New Jersey Task Force on Child Abuse and Neglect
Staffing and Oversight Review Subcommittee (SORS)
Marygrace Billek= Chair
Mary Coogan = Vice-Chair
Tuesday September 12 , 2017: 10:00 A.M. – 12:00 P.M.
DCF Commissioners Conference Room 2nd Floor
50 East State St.
Trenton, NJ

In Attendance- In Person

Marygrace Billek	Mercer County DHS
Lori Morris	Lifeties
Linda Porcaro	Office of Youth Services, Somerset County
Aubrey Powers	DCF Assistant Commissioner, OPMA
Jeyanthi Rajaramam	Legal Services of NJ
Lisa vonPier	DCF Assistant Commissioner, CP&P

In Attendance- Conference Line

Amy Fischer	Administrative Office of the Courts

Staff

Dawn Marlow	DCF-NJTFCAN SORS

Guests

Allison Blake	DCF Commissioner
Joseph Ribsam	DCF Deputy Commissioner
Leida Arce	DCF Communications
Nancy Caruso	DCF Legislative Liaison

Review of Minutes:
Introductions were made to include the Open Public Meeting Announcement and the July 2017 minutes were reviewed by the members and approved.

New Business:

DCF Commissioner Allison Blake and DCF Deputy Commissioner Joseph Ribsam presented an overview of the DCF findings of a five year analysis of child fatalities as recommended by the National Commission to Eliminate Child Fatality. Commissioner Blake began with an overview of the process which included comprehensive review and crosswalk of the recommendations made by the National Commissioner with DCF policy and procedures. The five year analysis was completed using the child fatality

cases that were reviewed by NJ Child Fatality and Near Fatality Review Board (NJCFNFRB) and regional boards. Looked at them better handle on trends and opportunities for system change & develop recommendations. Feedback received from presentation with be given to the Prevention Committee of the NJ Task Force on Child Abuse and Neglect and if accepted will be part of the State Prevention Plan.

Joe Ribsam provided the preliminary results and recommendations from the five year analysis of 109 fatality cases. Joe discussed that child fatality investigations take a long time due to the dual nature between child welfare investigations and law enforcement who take the lead. Part of the process included a deeper case review to gather other data elements regarding social issues such as socio-economic status, substance use, medical and educational data on the family and specific child fatality incident.

Joe went over the 2015 statewide overview data published by ACF. National average of fatalities per 100,000 children was 2.25 and NJ was below the national average at 1.25. Joe also reviewed how NJ compares with the bordering states in this metric: NY was 2.56; CT was 1.44 and PA was 1.26 per 100,000 children. Joe emphasized that although NJ is doing better than the national average and the bordering states, NJ is not satisfied until that number is 0.

The next data metric was geography of child fatalities and Joe cautioned that although the data shows that majority occur in Essex County, this county also has the largest population of people. He emphasized that what the data tells us is that the geography of incidents follows the population size of the area.

Joe then discussed/clarified terminology of what constitutes a child fatality by statute which includes the child under the age of 18, that the fatality is the result of statutory definition of child abuse/neglect and the act had to have been done by the statutory defined caregiver was the perpetrator- this includes parents, guardians and other defined caregivers who assume legal responsibility over the child (this includes teachers). Joe gave an example that a child fatality that was the result of an act by a stranger would not fit into the review.

Joe continued with demographic data showing that there were 109 children, 107 incidents with 131 perpetrators. In terms of age, majority of children were under the age of 2 (81 of 109) with males being at higher risk than females. Race and ethnicity did not show much disparity. One interesting subcategory that was looked at was disability and 28 out of 109 children (about 20%) had a documented disability which is higher than the general population. These disabilities were categorized as individual or a combination of the following:

1. chronic medical
2. developmental
3. physical
4. sensory

The next area in the review looked at the child fatalities where there were prior allegations (not findings) of abuse and neglect. Out of the 109, 33 children had prior allegations where 76 did not have any prior allegations.

