New Jersey Office of the Child Advocate

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Child Fatality Investigation Review

October 24, 2007

Sean F.
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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 services that need improvement?
- Were there systems deficiencies or issues; such as, case practice, lack of compliance with or existence of agency policies, poor record keeping or insufficient documentation, that contributed to this fatality?

By attempting to answer these questions, the OCA hopes 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 improvement based on those concerns. An annual report summarizing those concerns and recommendations will attempt to 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.
Name: Sean F.

Date of Birth: October 25, 2006

Date of Death: November 19, 2006

Age: 25 days old

Gender: Male

SUMMARY OF DEATH

On November 18, 2006, 24-day-old, Sean F. was brutally stabbed and thrown down stairs by his putative father’s estranged girlfriend, G.C. The following day, Sean died as the result of an eviscerating, abdominal stab wound. In addition, he suffered blunt head trauma. His cause of death was ruled a homicide. G.C. is charged with the death. Sean was only 25 days old when he died.

Sean was born on October 25, 2006. He was a full term infant, though he only weighed 5 lb., 4 oz. His mother, S.F., reportedly received no pre-natal care. The next day, DYFS received a referral from a social worker at a Camden hospital advising that Sean tested positive for cocaine at the time of his birth. Though the baby was not experiencing withdrawal, he displayed some worrisome symptoms such as jitteriness, irritability and poor muscle tone requiring observation in the newborn intensive care nursery. Clinicians felt that the baby could be medically cleared for discharge October 27, 2006, pending DYFS disposition.

Sean remained on a DYFS requested hold until November 1, 2006. Although DYFS initially filed a verified complaint for custody of Sean based on S.F.’s presumed inability to care for Sean due to her active substance abuse, that complaint was withdrawn and no further court proceedings were pursued. DYFS facilitated Sean’s discharge to his putative father, E.C., on November 1, 2006. Sean remained in E.C.’s home for 18 days until his violent death on November 19, 2006.

OFFICE OF THE CHILD ADVOCATE KEY FINDINGS

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

• Sean’s brutal death might have been prevented.
• The child welfare and legal systems failed in their mission to protect the child.
• DYFS was deficient in some aspects of its case handling following Sean’s birth:
  o DYFS failed to conduct a thorough assessment of E.C.’s ability to provide a safe and appropriate home environment for a newborn child.
  o DYFS failed to recognize or assess potential safety and risk factors in E.C.’s home.
  o DYFS failed to identify or thoroughly assess the presence of other individuals frequenting E.C.’s home.
  o Despite questions about paternity raised by E.C., DYFS failed to establish E.C.’s paternity prior facilitating Sean’s release to E.C.
  o DYFS withdrew its verified complaint upon representing to the court its recommendation to place Sean in the care of E.C.
FAMILY CONSTELLATION

Birth Family:
Birth Mother: S.F. (25 year old birth-mother of Sean)

Putative Father: E.C. (47 years old)

Child: Sean F. (10/25/06 - 11/19/06)

Siblings: Y.C. (d.o.b. 7/7/04) in care of maternal relatives via DYFS

Maternal Relatives
Maternal Grandmother: C.F. (47 years old)

Other
Alleged Perpetrator: G.C. (34 years old)

NARRATIVE SUMMARY
Division of Youth and Family Services Involvement

Division Local Office: This case was active in the Camden South Local Office. Staff of the Camden Central Local Office provided an immediate, courtesy child protective investigation response on October 26, 2006 upon receiving a referral from the hospital at the time of Sean’s birth.


Supervisors: C.D. was the intake supervisor of the Camden South Local Office and served as supervisor of A.Z. M.B. was the supervisor of the intake unit of Camden Central Local Office and served as supervisor of L.E. M.B. was also the SPRU worker who responded to the hospital referral on November 18, 2006, the day of Sean’s fatal injury.

Case History
On August 22, 2006, prior to Sean’s birth, DYFS received a referral in which the referent was concerned that S.F. was six months pregnant, in need of pre-natal care and had a substance abuse problem. The referral was coded as a Child Welfare Assessment.\(^1\)

The supervisor’s notes of August 23, 2006, indicate that sound instruction was provided to the worker to:

- Contact the reporter and mother to: clarify S.F.’s legal issues; clarify S.F.’s need for substance abuse treatment and gather information from S.F. about her contact with her other child, Y.C.

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\(^1\) Child Welfare Assessments pertain to non-abuse/neglect situations.
• Identify father responsible for her pregnancy and all possible family supports.
• Determine the mother’s pre-natal care and compliance.

On August 23, 2006, the worker learned that S.F. was on probation until June 2010, had a significant legal history, and was court ordered to complete a substance abuse evaluation.

