NEW JERSEY SAFETY TASK FORCE

Final Report & Recommendations

APRIL 2026

Contents

Executive Summary

In 2025, following a series of critical incidents involving families known to New Jersey's child welfare system, the New Jersey Department of Children and Families (DCF) convened a multi-disciplinary Safety Task Force (Task Force). The goals of the Task Force were to: 1) conduct a rigorous examination of the Division of Child Protection & Permanency (CP&P)'s safety decision-making during child maltreatment investigations and in-home services cases, with a focus on families who have repeated contact with the agency — referred to in this report as Frequently Encountered Families; and 2) make systems-level recommendations to improve CP&P safety decision-making and management. While Frequently Encountered Families represent only **11%** of open CP&P cases, they are at increased risk of serious or critical safety incidents[1] compared to families who are not frequently encountered, making them a priority population for systems improvements.

The Task Force's work was guided by Safety Science, an approach common in fields like aviation and healthcare that utilizes data and lessons learned from past incidents to find and address the underlying conditions that lead to harm. Rather than focusing on individual mistakes, Safety Science looks at how systems, workloads, and workplace culture shape the decisions people make under pressure. The Task Force met monthly between July 2025 and December 2025 to define the problem, empirically examine its root causes, brainstorm solutions, and draft recommendations.

[1] A critical incident refers to a serious safety event such as a child fatality or near-fatality involving a family with current or recent Child Protection & Permanency involvement.

A central finding of the Task Force was that child safety decisions are made in a complex, high-stakes environment where CP&P must ensure child safety while also respecting a family's right to autonomy. CP&P staff make the correct safety decision in the vast **majority (97%)** of encounters with Frequently Encountered Families. In the remaining **3%** of cases, important threats to safety or case circumstances are missed, leading to a decision that either does not adequately protect the child or is more intrusive than the situation required.

The Task Force recommended a shift toward systems change aimed at identifying high-risk situations before they escalate and creating conditions in which staff can work together effectively on the most complex decisions. Core recommendations from the Task Force include:

- ***Improve Early Identification of High-Risk Families:*** Use data and technology to recognize families who may be on a path toward escalating problems, so DCF can connect them with the right supports earlier. Strengthen existing decision-support tools with predictive risk modeling to improve the accuracy of safety and risk assessments. Where AI technologies are introduced, require rigorous ethical review, including independent audits for bias, and ensure that final safety decisions always rest with trained human staff.

- ***Explore and Pilot Evidence-Based Teaming Strategies:*** Bring more voices to the table when CP&P is making difficult safety decisions. Identify and adopt teaming models that have proven effective in other jurisdictions — models that bring diverse perspectives into safety decisions, support more objective judgment, and promote shared accountability. Pilot the chosen approach in select regions to refine processes before statewide rollout.

- ***Optimize Workload for CP&P Staff:*** Examine what supervisors and caseworkers are being asked to do and make sure they have the time and capacity to support staff managing the most complex cases. Conduct a time study to identify which activities are consuming the most of supervisors' and caseworkers' time. Use those findings to develop a strategy for redistributing or reducing lower-priority work. Build dashboards that give supervisors a real-time view of workload, so they can prioritize their attention where it matters most.

- ***Strengthen Psychological Safety in CP&P Local Offices:*** Build a workplace culture where staff feel safe raising concerns, asking questions, and pushing back on a decision when a child's safety is at stake. Examine how psychological safety in local offices affects decision-making, teamwork, and case outcomes. Use those findings to identify and implement specific practices that strengthen psychological safety and encourage open communication at every level of CP&P.

- ***Implement an Anonymous Internal Safety Reporting System:*** Provide staff a confidential way to flag safety concerns about how the system is working, so problems can be identified and fixed before they lead to harm. Build the technical and policy infrastructure for anonymous reporting, drawing on similar systems already used in healthcare and aviation. Review the aggregated data regularly to identify patterns and drive system-level improvements.

- ***Supplemental: Explore Peer Support Models for Earlier Engagement of Frequently Encountered Families***: Use peer workers who have navigated the child welfare system themselves to build trust with these families and encourage engagement in voluntary services.

What did we set out to accomplish?

Purpose of the Task Force

In June 2025, New Jersey Department of Children and Families' Commissioner Christine Norbut Beyer formally established a time-limited, Safety Task Force to ensure DCF safety practices in investigations and in-home cases meet the highest standards and to make recommendations for improvement. Following a series of critical incidents involving families whose cases were recently closed or currently open with CP&P, DCF initiated the Task Force to foster transparency around this issue and bring together experts across disciplines to generate innovative solutions focused on improving safety decision-making at the systems level.

