-conference case with supervisor once contact has been made with family.” In the note, the supervisor also expresses concern regarding A.B.’s feelings about current situation.

On December 29, 2004 the worker spoke with the detective in the case and learned S.M. had been indicted, but no trial date was set. The Prosecutor’s Office had not issued a No-Contact Order between S.M. and his biological daughter, Melanie, but expressed concerns for possible risk to Melanie “because of what had occurred to A.B.” and left the safety planning for Melanie and Scott Jr. to DYFS.

On a December 30, 2004 visit, the newly assigned DYFS worker and buddy worker visited the home. The visit developed into a contentious meeting. DYFS advised both W.B. and S.M. that: (1) S.M. could not reside in the home; (2) S.M. had to have supervised visitation with his children, while W.B. could supervise; (3) the children could not be left alone with their father. Also, there was to be no contact between S.M. and A.B. In addition, S.M. was to undergo a psychological evaluation. W.B. was quite surprised and upset by this because she stated that S.M. had been in the home for three months with DYFS and the police having knowledge of it. S.M. called his attorney and the DYFS supervisor was also contacted. W.B. signed the case plan, but S.M. refused. He reluctantly agreed not to reside in the home.
2005
Despite the DYFS plan to complete bi-weekly Minimum Visit Requirements (MVR’s)\(^5\), during 2005, only eight MVR’s were completed at the home. Contact sheets for that year reveal W.B. became increasingly more difficult to contact by phone in order to schedule appointments for MVR’s. During the visits that did occur the worker was informed about the family’s financial difficulties, Scott Jr.’s need for services at school, and W.B.’s questioning of the Case Plan requiring S.M. not to reside in the home.

On September 21, 2005, during an MVR, the worker learned that S.M. had been picking up the children from school unsupervised. W.B. and S.M. were counseled that this was not allowed according to the Case Plan; the same Case Plan the family had obviously had not been following for quite some time.

There is no documentation of any MVR’s at the home between July 21, 2005 – December 16, 2005\(^6\). One final MVR in 2005 does occur on December 16.

2006
There is no documentation to support that any MVR’s with the family took place, other than contact with A.B. or her biological family, from January 2006 until the deaths in May 2006. As 2006 progressed, DYFS experienced increasing difficulty with contacting W.B. via phone.

On April 4, 2006, the DYFS supervisor’s note records that the case was transferred to yet another worker and supervisor. It is noted that the case was slated to be closed, but there were still tasks to be completed such as the need to interview each family member separately, to assess whether the family “still needs services”, to send for school and medical collaterals, and to conference the case for closing.\(^7\)

The Division unofficially learned of the murders/suicide on May 25, 2006 when the assigned DYFS worker tried to establish contact with the children at their schools because W.B. had not been returning phone calls or allowing MVR’s.\(^8\)

INVESTIGATION OF Scott, Jr. and Melanie M.’s DEATHS

*Medical Examiner's Report:* Final Report date: 6/14/06  
*Cause of death:* Shotgun wounds to the head (all four deaths)  

\(^5\) With few exceptions, DYFS is required to complete in-person contact with families under supervision at least once per month.  
\(^6\) The family “was not present” for the next scheduled MVR on 7/26/05. The worker (N.M.) then was away for three weeks on medical leave.  
\(^7\) It is unclear why DYFS assessed that the case could be closed at that time.  
\(^8\) The worker tried to make contact with W.B. on 5/8/06 and 5/24/06. The worker had briefly spoken with Scott Jr. on 5/23/06. The new worker made contact with the A.B., at school on 5/23/06. At that visit A.B. again related to the worker that she had NOT been allowed any sibling visitation. A.B. further related that she missed her little sister “and want[s]to protect her.” A.B. further stated she was concerned because her step father was still living in the home.
Summary of ME findings: The Medical Examiner evaluations of both Scott, Jr., and Melanie M., revealed multiple skull fractures and injuries to the brains of both children from the inflicted gunshot wound. Each child had been shot once. Melanie M. also had a fresh contusion (bruise) to her R lower abdomen, left knee, left upper tibia and left mid-tibia. It is not mentioned whether any of this other fresh trauma, particularly the abdominal contusion, might also have been coincident with her murder. Scott, Jr. also had a fresh contusion to his left lateral abdomen, to the dorsum of his left wrist and to his right tibia. Again it is not known if these other fresh injuries were coincident with his murder. Results of toxicology testing on both children were negative. No other studies were done.