Prior to Sean’s birth, the worker’s casework was rigorous. Through diligent attempts to reach S.F., the DYFS worker reached out to some of S.F.’s family members but did not find S.F.

The worker received two telephone messages from S.F. on September 1, 2006 but S.F. later failed to follow through with a scheduled meeting. Attempts were made by the worker to contact S.F. through September. S.F. remained elusive.

The worker’s contacts with E.C. throughout September reflect that E.C. was concerned about S.F.’s lack of pre-natal care and continued drug use. He continued to express doubt that he was responsible for S.F.’s pregnancy. It was often difficult for the worker to reach E.C.²

The worker was finally able to speak with E.C. on October 16, 2006. E.C. again expressed concern that S.F. was still using drugs. The worker explained that if the baby tested positive for exposure to drugs at birth, DYFS would not allow S.F. to take the baby home. E.C. expressed interest in having the baby placed with him, but again conveyed doubts about paternity. He also expressed concern over his lack of preparedness for having an infant in his home.

E.C. told the worker that his home was cluttered with boxes due to his home business and the worker noted it was in need of organization and cleaning, “but otherwise is in working order.” He stated there was plenty of room for the baby and he could obtain whatever supplies were necessary. The DYFS record reflects that one pre-natal visit was made by the worker to E.C.’s home to verify E.C.’s representations.

The worker encouraged E.C. to prepare his home for a baby and provided E.C. with a list of necessities for a newborn. E.C. committed to obtaining the items as soon as possible. E.C. stated he had no family resources in New Jersey, but that he had friends to support him. The record does not indicate further discussion about those friends.

E.C. provided the worker with his identifying information and represented to her that his record was clean. The worker indicated that she would get information for him on paternity testing and told him that if his home assessment or background check were not satisfactory, the baby would be placed in foster care.

On October 18, 2006, the worker contacted a paternity testing lab and learned it would need 7 to 10 days following the birth to process a specimen. The lab further requested the worker fill out and return a request for service form. The DYFS records provided to the OCA did not contain any evidence these steps were completed. Instead, the record contains an undated, unsigned, and

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² Between September 27, 2006 and October 16, 2006, the worker made four unsuccessful attempts to reach E.C.
unapproved, partially completed a “Special Approval Request Form” specifying “paternity test” as the type of service requested.\(^3\)

On that date, the worker also submitted a Missing Persons Report on S.F., and a Human Services Police Request for Information Form for background on E.C. Child Abuse Record Information (CARI) Check and Promis/Gavel Forms were signed and dated by the DYFS worker and supervisor but were not filled out with any identifying information. Significantly, the DYFS record is missing some of the responses to these inquiries. Later, at the time DYFS allowed Sean’s release to E.C.’s care, on November 1, 2006, the DYFS record was devoid of documentation of any responses to background information requests relating to E.C.\(^4\)

**DYFS Involvement From Sean’s Birth until Death**  
On October 25, 2006, E.C. called the DYFS worker and left a message that S.F. had given birth to a baby boy at a hospital in Camden.

On the morning of October 26, 2006, the worker contacted a social worker at the hospital who confirmed the baby was born, that the child had tested positive for cocaine, and that the baby was in the “regular nursery.” The hospital social worker indicated that the baby had increased muscle tone and a low blood count but might be discharged the next day if the blood count improved. The hospital social worker had met with S.F., who was scheduled for discharge the following day, and she had identified E.C. as the father of the newborn.

On the afternoon of October 26, 2006 DYFS State Central Registry (SCR) received a call from a hospital social worker that S.F. had given birth to “Andrew F.” on October 25 and that the baby had tested positive for cocaine.

In response to the SCR referral, a DYFS worker and co-worker from the Camden Central Local Office went to the hospital to meet with S.F. and her newborn infant on October 26, 2006. An OCA interview with this worker clarified the practice in Camden County of having the Camden Central Local Office provide “courtesy” responses to all hospital referrals in its area, even when a case is currently open in another Camden Local Office. After the single courtesy visit, the identified, ongoing DYFS worker continues to be responsible for all follow-up.

The courtesy visit on October 26, 2006 resulted in a referral to a DYFS nurse consultant for determination of the child’s medical condition. The nurse consultant visited the hospital on October 27, 2006. She documented that the baby had an episode of limpness and twitching in the Intensive Care Unit and that he had all the medical risks inherent with an infant who was a drug exposed fetus. However, the DYFS RN further documented that Sean did not meet DYFS criteria for “medically fragile.”\(^5\) The baby was transferred back to the regular nursery on

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\(^3\) DYFS Form16-76, Special Approval Request to authorize DYFS expenditures.  
\(^4\) DYFS completes checks to determine the existence of previous involvement with the agency. Promis/Gavel checks are completed to ascertain criminal history. DYFS may seek this information from other sources such as local law enforcement, and state and federal fingerprint checks.  
\(^5\) “Medically Fragile” is a DYFS term that identifies a child as having medical needs beyond that of a healthy child. Children deemed medically fragile are typically followed by a DYFS nurse, and additional services and supports may be offered.
October 26, 2006 and was medically cleared for discharge pending DYFS disposition as of October 27, 2006.