The goals of the Task Force were to: 1) conduct a rigorous examination of CP&P's safety decision-making during child maltreatment investigations and in-home services cases, with a focus on Frequently Encountered Families; and 2) make systems-level recommendations to improve CP&P safety decision-making and management

Beyond the Task Force's Purpose

The Task Force was designed to examine CP&P's internal safety decision-making practices, not to evaluate the broader child welfare system or the quality of community-based services. We recognize that families involved with CP&P often have complex needs that extend well beyond the scope of this review, including access to supportive services and resources, which DCF is addressing separately through new quality standards for service providers and ongoing monitoring against those standards. A focused examination of internal safety practices was necessary to strengthen the systems most directly responsible for protecting children when safety decisions are made.

Safety Task Force Structure

Task Force Composition

The New Jersey Safety Task Force was composed of experts representing diverse disciplines from both inside and outside New Jersey, including child welfare practitioners, child abuse pediatricians, attorneys, and researchers. Members were chosen based on their expertise in child protection, safety-related decision-making, and child welfare data, and the group included multiple national leaders from the child welfare field. The Task Force membership is listed in Table I.

Table I: Child Safety Task Force Membership

Member	Title/Role	Organization
Chris Arnold, Esq.	Deputy Director, Division of Law	Office of the Attorney General
Christine Norbut Beyer, MSW	Commissioner	NJ Department of Children & Families
Laura Brennan, MD	Child Abuse Pediatrician Chair, NJ Child Fatality, Near Fatality Review Board	Rowan Medicine, CARES Institute
Christopher Church, JD	Senior Director, Strategic Consulting	Casey Family Programs
Mary Coogan, Esq.	President & CEO Chair, NJ Task Force on Child Abuse & Neglect; Member, NJ Staffing & Oversight Review Subcommittee	Advocates for Children of New Jersey
Michael Cull, PhD	CEO & Founder	Center for the Helping Professions
David Hansell, JD	Senior Child Welfare Policy Advisor	Casey Family Programs
Laura Jamet, MSW	Assistant Commissioner, Division of Child Protection & Permanency	NJ Department of Children & Families
Gladibel Medina, MD	Child Abuse Pediatrician, Medical Director	The Children's Hospital at St. Peter's University Hospital, Dorothy B. Hersch Child Protection Center
Melissa Merrick, PhD	President & CEO	Prevent Child Abuse America
Amanda O'Reilly, MPH	Assistant Commissioner, Analytics & Systems Improvement	NJ Department of Children & Families
Stephen Patrick, MD, MPH, FAAP	Professor & Chair, Department of Health Policy & Management	Emory University, Rollins School of Public Health
Katherine Stoehr, MPA	Former First Deputy Commissioner Managing Director	NJ Department of Children & Families Casey Family Programs
Traci Telemaque, Esq.	Assistant Public Defender Member, NJ Staffing & Oversight Review Subcommittee	Office of the Law Guardian

What was the process we used?

Task Force Methods

Safety Science-Based Approach

The work of the Task Force was grounded in the Safety Science framework.[2] Safety Science is the application of research and scientific methods to understand, assess, and manage safety. When a safety science approach is utilized in the context of child welfare, evidence is used to apply lessons learned from a critical incident or child fatality and inform preventive and responsive actions at the systems level.[3]

Utilizing a Safety Science-based approach, Task Force members were committed to 1) using evidence to inform decision-making; and 2) moving beyond identifying individual errors toward a systemic approach that recognizes child protection as a shared responsibility.

Meeting Structure

Over the course of six meetings, occurring between July and December 2025, the Task Force took a systematic approach to define the problem, empirically examine its root causes, brainstorm solutions, and draft recommendations (Table 2).

Table 2: Task Force Meetings and Topics Covered

Meeting	Topics Addressed
July 31, 2025	• What is the NJ Child Safety Task Force? • Why was the Task Force convened? • Define the problem to be solved
August 22, 2025	• Unpack the problem to be solved
September 23, 2025	• Identify DCF's areas of focus • Identify root causes of the problem
October 27, 2025	• Brainstorm and discuss possible solutions
November 17, 2025	• Draft recommendations
December 8, 2025	• Finalize recommendations

[2] Cull, M. J., Rzepnicki, T. L., O'Day, K., & Epstein, R. A. (2013). Applying principles from safety science to improve child protection. Child Welfare, 92(2), 179-196.

[3] Casey Family Programs. (2026). How can child protection agencies use safety science to promote a safety culture? Accessed from: https://www.casey.org/safety-science-implement-culture/

What did we learn?