OCA INTERVIEWS

DYFS Review of Case

OCA personnel spoke to a number of staff from DYFS who were involved in the case. This discussion clearly indicated that DCF provided a thoughtful retrospective analysis of its performance in this case and identified a number of case handling issues and areas for improvement.

SYSTEMS CONCERNS AND OPPORTUNITIES FOR IMPROVEMENT

DYFS Case Handling Issues

In general, the case handling with this family is replete with missed opportunities to effectively assess the needs of the individual family members and risk to the children. Through interviews, home visits and reports, DYFS had information regarding the family’s needs, that if applied correctly in the SDM tools, would have resulted in the identification of a variety of needs that went unidentified and unmet.

The DYFS initial Case Plan included keeping the case open for care and supervision. This initial Case Plan, signed by W.B., further stipulated that the children were to have “no contact with S.M. until all services are in place and DYFS deems safe”. Within weeks of signing this plan, W.B. did not “ensure” that her signed case plan was followed. This was clearly a “red flag” indicator of risk to the children in the home and should have immediately triggered conferencing for litigation.

There was also a fundamental flaw in the case plan. W.B. permitted S.M. access to the home and maintained he did not spend the night - a plan that DYFS approved and permitted. S.M.’s taped statements to the police and both the statements of A.B. and her friend indicate the previous acts of sexual abuse often occurred during daytime hours, and at times when W.B. was present in the home and allegedly unaware of the situation. DYFS’s presumption that abuse/neglect could only take place during overnight hours was flawed.

DYFS did not maintain bi-weekly visitations with the household. Additionally, DYFS failed to visit the family for over four months between January and May 2006. No MVR’s were completed with the family in the weeks leading up to and including the week of S.M.’s criminal trial.
The workers assigned to this case did not have adequate supervisory oversight, nor was there adequate documentation that supervisory conferences were provided throughout the period of DYFS involvement. When supervisory conferences occurred and concerns were noted by the newly assigned supervisors, there was no timely supervisory follow up to ensure the worker had followed through with required visits, completed Safety, Risk, and Strengths and Needs Assessments per SDM policies, provided the family services such as counseling, and in obtaining required medical and school collaterals.

The DYFS Policy Manual states that cases involving sexual abuse are always high risk situations when the alleged perpetrator has access to the victim and siblings. The high risk situation evidenced in this case was not identified as such by DYFS and thus, the children were left in an unsafe environment.

Components of the tools used by DYFS to assess child safety and risk of harm through the Structured Decision Making (SDM) process, requires that Risk Re-Assessments are completed every six months. DYFS failed to complete updated Risk Re-Assessments on the family for over 1 ½ years. Per conversation with the DYFS representatives, the staff did not apply the risk assessment tool to both parents (caregivers).

Additional SDM requirements call for the need for DYFS to complete Strength and Needs Assessments on individual children and caregivers minimally every six months. There is no indication that this assessment was ever completed for S.M., and no indication that subsequent assessments were completed on all other family members after the initial assessments on September 21, 2004.

Additionally, the foundations of Structured Decision Making, as cited within DYFS policy, recognize that safety plans requiring the non-offending parent to ensure the safety of the child in the presence of the perpetrator, should NOT BE MADE, when the non-offending parent does not believe that the perpetrator was responsible for inflicting the abuse/neglect on the child.

In this case, DYFS clearly relied on the birth mother to protect the children, despite the fact that within weeks of learning of the abuse, W.B. reconciled with S.M. and expressed doubt that the abuse of her daughter had in fact occurred. The fact that law enforcement staff contacted DYFS

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9 The DYFS file contained only four supervisory case notes.
10 DYFS Policy Manual; High Risk Cases - Situations that Always Indicate Risk of Harm - an incident of sexual abuse where the alleged perpetrator has continued access to the child victim and siblings; also, any sex abuse situation in which the caregiver is unable or can't be trusted to prevent the perpetrator from having access;
11 DYFS Policy- FAMILY RISK REASSESSMENT FOR IN-HOME CASES – “The risk assessment process is based on research on child abuse/neglect cases, that revealed:
   • Higher risk families have higher rates of subsequent referral and substantiation than lower risk families.
   • Higher risk families are more often involved in serious abuse or neglect incidents. (Note: DYFS Form 22-23 does not predict recurrence of child abuse/neglect).”
12 Strength and Needs Assessments are standardized tools used by child welfare agencies to assess areas of strength for the individual child/caregiver, as well as areas where the individual may need assistance and/or services, and for establishing a safety plan.
twice to express concern that A.B. was being pressured to drop charges should have prompted re-examination of the situation.\textsuperscript{13}

**Recommendations**

- DYFS field staff must regularly visit the families under their supervision in keeping with the assigned MVR schedule, as outlined in DYFS policy. Efforts to see the family and the results of these visits must be documented. All household members must be seen.