The nurse consultant’s October 30, 2006 report recommended: “(1) at least two mandatory home nurse visits; (2) extended nursing visits, including infant care teaching; (3) a clinic appointment be scheduled prior to hospital discharge; (4) the caseworker contact the nursing agency prior to the conclusion of home nursing visits to determine the necessity of additional visits, given E.C.’s lack of experience and lack of local supports.” The report provided useful detail for the DYFS worker on risks to the infant from intrauterine drug exposure.

During the courtesy in-patient visit, the Camden Central Office DYFS worker told S.F. that it was unlikely that DYFS would allow the child to be placed in S.F.’s care due to her pending criminal status and Sean’s drug test results. S.F. suggested DYFS consider placing the child with E.C. S.F. expressed understanding that continued drug use could result in termination of parental rights and indicated that she wanted to go into treatment. Additional information reported by S.F. to this DYFS worker was found to be partially inaccurate through OCA review of collateral information.

Later on October 27, 2006, E.C. called A.Z., the Camden South worker and was told that the worker was awaiting the report from the other worker who had responded to the hospital as a “courtesy” visit and that Sean could be ready for discharge that evening. E.C. informed the worker that his home was not completely ready for the baby, as he did not have all necessities yet. The worker told E.C. that the baby would likely remain in the hospital, and could then be placed in foster care until E.C.’s house was ready. The worker was to have a conference with her supervisor and get back to E.C.

On October 27, 2006, documentation shows that the worker and supervisor conducted a conference. This is the only notation of a supervisory conference after Sean’s birth. It was decided that a hospital hold would be put into effect for the baby to remain in the hospital for further medical monitoring and to allow E.C. additional time to prepare. No case plan was developed or discussed at this time.

The worker contacted E.C. after the conference to explain their conclusions and to encourage him to visit Sean at the hospital.

An OCA interview with DYFS supervisor C.D. revealed that between the time of Sean’s birth until the time of his release to E.C., C.D. was in the office only one day. In her absence, the casework supervisor was assigned supervisory responsibility of A.Z. in addition to supervising the entire intake unit.

According to records submitted to OCA, the DYFS worker made a visit to E.C.’s home on October 31, 2006, the day before Sean was released to E.C.’s care. The DYFS worker observed

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6 S.F. said E.C. would care for the baby and he wanted full custody. She also advised that her assigned DYFS worker, A.Z., had done background checks on E.C. and they had come back “clean.” When asked, S.F. denied that E.C. had a past or current history of drug use. S.F. assured the workers that E.C. was prepared for the baby and listed the items he had obtained including referrals to Medicaid and WIC.
smoke detectors and noted that all the utilities were functional. Although the worker observed all the necessary baby items, a large number of boxes and clutter were documented all around the house, which E.C. indicated were items he sells in online auctions. The worker suggested that E.C. needed to organize the home and designate a specific area for storing the boxes.

Of great significance in that day’s case notes is that the worker asked E.C. about a 1996 criminal charge and domestic violence history. E.C. claimed that he was the victim of domestic violence by his former girlfriend, G. (last name not in contact sheets) and that they had been together for years. He told the worker that he was excited about finally becoming a father since he had been unable to have children with G.C. He described G.C. as a drug addict with severe mental health issues due to her drug use. He advised that he had an active Restraining Order against G.C. There is no mention or discussion of the temporary restraining order that had been filed by G.C. against E.C. and it was not until November 15, 2006 that the caseworker received official written documentation regarding E.C.’s background check. Contrary to information provided to DYFS by E.C. and S.F., his record reflected a past charge that resulted in restitution.

These dual restraining orders between E.C. and G.C., along with E.C.’s concealment of the DV order against himself, should have heightened the worker’s scrutiny and need to verify E.C.’s representations. Per OCA consultation with domestic violence experts, this case was an atypical domestic violence case. Records reviewed reveal that much was never assessed by DYFS to evaluate the nature of the relationship and the violence between E.C. and G.C.