Review of the Evidence

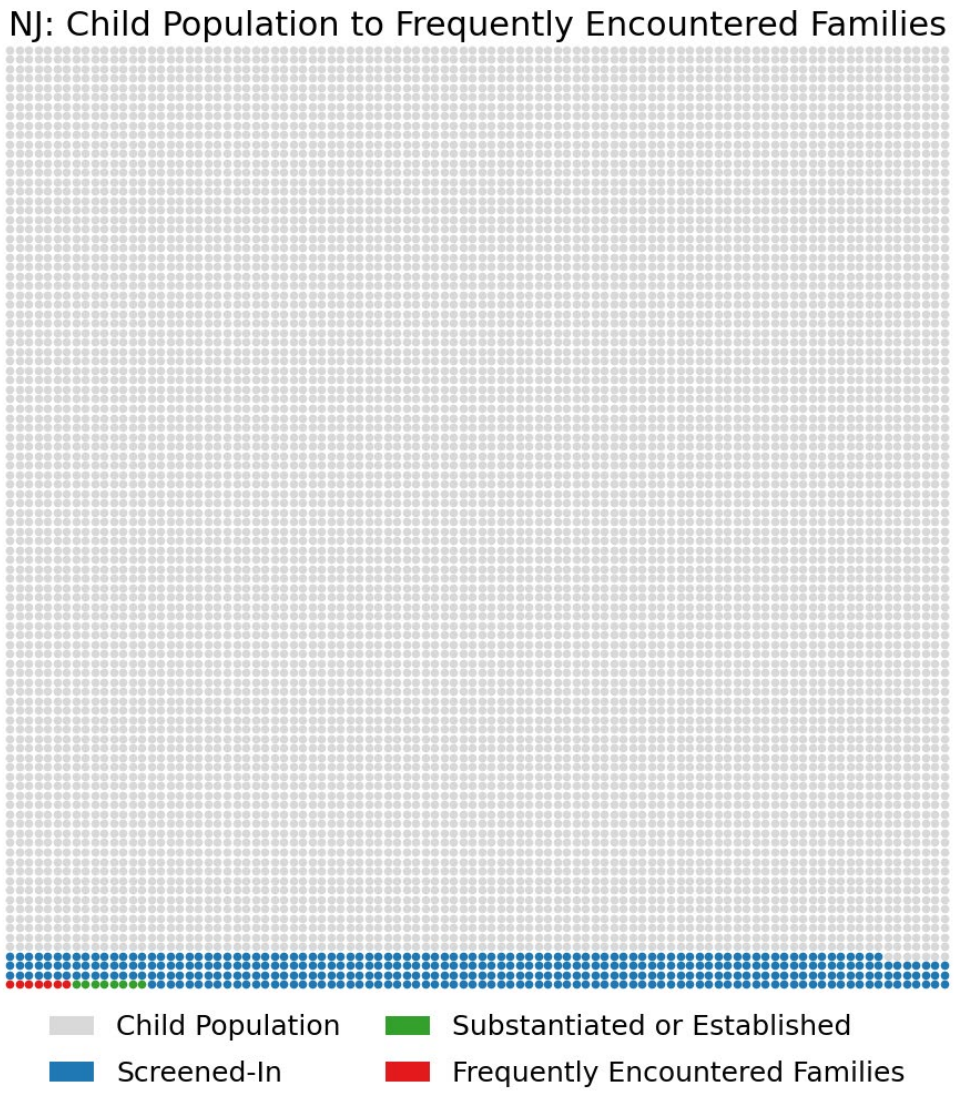
Child Welfare-Involved Families in New Jersey

Child maltreatment and involvement with the child welfare system are uncommon among New Jersey families. In 2023, DCF responded to more than 78,000 allegations of child maltreatment (39.3 CPS responses per 1,000 children), a response rate that ranks near the mid-point (29th highest) nationally. However, those responses led to the formal identification of approximately 3,000 victims of maltreatment, resulting in the lowest child victimization rate in the nation (1.5 victims per 1,000 children). For those 3,000 children, DCF's response can range from providing in-home services that address the safety concern to seeking a court order to remove the child and place them in foster care.

For children whose investigations do not result in a maltreatment finding, DCF most commonly refers the family to community partners or asks the family to accept voluntary services in their home. In New Jersey, only 2.9% of children with a finding of maltreatment experienced subsequent maltreatment within six months, significantly below the national rate of 6.6%. Additionally, only 1% of children with no maltreatment finding experienced maltreatment within six months, compared to 3.7% nationally. While national child fatalities attributed to maltreatment have increased steadily since 2014, New Jersey's rate has remained relatively stable and well below national rates.

