



State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
P.O. Box 729
TRENTON, NJ 08625-0729

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

July 15, 2011

Dear Colleagues:

I am writing today as a follow up regarding the Department of Children and Families' (DCF's) case record review of the Ovilde case from May 22, 2011 to the present, conducted by the DCF Office of Continuous Quality Improvement (OCQI).

As you may recall, I first wrote on June 10, 2011 regarding the Division of Youth and Family Services' (DYFS') involvement with the family from 2006 through 2008. That review concluded that while the investigations conducted during that time period were appropriate, given our case practice expectations today, opportunities exist for additional improvement and practice changes. My letter to you today represents the balance of our review of DCF's handling of the Ovilde matter. Specifically, this review examined the report and follow up regarding Christiana Glenn's death on May 22, 2011, and a previously unlinked anonymous call received by our child abuse hotline on May 13, 2011.

DYFS first became aware of Christiana Glenn's death on May 22, 2011, when a Child Protective Service (CPS) report was received from the Essex Regional Medical examiner. The matter was assigned to the Essex Special Response Unit (SPRU), whose immediate response included visual observation of the home and a visual observation of the two surviving children (Christiana Glenn's siblings) at the hospital. The SPRU worker was unable to interview the mother and the secondary caretaker, Myriam Janvier, at that time due to ongoing law enforcement activity. Immediate follow up was initiated by the Essex South Local Office the next day, including appropriate medical referrals.

Our review of this matter reveals that appropriate and timely interviews and evaluations were conducted by the DYFS office in relation to the child death investigation. DYFS spoke with the medical examiner, the children, the father and other relevant parties. DYFS also referred this matter to a Regional Diagnostic Treatment Center for appropriate and expert evaluation.

I am happy to share that the review did not reveal any significant case practice issues regarding DYFS handling of the current child death investigation. That investigation has included numerous family, professional and collateral interviews

Dear Colleagues
July 15, 2011
Page 2

that accurately support the findings. While there was a concern raised regarding the timeliness of the Safety Assessment and accuracy of the Risk Assessment Structured Decision Making Tools, these factors did not have an impact on the care the children are currently receiving.

With regard to the ancillary issues raised regarding the involvement of different systems during the life of Christiana Glenn, and after DYFS' last interaction with the family in 2008, several concerns have been brought to my attention.

During this investigation, DCF became aware of previous family court litigation that was initiated in 2009 by the godparents of Christiana Glenn for custody and visitation with Christiana. On June 8, 2011, the Star Ledger reported that a court appointed psychologist evaluated Christiana Glenn, her mother and godparents in 2009, as part of an application for visitation made by the godparents. The Star Ledger reported that Christiana disclosed possible physical abuse by her mother to the psychologist during that evaluation.

Upon reviewing this matter in the Star Ledger, DCF again confirmed it had no record of these allegations being reported to the hotline at that time. We then made a request to the Essex County Superior Court for a copy of the file. After filing a motion, DYFS was able to obtain the complete file; however, on June 21, 2011, the court entered an order determining the record confidential. Thus, while DCF has reviewed that file, we are limited in what can be shared publicly.

Because of concerns identified regarding the handling of that matter, including the question of why DYFS was not contacted in 2009 by the court or its appointed psychologist, I have contacted the Administrative Office of the Courts to review how we can work together to continue to improve our systems and prevent future lapses of this nature. Similarly, it is my intention to work with the appropriate professional licensing boards to ensure adequate review and evaluation of this issue.