On November 1, 2006, DYFS filed a Verified Complaint, requesting that DYFS be granted custody of Sean.7 The DYFS record and court transcripts indicate that DYFS withdrew its complaint representing to the court that it had no concerns about E.C.’s home, and recommended E.C. to be Sean’s caretaker. Neither the law Guardian nor the Judge raised any objection to the withdrawal of the litigation and no issues of concern about E.C. were identified in the Complaint. The litigation was terminated and E.C. was urged to apply for residential custody.8 DYFS stated its intent to keep the case open for services and monitoring. Without any further legal action, E.C. assumed physical custody of Sean.

In facilitating Sean’s release to E.C.’s care and representing that the case would be kept open for services and monitoring, DYFS publicly acknowledged its commitment to ensuring this child’s safety, particularly through regular visits and communication.

S.F. was arrested and the judge directed that she be detained until December 15, 2007 for immediate admission into a drug treatment program. No other legal action was taken to prevent S.F. from attempting to assume physical custody of Sean upon her release.

After the hearing, E.C. and the worker proceeded to the hospital where they met with a social worker and two nurses. E.C. was provided with extensive instruction on how to properly care

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7 The allegations contained in the complaint focused exclusively on S.F. with the exception of a single paragraph which identified E.C. as the putative father and made reference to the existence of an active domestic violence restraining order, and that E.C. had been the victim of DV. No information was provided to the court to show that in the past E.C. also had been a perpetrator of DV.

8 There is nothing in the record to reflect that E.C. was provided guidance on how to pursue legal custody.
for Sean in addition to viewing videos on car seat safety and infant CPR. An appointment was scheduled for Sean to see a clinician at the hospitals’ clinic on November 6, 2006. The infant was discharged from the hospital to E.C.’s care.

On the following day, E.C. contacted the DYFS worker, concerned that he had no documentation to prove Sean was legitimately in his care and custody. He requested legal documentation. On November 3, 2006, the caseworker advised E.C. that she would provide him with a copy of a letter addressed to the hospital that stated DYFS had withdrawn its Complaint. No additional documentation is included in the DYFS records reviewed by OCA.

Significantly, the records contain no documentation of any home visits by DYFS to E.C.’s home subsequent to November 1, 2006, following Sean’s release from the hospital to E.C.’s care. The only contact DYFS had with E.C. or Sean was with E.C. via two telephone calls.

Sean was a medically high-risk infant, a categorization that requires a higher level of monitoring and scrutiny in making certain Sean was safe in E.C.’s care.

On November 3, 2006, the worker spoke to a visiting nurse who provided information about infant care training for E.C. The worker was advised that the nurse would be contacting E.C. to begin infant care training on November 7, but was then told minutes later that a clinical nursing supervisor had set up an appointment to meet with E.C. on November 14, 2006 at 12:00 p.m.

Earlier in the day on November 3, the worker spoke with E.C. about Sean and was told he was adjusting well and sleeping approximately 3.5 to 4.5 hours at a time. E.C. described Sean as “a very good baby” who cries only when hungry or soiled.

The worker spoke to E.C. again by phone on November 9, 2006. Sean was described by E.C. as being on an “excellent schedule and a very easy baby to care for.” E.C. questioned the necessity of visiting nurse visits. The worker reiterated that although the baby seemed to be doing well, the nurse still needed to discuss issues regarding caring for cocaine-exposed infants.

On November 13, 2006, the worker followed up with a treatment center on the referral for substance abuse treatment for S.F. The treatment center staff instructed the worker to request that the jail social worker assist S.F. in completing the telephone pre-admission intake.

The visiting nurse made one unsuccessful attempt to visit E.C. on November 14, 2006. Later, the nurse reported to the DYFS worker a phone conversation with E.C. during which he questioned the need for home visits as his questions and concerns had already been addressed by the pediatrician. The worker was also told that the visiting nurse felt that E.C. had a good understanding of “everything.” No further contact was made by either the visiting nurse, the DYFS nurse consultant, or the DYFS worker before Sean’s death, four days later.

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9 The record includes a letter written to the hospital social worker dated November 3, 2006 stating that DYFS was withdrawing its complaint for custody and that custody of the minor child, Sean F., was with the father, E.C. The letter further advised that there would be no further court proceedings at this time.
Medical records obtained by OCA reflect that Sean was in fact seen at a health center on November 9, 2006 for a well baby visit. This one clinic visit was unexplainably three days after the date that had been scheduled for his first visit by the hospital before releasing Sean to E.C.’s care. Clinic notes reflect “dad and a female friend” brought the baby to the clinic. The woman was not further identified in the medical record. Although within DYFS policy for timeframes, there is no indication that DYFS attempted to obtain medical collaterals from the clinic prior to the baby’s death – a practice that is not ideal. Of note, the clinic had not received the infant’s newborn nursery discharge summary at the time of the November 9 visit.