Frequently Encountered Families – defined as families who have experienced three or more CPS reports in a 12-month period – are uncommon in New Jersey, constituting only 11% of families involved in the child welfare system at any given time. Most (62%) of these families have 3 reports in a year, and 6% experience 6 or more CPS reports in a year. The majority of Frequently Encountered Families are involved with CP&P through an active investigation; only about 1 in 3 are currently receiving in-home services.

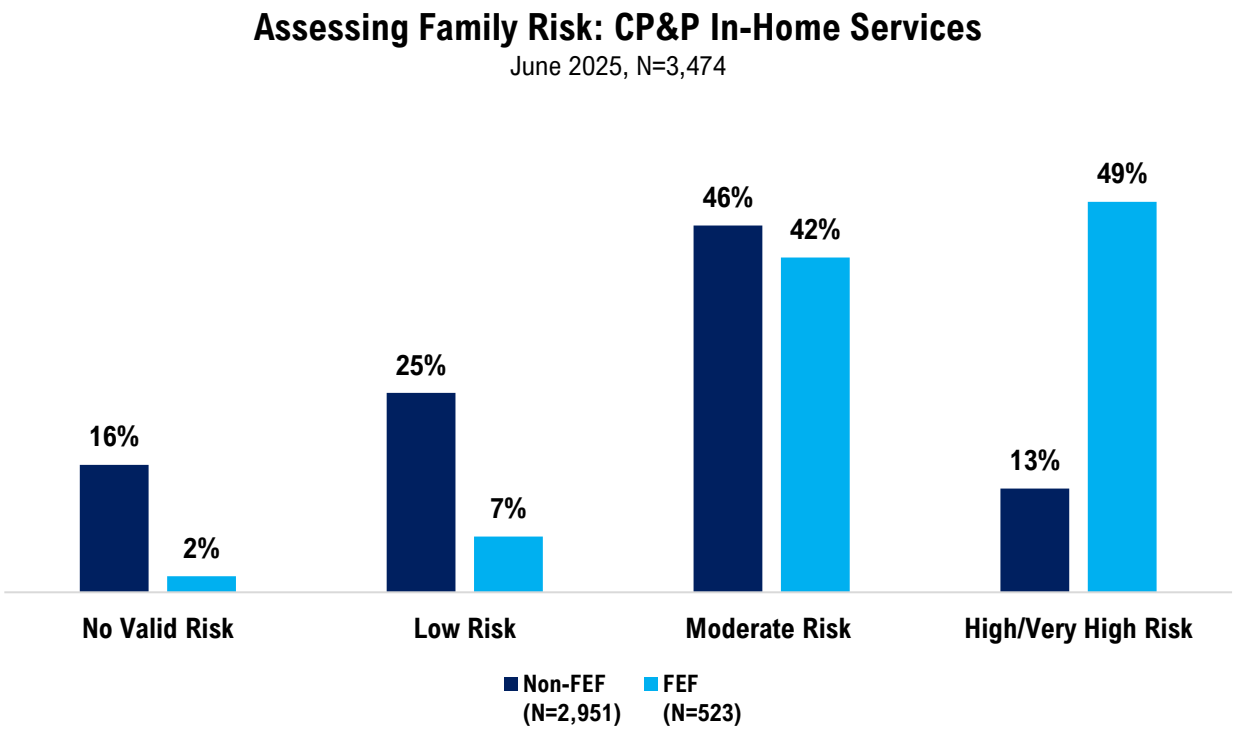
Figure I: New Jersey Child Population Compared to Frequently Encountered Families



**one dot represents 200 children*

Frequently encountered families receiving in-home services are more likely to be considered high risk than families who are not frequently encountered (Figure 2). Forty-nine percent of frequently encountered families are assessed as high or very high risk by CP&P staff compared to only 13% of families who are not frequently encountered. Additionally, these families often have young children in the home. Over half of frequently encountered families have children under the age of 10.

Figure 2: Risk Levels of Frequently Encountered Families Compared to Non-Frequently Encountered Families, 2025



Source: SafeMeasures Reports – All Open Cases (By Service Type), Frequently Encountered Families (Non-Placement Cases)

Quality of Safety Decision-Making

When DCF's child abuse hotline or State Central Registry (SCR) screens-in a CPS report, SCR sends it to a CP&P local office so that an intake caseworker can begin an investigation. The intake caseworker will complete an initial safety assessment at the first contact with the family and document their findings within three business days. Within 45 days of the report, the intake caseworker also completes a risk assessment, which considers the longer-term likelihood of future maltreatment. Both assessments are repeated at least every 90 days while the case is open, and they are central to how CP&P assesses child safety.