The final matter I wish to address is the anonymous call received by DYFS' State Central Registry (SCR), the state's 24 hour/7 day a week child abuse and neglect screening center, on May 13, 2011. As reported previously, the investigation into this child fatality revealed an additional anonymous call to the SCR on May 13, 2011. In addition to reviewing the tape of the call itself, I immediately requested that the OCQI conduct a review of the receipt and handling of this call. They have determined the following:

An anonymous male reporter with a heavy accent called with concerns about seeing two children that day for the first time, when he had seen the women they were accompanied by every day for a year, but never with the children. He indicated that he did not know the women, but they "dressed like Christians," and he focused somewhat on their religious practices, such as chanting. He

Dear Colleagues
July 15, 2011
Page 3

expressed concerns about the children's physical appearance, including their height, the manner in which they walked and how they were placed in the car. He reported seeing the children in the evening that day as well, and reported that they looked malnourished. When further questioned by the screener regarding that statement, the reporter did not elaborate, but instead raised concerns about whether the children should be in school. The call ended after the screener advised that the call did not rise to the level of an abuse or neglect report, but that she would keep record of the report, referred to as an Information and Referral in our system (I&R). The reporter did not provide any identifying information about the family except their address.

The OCQI review identified case practice concerns with respect to this call, as well as larger operational issues regarding our hotline. Specifically, the screener's engagement with and interviewing of the caller was weak, which resulted in critical information being misunderstood and/or taken out of context. System searches were not properly documented or may not have been conducted at all, and there is no documentation in the screening summary that there was a conference with the SCR supervisor. The review also determined that the screener who received the anonymous call was employed by DCF for less than one year, and that DCF hired the screener directly into SCR without requiring a field assignment at a local office first, which was a departure from prior DCF hiring and staffing practices.

Please be assured that despite these concerns, I am confident that our practice in our hotline is strong. Our system will benefit from a number of changes we have already undertaken. Some of the immediate action has included assignment of additional supervisory and specialty staff, re-instituting our earlier practice of requiring SCR staff to have prior local office experience, and requiring staff promoted to positions at SCR to make a two year commitment to the office.

The review identified additional recommendations for areas of improvement both within DCF and in regard to our system partners that are summarized as follows:

State Central Registry:

A review and revision of the SCR screening training curriculum is planned. The establishment of clinical supports to staff and supervisors is being explored.

A thorough review of the current screening policies and procedures at SCR will also be conducted to determine necessary changes to practice as well as a reinforcement of the current search policies.

In addition, a Qualitative Review of SCR operations will be conducted by OCQI and the New Jersey Child Welfare Monitor.

Dear Colleagues
July 15, 2011
Page 4

Mandatory Reporting of Suspected Child Abuse and Neglect:

DCF will work in partnership with the New Jersey Task Force on Child Abuse and Neglect to develop a new public education campaign to encourage reporting of child abuse and neglect. This will include a targeted effort to reinforce the current law regarding mandatory reporting of abuse and neglect by professional staff in other disciplines such as psychologists, teachers and pediatricians. DCF will explore ways to further enhance this requirement.

DCF will advocate for continuing education requirements for licensed psychologists, including a minimum hourly requirement on child abuse and neglect.

DCF will also work with the court system to improve communication between the courts and the child protection system to assure all suspected cases of child abuse and neglect are reported to DYFS.

Home Schooling:

DCF will also coordinate with the Department of Education to fully understand the requirements of home schooling in New Jersey to inform the development of policies and protocols, if warranted, to increase child safety for home schooled children.

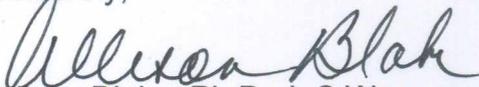
Child Fatality Near Fatality Review Board:

Additionally, DCF will communicate concerns in this review to the New Jersey Child Fatality Near Fatality Review Board, a multidisciplinary review board who assists in the review of many child deaths in the State, and seek feedback and guidance for future actions.

In closing, I want to reassure you all of my continued belief that New Jersey has made continuous and sustained progress in reforming and improving our child welfare system. As painful as self-analysis may be, I greatly value the opportunity to critically examine our practice in real time and respond accordingly. Becoming a self-correcting system is a goal we are actively pursuing, and this current self-analysis should not be misinterpreted as an indictment of our system or any individual, but instead, it should be viewed for what it is: a reflection of system maturity, a commitment to transparency, and true partnership with the community.

Thank you for your efforts on behalf of the children and families of our state.

Sincerely,


Allison Blake, Ph.D., L.S.W.
Commissioner