The next DYFS contact was the referral received from the Camden County Prosecutor’s Office on November 18, 2006 indicating that Sean had been gravely injured.

**INVESTIGATION OF SEAN’S DEATH**

Records provided to the OCA indicate that despite E.C.’s final restraining order against G.C., G.C. violated the restraining order and spent significant amounts of time in his home caring for Sean. According to statements made by E.C. to police and the SPRU caseworker, he allowed G.C. into his home because he was worried about her. He admitted knowing that G.C. had an ongoing drug problem and claimed that he even sought treatment for her in the weeks preceding Sean’s death. E.C. told investigators that G.C. frequently used drugs in his home and he had seen evidence of that use. In spite of all this, when G.C. violated E.C.’s restraining order, he did not recognize the risks that her presence might pose to Sean and even allowed her to care for the baby.

E.C. stated to investigators that on the evening of November 17, 2006, he unsuccessfully tried twice to obtain emergency mental health services for G.C., which she refused. He then allowed her to stay at his house for the night. Investigation records reflect that at approximately 11:30 p.m. that evening, G.C. left E.C.’s house, stating that she was going to retrieve an item from a van. When she didn’t return right away, E.C. stated he went outside to look for her, attempted to reach her on her cell phone, and ultimately called the police to express concern about her.

G.C. eventually returned at approximately 4:00 a.m. on November 18, 2006, at which point E.C. reported that he allowed G.C. back into the house. E.C. and G.C. went to sleep on couches in the living room. E.C. stated that he did not want her to sleep in the upstairs bedroom because she habitually used it as a “drug room.” At approximately 7:30 a.m. on November 18, 2006, E.C. woke to hear Sean crying. When he saw that G.C. was no longer asleep on the couch, he assumed that she had gone to tend to the baby. E.C. reported that Sean continued to cry, so E.C. went upstairs to the bedroom, where he saw G.C. standing over Sean. E.C. reported a horrific scene. Sean had been stabbed and eviscerated.

E.C. tried to run down the stairs with Sean, but put him down when G.C. attacked E.C. again. G.C. then picked up Sean and threw him down the stairway into some boxes that were stacked at the bottom of the stairs. E.C. again tried to pick up Sean, but G.C. assaulted him once more. E.C. ran outside, leaving the baby in the house with G.C., and shouted for neighbors to call the police.
Medical records indicate that Sean was admitted to the hospital by ambulance and put on life support. His condition was grave. Sean died at 5:47 a.m. on November 19, 2006. The Medical Examiner listed his cause of death as an eviscerating wound to the abdomen; the manner of death was homicide.

**Summary of M.E.’s findings**

*Medical Examiner's Report: January 5, 2007*

**Cause of death:** Eviscerating wound to abdomen  
**Manner of death:** Homicide

An autopsy was conducted on November 19, 2006, the date of the infant’s death. His injury was described as a sharp-force cut that began in the middle of his abdomen and extended four inches to the right, penetrating the peritoneal cavity. His body had various abrasions, scratches and contusions. There was an irregular, non-depressed fracture of the skull.

Due to the nature of Sean’s injuries, his death was ruled a homicide. The Medical Examiner’s investigator reported that Sean’s injuries made him unsustainable even with life support due to the complete evisceration of his abdomen.

**SUMMARY OF DEATH INVESTIGATION FINDINGS**

- Sean was 25 days old when he died from an eviscerating wound to the abdomen.
- His injury occurred while he was living with his putative father. His putative father’s former girlfriend, G.C., violated a restraining order against her and was allowed to care for the baby and allowed to spend the night in E.C.’s home.
- G.C., the alleged perpetrator of Sean’s fatal injuries, was reported by E.C. to abuse drugs.
- Sean was removed from life support shortly before his death on the morning of November 19, 2006. His injuries were too grave to sustain life.
- G.C. was arrested on the morning of November 18, 2006. An eight-count indictment was later returned, charging G.C. with murder, endangering the welfare of a child, possession of a weapon for unlawful purpose, unlawful possession of a weapon, aggravated assault, aggravated assault on a police officer, resisting arrest, and hindering apprehension or prosecution.

**OFFICE OF THE CHILD ADVOCATE FINDINGS AND RECOMMENDATIONS**

Sean F.’s untimely death might have been prevented.

The Division’s case practice between August 22, 2006 and the day of the child’s birth was diligent, while case practice subsequent to the infant’s birth was deficient.

The OCA recognizes that, based on how DYFS interpreted and coded this case, some basic policies were followed. However, the OCA contends that had attention to detail and process been greater, and had DYFS followed best practices for casework and been more diligent in the
handling of this medically high-risk infant, the caseworker could have discovered information
that would have required this case be handled differently.