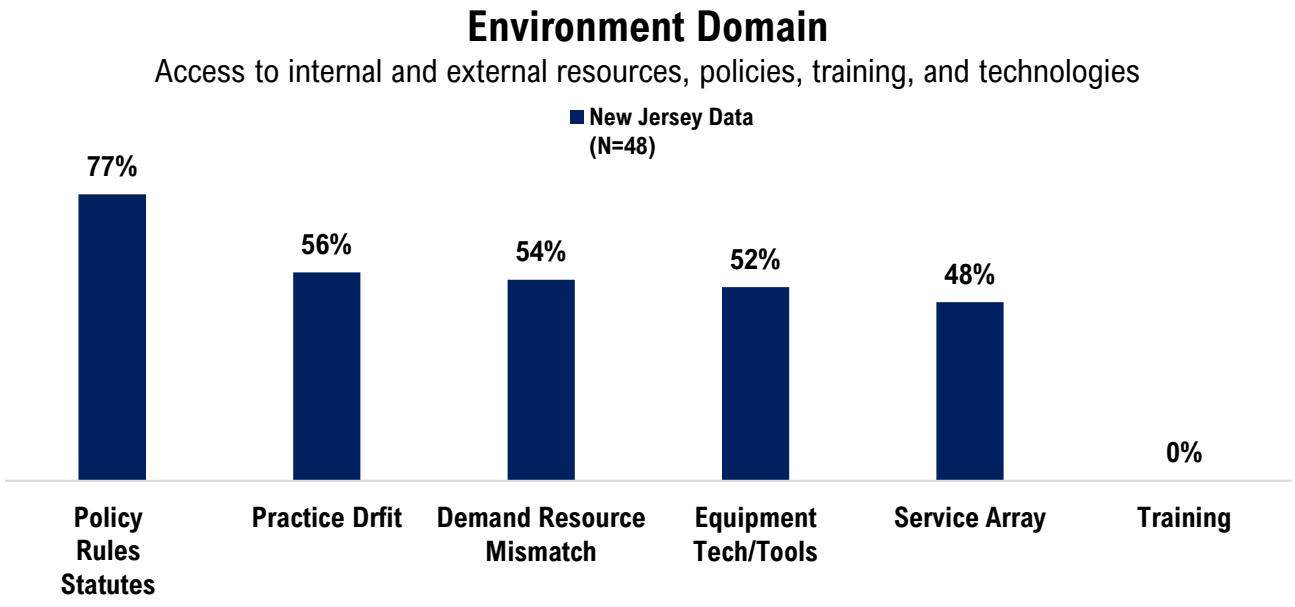
An internal DCF review of all Frequently Encountered Families with open CP&P cases on April 7, 2025 found that a correct final safety decision was made in 97% of cases. In 3% of cases, important threats to safety or case circumstances were missed, leading to a final decision that either did not adequately protect the child or was more intrusive than the situation required. In 82% of Frequently Encountered Families, the risk level from the Initial Risk Assessment was correct. When the assessment was incorrect, the risk level most often needed to be raised (65%) rather than lowered (35%). The most common reason for an incorrect assessment (35%) was that family characteristics evident in the case were not selected in the assessment tool.

Factors Associated with Critical Incidents

Using the Safe Systems Improvement Tool[4], a research-validated approach for examining systemic factors that contribute to a critical incident, DCF regularly reviews cases in which critical incidents occur (see Appendix A). At the time of a critical incident, the most common family factors present were family conflict (35%), caregiver substance use (33%), and caregiver mental health challenges (29%). Cognitive bias – unconscious patterns of thinking that can distort judgment, even with the best intentions – played a role in 94% of cases, compared to 48% nationally. Challenges with teamwork and coordination within DCF were also significant contributing factors, appearing in 3 out of every 4 critical incident reviews. Finally, production pressure – demands on professionals to increase efficiency – was identified in 52% of critical incidents in New Jersey, compared to 26% nationally.

When examining the factors that influence the environment in which teams work, DCF found that the absence or ineffectiveness of policies, rules or statutes was a contributing factor in 3 of 4 critical incidents. Practice drift or departure from work-as-prescribed (56%), mismatches between resources and demand (54%), and availability of appropriate equipment and technology to carry out work (52%) were identified as challenges in over half of critical incidents (Figure 3).

Figure 3: Environmental Factors Contributing to Critical Incidents



[4] Cull, M. J., Lindsey, T. O., Riley, E. N., & Lyons, J. S. (2022). The Safe Systems Improvement Tool. Child Welfare, 99(6), 115-136. https://centerforthehelpingprofessions.org/wp-content/uploads/2025/04/SSIT-Reference-Guide_CHP.pdf

Root Causes of Practice Vulnerability

In alignment with the Safety Science framework, the Task Force sought to identify root causes of critical incidents that moved beyond individual performance and instead focused on systemic contributors to practice vulnerability across three domains: Professional, Team, and Environment.