- DYFS staff must utilize the policies and information described within the framework of Structured Decision Making in assessing safety and risk and in developing appropriate case plans.

- Structured Decision Making tools, including Safety and Risk Assessments, Strengths and Needs Assessments and other DYFS case handling/assessment tools, must be consistently utilized by DYFS staff in accordance with specified time frames. Supervisory oversight must ensure these tools are completed and used appropriately.

- Timely and updated safety and risk assessments must occur for all cases under DYFS supervision. Re-assessments of safety must occur in cases of substantiated abuse and neglect when children remain in the home and when the perpetrator has access to the child/siblings. Safety assessments must be done if there is any change in the family structure. This accountability can be tracked and measured through the DYFS tool Safe Measures.

- Supervisors must provide and document timely case supervision, and timely corrective action plans, when red flag issues within a case are not properly addressed. A system for accountability for supervision must be developed, implemented, and monitored.

- The Department of Children and Families should establish and support protocols and tracking mechanisms for services needed and obtained.

- Timely and full implementation of the NJSPIRIT system will help improve tracking, completion of tasks, MVRs, and service needs.

A valid psychological evaluation and sexual abuse perpetrator assessment were never completed on the alleged perpetrator in this case.\textsuperscript{14} At the time of S.M.’s arrest and in his initial statements

\textsuperscript{13} On August 25, 2004, the DYFS worker was contacted by a detective on the case who wished to express concerns that he felt that A.B. was being pressured to drop her charges against S.M. The assigned worker and a buddy worker\textsuperscript{13} made a visit to the home, and spoke with A.B. there. The workers found that A.B. felt somewhat unsure of how to proceed with the charges. They encouraged her not to drop the charges and to follow up with an appointment for services, as the appointment had twice been cancelled. The worker further followed on 8/30/04 and learned that A.B. had completed her evaluation. On 10/7/04 the new worker was contacted by a detective who was also concerned that A.B. was being pressured by her mother to drop charges against S.M.

\textsuperscript{14} The first scheduled psychological evaluation appointment for S.M. was on 1/27/05; he failed to appear for this appointment. The next appointment was scheduled for 3/3/05; he again failed to appear for this appointment,
to law enforcement, he expressed a desire to obtain counseling. The Parental Fitness Evaluation that was attempted by the DYFS-contracted psychologist was invalid due to S.M.’s resistance to fully participate in the process. Also, this assessment was not scheduled in a timely fashion.

Based on the OCA’s review of the DYFS record, there is no evidence that DYFS field staff interpreted or understood the results of this invalid and delayed attempt to assess S.M.’s psychological functioning. S.M. was allowed back into the home without any valid assessment of his parental or personality functioning.

There was no follow through on scheduling psychological assessments and/or treatment for W.B. and the two children during this case, although it was a goal noted in the case plan. Access to appropriate mental health assessment and possible treatment for all family members is needed to appropriately assess risk and adaptation to changes in family functioning when a caregiver has been substantiated for abuse and asked to leave the home. As illustrated in this case, a victim who has suffered the physical or sexual abuse is unlikely to be the only victim in the household.

**Recommendations:**

- Valid, timely and complete psychological assessment of perpetrators of abuse should occur before they are allowed to reunify with children in the household.

- Comprehensive family strengths and needs assessments, when applied as intended, must lead DYFS to provide psychological assessments of other household members in a home where there has been substantiated abuse or other identified risk factors. Timely follow up on all treatment recommendations must occur.

- Assessments provided to the Division by consultants must be dated, signed and reviewed by the Division upon receipt.

It is concerning that DYFS did not fully assess the relationship between W.B. and S.M. S.M.’s return and A.B.’s subsequent removal from her family to her grandmother’s house as decided by W.B. indicates there might have been power and control issues indicative of domestic violence involved in W.B.’s and S.M.’s relationship. In retrospect, this case clearly raises issues of domestic violence, which may not have been apparent at the time, but should be noted as potential indicators of increased risk in the future.