It is the opinion of the Office of the Child Advocate that Sean’s untimely death can be partially
attributed to DYFS’ failure to fully investigate the appropriateness of Sean’s release from the
hospital to E.C.’s care. Although DYFS kept the case open for supervision after the release,
DYFS failed to visit and monitor E.C. and his care of Sean.¹⁰

SYSTEMS CONCERNS AND OPPORTUNITIES FOR IMPROVEMENT

DYFS Case Handling Issues Summary
DYFS involvement with this family began as a Child Welfare Assessment in accordance with
DYFS policy when S.F. was pregnant. The casework during S.F.’s prenatal period was good and
focused appropriately on the coordination of interventions from various systems, the engagement
of both S.F. and the putative father, and planning for the child. Once Sean was born, DYFS
failed to conduct a comprehensive and thorough assessment of the putative father and his ability
to provide a safe and appropriate home environment for Sean, despite the case becoming a Child
Protection Services case upon Sean’s birth.

Supervisory Oversight and Documentation
During the more than four months that this was an open case with DYFS, only two supervisory
conferences are documented in the materials supplied to the OCA.

The assigned caseworker did not use required case notes in documentation of her ongoing case
management, and instead recorded all her contacts as free-running documentation on the Child
Welfare Assessment Response Report.¹¹ This raises some concerns as to whether records were
entered concurrent with case management or retrospectively. Retrospectively written records
may represent a skewed viewpoint and do not permit the timely, appropriate and thoughtful
supervision that all cases require. Use of appropriate contact sheets verifies appropriate contact
and documentation dates.

This case also demonstrates examples of inaccurate documentation and information in DYFS
files.

Recommendations
• This case demonstrates a lack of consistent supervisory oversight. DCF must
develop timely and reportable accountability measures for high quality supervision
concurrent with the goals cited in the Modified Settlement Agreement for the
reduction of supervisory caseloads to specified ratios.

¹⁰ The DYFS Policy Manual section titled “Philosophy on Child Safety” contains the following in bold: “in all
interactions with children, the Division worker’s role is to assess the child’s immediate safety and well-being.” In
that role and responsibility DYFS was to provide services to support E.C. in his care of Sean and to ensure Sean’s
safety by placing him in a safe and appropriate environment, after full and complete investigation.
¹¹ DYFS Policy Manual; DYFS Form 26-52: instructions, 12/8/06, Purpose and Use for Contact Sheets / When to
Complete Contact Sheets
• DYFS must develop a better system of accountability for the supervision of workers. This must include: (1) well documented case conferencing; (2) demonstrated follow-up and compliance with clear directives to be followed by the caseworker; and (3) consistent accountability, even in the face of temporary personnel changes.

• Existing policies regarding accurate and timely documentation of case notes must be followed. Supervisors for any caseworker who fails to follow documentation policy must develop immediate corrective action plans.

• Accuracy of information in DYFS records is vital and must be checked on a regular basis by supervisors.

Case Planning and Assessment
DYFS failed to develop a case plan with E.C. or S.F. This is a fundamental failure and undermines the partnerships DYFS must have with families, service providers and other stakeholders.

DYFS failed to verify E.C.’s paternity. Nevertheless, DYFS allowed Sean to enter the care of his putative father, who had questioned his own paternity and parenting ability, seemingly without evaluating any other options for Sean’s care.

Further, no comprehensive assessment of E.C.’s home or completed safety assessment was documented about this household. DYFS did not conduct a full assessment of E.C’s supports and regular contacts, such as other adults who might be present in the home and caring for the child. If the worker had completed a safety assessment, a risk assessment and strengths and needs assessment would have been due within 60 days of the child’s release into E.C.’s home.

Through OCA interviews with DYFS staff, it seems the Camden South Local Office did not have a system to track or log requests for background checks. In this case, the information from Human Services Police was not received until November 15, 2006, even though it appears that the worker requested it on October 18, 2006. Had the results of the background check been followed up on and known prior to Sean’s release to E.C., risk factors would have been identified and alternative plans could have been effected.

Recommendations
• Each family with open DYFS cases should have a comprehensive and current Case Plan that clearly states the tasks and goals of DYFS intervention and those responsible for achieving the goals. This is a basic tool and requires 100% compliance. The Case Plan should be developed with the family in accordance with the best practice of family engagement cited in the Modified Settlement Agreement.