Within the Professional Domain, New Jersey's critical incident reviews identified higher levels of cognitive bias compared to national averages. Factors such as psychological strain, extreme tiredness, and confirmation bias were found to cloud objective assessments. This was particularly evident when long-standing relationships with a family led staff to trust a caregiver based on past cooperation while inadvertently dismissing new, escalating safety signals. This challenge was particularly relevant to Frequently Encountered Families who, by definition, had multiple interactions with CP&P.

In the Team Domain, existing structures were found to be overly hierarchical, which can prevent frontline staff from challenging a supervisor's assessment. Reviews suggest that supervisory energy is frequently consumed by administrative approvals and data monitoring rather than directed toward the high-level clinical decision-support required for complex safety assessments.

The Environmental Domain also weighs heavily on the quality of work. Practice drift -- the gradual gap that develops between official policy and how work actually gets done in the field -- remains a persistent challenge. While 62% of safety assessments met every policy requirement, late documentation alone accounted for 80% of the gaps. Setting the timing requirement aside, more than 92% of assessments met all substantive policy requirements, indicating that errors in the assessments themselves were uncommon. This drift is exacerbated by intense production pressure, specifically the mandate to close investigations within 60 days, which can compromise the depth and quality of information collection.

The CP&P Staff Experience

While DCF has studied and improved caseworker caseloads, supervisor workloads and duties have not received as much attention. There is also a significant complexity mismatch in how work is assigned; for example, fatality and near-fatality cases "feel like five cases in one," yet they are often added to a worker's queue without any corresponding reduction in overall volume. Finally, there is a pervasive concern that a metrics-driven culture focused on tracking administrative data points can inadvertently overshadow the complex qualitative needs of families and the intellectual rigor required for sound safety decision-making.

Review of Potential Interventions

The Task Force focused their review of potential interventions around systems-level improvements to safety decision-making, particularly within the context of Frequently Encountered Families at high risk for critical incidents. Under consideration were models from other industries that: 1) foster a non-punitive culture focused on uncovering systemic vulnerabilities that compromise safety; and 2) shift the focus away from blaming individuals for errors that are often driven by unsustainable environmental pressures. The following areas were prioritized as targets for intervention:

- ***Quality of Assessments***:
  The Task Force discussed creating a Frequently Encountered Families protocol that would include an independent review of assessments in these cases by staff who are not closely involved with the families, such as DCF staff from other regions. The Task Force also discussed using technology to automate and synthesize case histories.

- ***Quality of Supervision***:
  The Task Force discussed how DCF should explore models of supervision that guide decision-making and collaboration rather than focus on approvals and monitoring. One model the Task Force identified as promising was the Safety Science Consultant, which is based on the principles of Safe Systems Improvement and integrates a third-party clinical coach. The Task Force also felt DCF may need a time study to better understand supervisors' workloads and production pressures. Finally, the Task Force discussed ensuring that more experienced workers and supervisors are assigned to the most complex cases.

- ***Quality of Teaming***:
  The Task Force recognized the overlapping root causes (cognitive bias, hierarchical supervision, and practice drift) and agreed that many of the strategies discussed above (e.g., independent review of assessments, flattened hierarchy) would also improve the quality of teaming for Frequently Encountered Families. The Task Force also considered the use of peer mentors or peer partners to work alongside DCF staff to encourage Frequently Encountered Families to engage with DCF and participate in services.

Learning from Industries that Utilize a Safety Science-Based Approach to Improvement

The aviation industry relies on a flattened hierarchy to encourage all staff to speak up if they observe a safety risk, regardless of their rank within the organization.

Health care focuses on mitigating the impact of cognitive bias through safety huddles or RED team approaches that routinize multidisciplinary, collaborative meetings to discuss potential safety risks of current patients or open cases, respectively.

- ***Cognitive Bias***:
  The Task Force discussed identifying pause points — moments when a case must be paused for independent review — for assessments and decision-making involving Frequently Encountered Families. The Task Force also discussed using technology to quickly identify Frequently Encountered Families and synthesize background information contained in DCF databases. This could also include the use of technology to flag meaningful patterns or identify gaps in documentation for these cases.

Strategic Recommendations

With the goals of increasing family engagement, reducing families' repeat involvement with CP&P, preventing case escalation, and reducing critical incidents, the Task Force developed five core recommendations and one supplemental recommendation to address systemic vulnerabilities.