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claiming DYFS had never informed him of this appointment. On 3/7/05 S.M. met with the DYFS’s contracted psychologist, but allowed only very limited interviewing. DYFS’s contracted psychologist found that the client was so defensive, skeptical, and dismissive that he could not complete testing. The psychologist concluded that that findings on S.M.’s limited testing was “invalid”. The psychologist concluded that S.M.’s “defensiveness and/or his denial during the evaluation preclude[d] making any statement about his [S.M.’s] personality characteristics. As a result of the invalid and unsuccessful attempt at obtaining a psychological evaluation, the psychologist further stated that he had “no basis for making any inferences about the degree of danger that he [S.M.’s] presents to his children,” nor could the psychologist make any recommendations about possibly needed services.

15 DYFS Staff Interviews
16 Domestic violence can be defined as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. U.S. Department of Justice, Office on Violence against Women. [http://www.usdoj.gov/ovw/domviolence.htm](http://www.usdoj.gov/ovw/domviolence.htm)
Recommendations:

- As a result of this case and others like it, planning has started to place Domestic Violence experts in all Division offices. The OCA urges that this initiative be fully implemented by June 2008. Revised DCF Domestic Violence policies should be concurrently implemented.

- DYFS local office should have access to and regularly query the domestic violence registry.

Legal Communications Issues

DYFS was not notified by either the Millville Police Department, Cumberland County Sheriff’s Office, the Cumberland County Department of Corrections, or by the Cumberland County Prosecutor’s Office when S.M. was released on bail. According to DYFS records, there was no communication between DYFS and law enforcement at the time of S.M.’s release. Such communication would have allowed DYFS the opportunity to make appropriate case decisions such as establishing an adequate case plan.

Further, the records indicate that in 2004 the Cumberland County Department of Corrections had a limitation on when DYFS staff might interview inmates, suggesting that DYFS workers could only interview detainees on Mondays.\(^\text{17}\)

Litigation should have been filed as soon as DYFS recognized in October 2004 that W.B. was not following the Case Plan and that S.M. had moved back in the home. Litigation wasn’t pursued until eight months later, in March 2005, when the case was transferred to yet another DYFS supervisor and worker team. At that time, the court granted DYFS care and supervision of Scott Jr. and Melanie. DYFS did not provide protective services or supportive services to the family as ordered by the court.

Additionally, it is puzzling that Family Court proceedings were dismissed prior to fact finding based on the fact that there was a criminal trial pending.\(^\text{18}\) Litigation was terminated on August 23, 2005 and DYFS was ordered to continue its supervision of the family.

Recommendations:

- DYFS, Prosecutors’ Offices, and local and county law enforcement should assess their current policies and seek to improve professional communication to assure the safety of other children in families where abuse has been alleged have an appropriate and timely safety plan. This can be facilitated through the county Multi-Disciplinary Teams, and/or other venues, and a directive by the Office of the Attorney General.

- By law, Criminal Court cases do not take precedence over Family Court hearings.\(^\text{19}\) Family Court hearings should assure that other children and possible victims in a

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\(^{17}\) The DYFS worker contacted the Cumberland Co. Jail on July 16, 2004 to interview S.M., but was told DYFS could only see inmates on Mondays. The worker was not available the next Monday and scheduled an appointment to interview S.M. at the jail on Monday July 26, 2004. On that day the worker went to the jail and discovered that S.M. was released on bail on 7/23/04.

\(^{18}\) In some venues Family Court has had a long-standing deference to criminal trials and pending criminal cases.

\(^{19}\) N.J.S.A. 9:6-8.24.d
household: (1) have comprehensive risk assessments and strengths/needs assessments; (2) have necessary services provided to those identified as needing them; (3) are seen routinely; and have a solid safety plan in place that is being followed.

- Prosecutor’s Offices and local and county law enforcement must define and implement protocol regarding notification of interested stakeholders prior to the release of an alleged perpetrator.

Associated Concerns

While these concerns are not directly related to these deaths, they are significant in that they are related to the overall quality of how this case was handled.

DYFS Medical Systems Issues

Scott and Melanie M.’s Medical Care

DYFS never procured the medical or school records on these children in the 20 months it had the case open.

On June 14, 2007 the DYFS provided the State Fatality Review Board and the OCA medical records of both children. These medical (and school) collaterals were never collected by the DYFS Local Office during the time this case was open, as required by policy and in keeping with best practices. Collateral information assists DYFS staff in accurately assessing the family and individual’s need for services, and provides information as to the family/individual’s functioning. The need for DYFS to obtain collateral medical and school information were among the tasks noted throughout the DYFS records sent for review, yet this task was never accomplished. These records were only collected DYFS as a result of a request by the CCAPTA unit for the Board Fatality Review.