• DYFS must utilize its own established tools for completing safety, risk, strengths and needs assessments in accordance with agency policy on Structured Decision Making (SDM.) Policy requires a preliminary Safety Assessment for children in
their own homes and those to be placed with non-custodial parents, as was the case with Sean and his father.12

- The deadline for completion of a Strength and Needs Assessment and Risk Assessment, 60 days from placement, is too long and unnecessarily puts children at risk. Policy must be changed to shorten that timeframe or to mandate an initial, immediate assessment and subsequent assessments due during that 60 day period.13

- DYFS must request and receive background check documentation prior to placement or release of any child under its supervision to a caretaker.

- Local DYFS offices must adhere to a standard system of tracking background information. Policies and procedures must be developed for this system.

- Upon placement or allowing release of any child under its supervision, including those placed with a non-custodial parent, DYFS must re-visit the home within the first 5 days.

- The policy and procedures for placement of a child with a non-custodial parent remain unclear. DCF must assess these situations and develop policy to ensure child safety and well-being.

Eliminating Certain “Courtesy” Response Practices

OCA interviews with DYFS revealed the practice of sending workers from the Camden Central Local Office to provide one-time “courtesy” responses to Special Response Unit referrals received from hospitals in the city of Camden. In this case, which was already open and had an assigned DYFS worker from a different Camden office, this process appears to be only for the convenience of DYFS. This unnecessary introduction of uninformed workers for a one-time assessment is not good case practice. It defies the principles of family engagement and wastes opportunities for workers familiar with families to work with them during critical times. Continuity provided by assigned workers is best case practice.

Recommendations

- DYFS should eliminate unnecessary courtesy case responses. Local practices of assigning substitute caseworkers to respond contradicts statewide policies promoting maximum family engagement and should be discontinued.

Correct Use of Hospital Holds

Documentation provided to the OCA contains numerous references to discussion and existence of a hospital hold being in effect for Sean to remain in the hospital while E.C. prepared for his placement in the home.14 There is no documentation in the hospital record that the hold was

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12 DYFS Policy – Structured Decision-Making Initiative; “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.”

13 DYFS asserts the timeframe is now 45 days, though OCA’s review of policy, completed just prior to this report’s release, confirms many areas of policy that reflect the 60-day timeframe. The OCA considers both timeframes too long for purposes of establishing an immediate baseline regarding risk and individual safety and needs.

14 N.J.S.A. 9:6-8.16 to 8.20 authorizes physicians and hospital directors to take children into protective custody for a period of up to three court days when that medical professional believes that child may be at serious risk of abuse
officially invoked by the hospital or that the mother was provided with written notification of the hold.

**Recommendations**

- DYFS must adhere to state statute and agency policy requirements when requesting that a physician or hospital director hold a child in a hospital.

**Use of Consultative Notes**

This is not the only case from 2006 where it appears DYFS staff did not read or act on recommendations contained in the reports provided to it by consultants. In this case, a Nurse Consultant outlined in a report that cocaine-exposed babies can be quite symptomatic or they can present as “too good.” The worker did not seem to link the “too good” variable with her phone contacts with E.C. stating what an easy baby Sean was with no problems.

The DYFS Nurse Consultant’s recommendation also specified that at least two nurse home visits were needed after E.C. took Sean home. The nurse also recommended the extended nursing visits include infant care instruction. No home nurse visits occurred. **When the DYFS worker discovered the visiting nurse was unable to make contact with E.C. or Sean she could have requested assistance from the DYFS nurse for a DYFS RN home visit.**

**Recommendations**

- DYFS must develop a system to ensure that assessments and evaluations provided to the Division by consultants are: (1) logged in, reviewed, and discussed by both workers and supervisors; (2) that follow-up occurs, and (3) if adopted, consultant recommendations are reflected in case plans.

- When recommendations made by consultants cannot be completed within a timely basis for any reason, DYFS protocols must be developed to ensure such matters are discussed with supervisors and documented.

**Services to Parents**

There is no record of any services provided to E.C. to help deal with his lack of parenting skills, especially as a caregiver of a baby born cocaine-exposed. E.C. might have also benefited from a psychological assessment and psychological support around the time of Sean’s placement.

The DYFS worker did not consult with the in-office Substance Abuse Counselor concerning substance abuse treatment options and possible solutions to delays in treatment availability for S.F. The worker missed a valuable opportunity to seek and obtain guidance on options for treatment for S.F. and did not adhere to DYFS policies regarding case handling and case planning for individuals in need of substance abuse treatment.