Improve Early Identification of High-Risk Families

Why it Matters:
Delayed intervention can lead to unmet needs and crisis situations.

Action:
Use data and technology to recognize families who may be on a path toward escalating problems, so DCF can connect them with the right supports earlier. Strengthen existing decision-support tools with predictive risk modeling to improve the accuracy of safety and risk assessments. Where AI technologies are introduced, require rigorous ethical review, including independent audits for bias, and ensure that final safety decisions always rest with trained human staff.

DCF should use ethical, human-centered technology to identify and predict Frequently Encountered Families or families at risk of becoming frequently encountered. This involves leveraging technology to identify causal or meaningful connections, such as subtle patterns across historical case notes, that are difficult for humans to isolate in high-stress, time-sensitive situations. By shifting from manual review to data-driven identification, DCF can trigger supportive, preventative interventions.

Explore and Pilot Evidence-Based Teaming Strategies

Why it Matters:
Hierarchical decision-making can limit collaboration and diverse perspectives, reflect biases, and prevent staff from sharing critical concerns.

Action:
Bring more voices to the table when CP&P is making difficult safety decisions. Identify and adopt teaming models that have proven effective in other jurisdictions — models that bring diverse perspectives into safety decisions, support more objective judgment, and promote shared accountability. Pilot the chosen approach in select regions to refine processes before statewide rollout.

A transition toward a collaborative teaming model for Frequently Encountered Families is essential to flattening the local office hierarchy and improving decision quality. Under this model, Frequently Encountered Families case reviews would be expanded to include more than the standard worker-supervisor pair, ensuring that decisions involve multiple perspectives. A key component is the integration of "Outside Eyes," where experts or colleagues not directly connected to the family participate in reviews to identify blind spots that may be missed by those too close to the case.

Such models could include brief, structured team huddles for rapid information sharing or safety pauses to move from intuitive judgment to analytical deliberation. Furthermore, the hierarchy must be flattened so that caseworkers are empowered to share safety concerns without the fear of being overruled by supervisors. This broader review process is expected to reduce individual bias and lead to more robust, accurate safety decisions.

Optimize Workload for CP&P Staff

Why it Matters:
High workloads create decision fatigue, cause delays in service delivery, and increase the risk of errors.

Action:
Examine what supervisors and caseworkers are being asked to do and make sure they have the time and capacity to support staff managing the most complex cases. Conduct a time study to identify which activities are consuming the most of supervisors' and caseworkers' time. Use those findings to develop a strategy for redistributing or reducing lower-priority work. Build dashboards that give supervisors a real-time view of workload, so they can prioritize their attention where it matters most.

To ensure high-quality oversight, DCF must develop clear workload standards for supervisors and casework supervisors. The primary goal is to shift management capacity away from purely administrative monitoring toward active safety decision-support. Assignments could move toward a complexity-based model, which distinguishes between raw case volume and case intensity, such as sexual abuse or critical incidents, to balance workload pressure across management. By aligning workload with the intellectual demands of safety work, management will reclaim the bandwidth to provide experienced oversight and quality, case-specific guidance.

Strengthen Psychological Safety in CP&P Local Offices

Why it Matters:
Psychological safety -- the shared belief that a team is a safe place to raise concerns, ask questions, and admit mistakes -- supports a culture of learning and improvement that allows staff to safely challenge decisions without fear of retaliation.

Action:
Build a workplace culture where staff feel safe raising concerns, asking questions, and pushing back on a decision when a child's safety is at stake. Examine how psychological safety in local offices affects decision-making, teamwork, and case outcomes. Use those findings to identify and implement specific practices that strengthen psychological safety and encourage open communication at every level of CP&P.

The Department should implement strategies to ensure that all staff feel safe speaking up about child safety risks without fear of retaliation. This requires fostering a safety culture where challenging a decision in the interest of child safety is normalized as a professional duty. Leadership must be trained to treat safety-related feedback and the identification of errors as systemic learning opportunities rather than performance failures. This environment of psychological safety should surface critical concerns earlier, directly protecting children in the highest-risk situations.

Implement an Anonymous Internal Safety Reporting System

Why it Matters:
Frontline staff often notice systemic problems first, but without a safe channel, those warnings can stay buried until they lead to harm.

Action:
Provide staff a confidential way to flag safety concerns about how the system is working, so problems can be identified and fixed before they lead to harm. Build the technical and policy infrastructure for anonymous reporting, drawing on similar systems already used in healthcare and aviation. Review the aggregated data regularly to identify patterns and drive system-level improvements.