Had DYFS acquired these records, as required by policy at the beginning of this case, they would have been better able to identify many unmet medical and mental needs and serious health concerns in this family. Overall, major changes are needed in the way medical records are handled by the Division.

Recommendations:

- Medical, mental health, and educational/school collaterals, on each child, as age appropriate, should be periodically obtained and reviewed by DYFS field staff. Consultation with the DYFS local office nurse on health related information should occur as needed.

- The organization of medical records in DYFS charts must be improved.

- The medical chart of each child needs to have an individual tab under which his/her medical records are collated and chronologically ordered. When medical records are received, they must be dated and include documentation that the records were read and that appropriate action was taken.
• Additionally, a medical issues sheet for each child should be included in the child’s DYFS record. The needs identified on this chart should be integrated and addressed in the DYFS case plan and considered whenever case-related decisions are made.

• DYFS needs to develop and implement a form for gathering background medical information. Background medical information forms must be completed at a 72-hour family meeting, and updated periodically throughout the life of the case.  

**Associated Concerns RE: S.M., Sr.**
This is not the only case in which the alleged perpetrator of significant child abuse has taken his own life near the time of criminal proceedings. A criminal trial is a stressful event for witnesses and defendants alike. In this case, a valid psychological assessment of S.M. was never obtained.

In cases where alleged perpetrators are facing criminal charges of child abuse, and there is no identified or on-going mental health treatment, Prosecutor Offices and/or the criminal court system, working with DYFS, should offer psychological support during the trial process and consider providing the defendant with a pre-trial suicide risk assessment screening, consistent with the attorney client privilege between defendant and their counsel.

DYFS must be made aware of the date for any criminal trial for which DYFS has also had an ongoing case. DYFS should assess the stresses and possible risks that the criminal trial may pose to family members at that time.

The implications of this stress on the families of the alleged perpetrator should be of utmost concern and priority for DYFS.

Another significant risk factor was that S.M. had access to a shotgun on May 25, 2006 that was not legally registered to his name. The shotgun was originally purchased in Delaware but ended up in the possession of S.M.’s neighbor, with whom S.M. was spending some nights. This neighbor loaned S.M. the gun at some point before the incident so he could use it to “shoot rats in the barn.” He had access to this weapon at a time when he was under significant psychological stress.

**Associated Concerns RE: A.B.**

W.B. placed her daughter into the home of the paternal grandmother. DYFS policy for ensuring the safety and well-being of children placed in out-of-home settings by the parents or family, in a situation such as this, is unclear. The record shows that in this situation DYFS did not conduct a thorough assessment/evaluation of the placement.

After A.B.’s placement, there were significant gaps - as long as a year - between DYFS visits to A.B. In addition, no sibling visits were provided between A.B. and her younger siblings, although they were requested by A.B. on numerous occasions. DYFS Case Notes from February 6, 2006 indicate A.B. “desperately wants to visit siblings” as she had not seen them since May

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20 This practice can only be followed in the areas that complete 72 hour meetings, which are not consistently practiced in all DYFS local offices.
2005. A.B. was advised at that time to apply for sibling visitation through the courts – a recommendation that directly contradicts DYFS policy.\(^\text{21}\)

On May, 23, 2006 A.B. asked for visitation and expressed concern for her siblings and a desire to protect her little sister, just two days before the murders. Siblings have a right to visits. The failure to provide A.B. with sibling visitation further isolated her from her siblings and deprived them of needed emotional support.\(^\text{22}\)

As the court dismissed DYFS’s care and supervision of Scott, Jr. and Melanie and DYFS never had custody over the two younger siblings, DYFS had no authority to mandate visitation among the children.

**Recommendations:**

- DYFS policy regarding the agency’s responsibility to thoroughly evaluate and access households in situation where parents arrange for placement of their children needs to be established.
- Siblings must be afforded opportunities to visit. For all cases under DYFS custody, DYFS has the responsibility to arrange and supervise these contacts.
- DYFS must acknowledge the visitation requests of children in their case plans and strive to honor a child’s request to stay connected to their family.

\(^{21}\) In accordance with N.J.A.C. 10:122D-1.4(d); N.J. Stat. 9:2-7.1, Sibling visitation must be included in the plan. The visitation plan must include visits with siblings, if any. Sibling visits may take place with parents or separately.

\(^{22}\) On February 7, 2006, the DYFS worker told A.B. and her biological father that “she could go to court and apply for visitation with her siblings.”