OCA applauds DCF’s decision to make Domestic Violence consultants available to all local DYFS offices in 2008. One of the Domestic Violence experts consulted by OCA on this case stated that this death might have been prevented had DYFS conducted a full screening for the domestic violence history for both E.C. and G.C. as part of its routine investigation.

and/or neglect if he continues in the care of his parent caretaker. DYFS cannot invoke a hospital hold but can suggest the hold to medical professionals. In these situations, DYFS has other alternatives such as emergency removal without a court order (DOD) or requesting a 10-day social hold of the child due to necessity.
At present, Domestic Violence screenings are not yet a routine part of DYFS policy and investigation. As a second Domestic Violence expert pointed out, neither psychological evaluations nor substance abuse evaluations are designed to identify victims or perpetrators of domestic violence. While a psychological evaluation of E.C. and substance abuse screening would indeed have been helpful, a domestic violence screening or a Danger Assessment in this case was needed. Such screenings are needed in any DYFS investigation in which domestic violence issues are present.

Domestic Violence experts have expressed that this death might have been prevented had the significance of the restraining orders been recognized and had a full assessment of the dangers in the home occurred. The experts concurred that this case was atypical of domestic violence cases. The effects of this were compounded by G.C.’s psychopathic tendencies, mental health disorder, and severe substance abuse.

**Recommendations**

- DCF needs to develop and adopt policy for conducting Domestic Violence screening to supplement all routine DYFS safety assessments.
- DCF needs to make Domestic Violence consultants available to all local offices as soon as possible along with guidelines for when they should be consulted.
- After thorough assessment of the needs of each family member, DYFS must provide and monitor timely and appropriate services to meet identified needs within explicit timeframes.
- In working with all families affected by substance abuse, DYFS staff must follow existing agency policy on consulting with/referring to the Substance Abuse Counselors out-posted in each DYFS office and management must develop and adhere to accountability measures for following those policies.15

**DYFS Legal Systems Issues**

Upon Sean’s placement, DYFS withdrew its Verified Complaint and chose not to pursue litigation despite removing Sean from his biologic mother’s custody at birth and in spite of placing Sean in a high-risk home situation. Litigation seeking court-ordered care and supervision of Sean likely would have resulted in court-ordered services for E.C., and would have provided separate legal representation for Sean through the Office of the Law Guardian.

The serious omissions cited in this report, e.g. (1) lack of a written case plan and (2) failure to make any home visits after Sean was placed with his alleged father, would almost certainly have been corrected. The assignment of a law guardian in Sean’s case would have provided the opportunity for independent investigation of Sean’s home environment and would have supplied one more safeguard to ensure Sean’s safety and well-being.

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15 DYFS policy II.C.2427 requires “each DYFS client who presents with, or is assessed to have, a substance abuse problem requiring treatment shall have a comprehensive, integrated child welfare/substance abuse case plan.
**Recommendations**

- Before a decision to withdraw litigation is made, all parties must ensure thorough consultation has occurred with DYFS, the assigned Deputy Attorney General and the Office of the Law Guardian. Case conferencing protocols should be developed to reflect such a system. The DYFS supervisor must monitor follow-up and the child’s law guardian and the courts must be kept apprised of any significant developments or concerns.

**Associated Concerns**

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

**Medical Systems Issues – DYFS Case Handling**

While E.C. did take Sean to a medical well baby appointment on November 9, 2006, there is no documentation in the DYFS record showing that the worker obtained any follow up medical collaterals, nor did DYFS notify the clinic or pediatrician that this was a medically high-risk child who had an active DYFS case. The clinic notes from Sean’s only medical visit reflect that the clinic had no hospital discharge information about Sean or his family and further and no information that there was active DYFS involvement. Had the outpatient clinic received the one-page newborn nursery discharge sheet, treating physicians would have known that this baby had active DYFS involvement at the time of his birth.

**Recommendation:**

- DYFS must develop policy requiring that clinicians providing care for a child with an active DYFS case are fully informed about DYFS involvement and are provided with information about that child.

**Medical Systems Issues – Medical Providers**

There were deficiencies noted in some of the medical systems involved in Sean’s case. The dictated hospital discharge summary about “Baby Boy F.” refers to this infant as “baby girl” in the dictation summary, a deficiency never corrected by the attending physician. No newborn nursery hospital discharge summary was ever provided to the hospital’s follow up clinic, nor was it sought by the clinic at the time of Sean’s one outpatient assessment on November 9, 2006. The clinic note did not accurately document the identity of the adults who accompanied Sean to clinic on June 9, 2006.

**Recommendations**

- Attending physicians are required to sign dictated notes and to correct inaccuracies found in such reports. Medical records quality improvement programs should track timeliness of completion of dictated summaries and should monitor accuracy in records.

- Continuity of care and transfer of information from one hospital system to another hospital system is a key point in hospital accreditation. Lack of the newborn nursery discharge summary at Sean’s November 9, 2006 follow up visit is a notable and correctable deficiency.