Modeled after successful systems in high-stakes industries like healthcare, DCF should establish a confidential pathway for staff to report systemic safety concerns. This internal reporting should center on identifying systemic patterns and flaws, such as unclear policies, faulty tools, or recurring practice drift, that compromise child safety. Importantly, this system should provide a hierarchy bypass, allowing concerns to reach higher-level review if they are not adequately addressed at the local office level. This provides a vital warning signal for identifying and fixing latent system flaws before they lead to an adverse outcome.

Supplemental Recommendation: Explore Peer Support Models for Earlier Engagement of Frequently Encountered Families

Why it Matters:
Increased family engagement can prevent case escalation.

Action:
Explore peer support models to improve family engagement and support.

To improve outcomes for Frequently Encountered Families, DCF should use seasoned peer workers, such as Parent Partners, to encourage Frequently Encountered Families to accept voluntary services and supports. Peers who have successfully navigated the child welfare process are uniquely positioned to encourage families to engage in voluntary services they might otherwise refuse. By leveraging lived experience to build trust and resolve concrete family needs, this model bridges the gap between the agency and the families it serves. The expected outcome is strengthened family engagement that resolves safety and risk issues earlier, ultimately reducing the cycle of repeated hotline referrals.

Next Steps

Planning and Piloting

To ensure that interventions are both effective and sustainable, the Task Force recommends a disciplined, phased approach to implementation. Initial efforts should focus on geographic piloting, where recommendations, particularly the new collaborative teaming strategies, are tested in specific local offices or regions before a statewide rollout. These actions must be sequenced to build upon one another, allowing DCF to measure specific outcomes at each stage of the rollout. Furthermore, the implementation must be treated as a process of continuous learning; data gathered during pilot phases will be vital for refining onboarding processes and addressing practical operational challenges, such as staff turnover and workload balance.

Strategic Communication and Engagement

The success of these recommendations depends heavily on the culture within which they are implemented. Consequently, internal communications must center on non-punitive messaging, making it clear that these changes are grounded in feedback from staff and are designed specifically to support them in their most difficult safety decisions. To maintain this alignment, DCF should establish workstreams that incorporate ongoing engagement from frontline staff and families. This inclusive approach ensures that systemic changes remain responsive and relevant to the needs of DCF staff and the families they serve.

Oversight and Accountability

This report represents the formal conclusion of the NJ Safety Task Force's work. Having established a shared understanding of system vulnerabilities and evidence-based solutions, the Task Force is releasing its findings and recommendations to the public and submitting them to the Staffing and Oversight Review Subcommittee (SORS) of the NJ Task Force on Child Abuse & Neglect for collaborative review, discussion, and operationalization. This transition will ensure the Task Force's strategic vision is integrated into DCF's long-term administrative and governing structures.

Resources

- **Child Maltreatment Reports (2023):** U.S. Department of Health & Human Services, Administration for Children and Families.
- **Child Welfare Outcomes Report (2023):** U.S. Department of Health & Human Services.
- **New Jersey Child Welfare Data Hub:** Rutgers University, School of Social Work.
- **New Jersey Child Fatality & Near Fatality Review Board Reports:** State of New Jersey.
- **Structured Decision Making (SDM) Policy:** New Jersey Department of Children & Families.
- **Safety Science Frameworks:** National Partnership for Child Safety (NPCS).
- **The Wisconsin Well for Safety Culture:** Safety culture and collaborative teamwork resources.
- **Crew Resource Management in Healthcare:** Umbrella review on its effectiveness in high-stakes decisions.
- **Awaken Curriculum (Oregon):** Addressing cognitive bias in professional practice.
- **Worker Safety Survey (Tennessee):** Assessing workplace safety and psychological factors.
- **Evident Change:** Research and assessment questions for Structured Decision Making.
- **NPCS / Center for the Helping Professions:** Analytical reports on New Jersey's system factors and critical incident reviews.
- **START (Sobriety Treatment and Recovery Teams):** Evidence-based peer mentoring models for high-risk families.

Appendix A: Safe Systems Improvement Tool (SSIT) Domains and Items

Child & Family Domain		
Family Conflict	Substance Use	Child Medical/Physical
Developmental	Economic Stability	Child Development/Intellectual
Mental Health	Parenting Behavior	Child Mental Health
Cultural Stress		Child Substance Use
Professional Domain	**Team Domain**	**Environment Domain**
Cognitive Bias	Teamwork/Coordination	Demand-Resource Mismatch
Stress	Supervisory Support	Equipment/Technology/Tools
Fatigue	Supervisory Knowledge Transfer	Practice Drift
Knowledge Base	Production Pressure	Policies/Rules/Statutes
Documentation		Training
Information Integration		Public Service Array
		Private Service Array