Family environment data revealed that the assumption that the majority of child fatalities occur in single parent household was not true through the case review: 58 out of 109 children were part of a two parent household and another 30 were found to be living with a single primary parent and a co-parenting adult household member (such as a relative or significant other); 17 were living in a single parent household and 4 were with another caregiver (such as foster care or private arrangement by family).

Health system interaction data revealed that 76 children had documented health records, 18 cases had missing records so there is no determination as to whether they had been seeing a pediatrician and 15 cases had a definitive no record. Question was raised as to what type of medical office was seen and it was revealed that it was either a family practitioner or pediatricians who are medically seeing these children- not urgent care or ER.

Perpetrator data was discussed. The assumption usually falls to the paramour of a mother however the data revealed that the majority of perpetrators were a biological parent, majority being the mother or female caregiver. Other categories of perpetrators included paramour, relative, foster parent, babysitter, etc… Question was raised whether there was a category for siblings. It was explained that under the statute definition of a perpetrator they would have had to be in a caregiver role so sibling was not in and of itself a category. Joe emphasized that there were no cases in the review where the identified perpetrator was a sibling. Surprising data regarding the mean age of the perpetrator revealed that the assumption that they are young were shown to be not true, biological mothers mean age was 28, biological fathers mean age was 30 and the mean age for the mother's paramour (3rd highest category of perpetrator) was 26. Race and ethnicity data of the perpetrator revealed that the majority of perpetrators were Caucasian. One interesting perpetrator data point was that 48 of 131 were identified as unemployed which is higher than the average unemployment rate.

Joe discussed that the education level of the perpetrator was difficult to ascertain as there was a lot of missing data- 75 of 131 were unknown. Joe discussed that this area is not something that CP&P investigators prioritize as part of their investigation and if there is no prior history and/or no further intervention educational level of the perpetrator usually will not get captured. Joe discussed that this is an area that will be looked at moving forward as they develop recommendations. Of the data that is known 29 finished HS, 16 dropped out of HS, 9 graduated college and 2 completed graduate school.

Another area that was missing a lot of data was what other social service supports were involved with the perpetrator at the time of the incident. 93 of 131 there was no documented data available again suggesting that investigators may not view this information relevant to the investigation. Of the ones where information was available,

majority were receiving multiple social supports such as Medicaid, TANF, food stamps and WIC suggesting that there is an important role for county Board of Social Services in partnering with recommendations.

Next reviewers looked at reported history of substance misuse and/or illegal substance use. 61 of the 131 had documented reported history of substance misuse and/or illegal substance use.

Another data point reviewed was perpetrator history of victim of abuse and/or neglect as a child revealed that majority of perpetrators did have a victim history showing that there are multi-generational victimization happening. Almost half of the perpetrators also had prior CPS referrals as perpetrators with 37 of them having more than one prior referral. In terms of Domestic Violence (DV) or criminal delinquent history, 60 had criminal history and 53 a history of DV (whether victim or perpetrator). Other risk factors were looked at a well and majority of perpetrators – 93 of 131had at least one or more risk factors (IE DV, criminal history, mental health, substance use/misuse). This suggests that majority of perpetrators should be intersecting with other social services.

Joe transitioned into the types of child fatality incidents- 107. Of the 107, 44 were abuse only, 43 were neglect only and 20 were for both. Joe gave an example that one incident could result in abuse by one perpetrator and neglect (lack of intervention such as seeking medical attention) by another perpetrator. Manner of death was also looked at which is defined by Medical Examiner- Joe cautioned that child welfare and medical examiner systems don't always align. Majority of the incidents were identified by ME were homicide= 64. Joe went into detail and broke down the manner of death data further to include looking into how impactful to the child fatality were situational factors such as active drug use or distracted parenting at the time of the incident revealed some data however he did caution that there was a lot of missing data and conclusions should not be drawn.

Lessons learned: Joe discussed that data collection is an area to focus on; majority of victims are very young children and majority of cases are not known to the child welfare system so we need to look at the broader system partners. These families also have a lot of stressors and risk factors. Reporting inconsistencies were also seen- for example law enforcement responding to DV with children present and do not make a report to child welfare.

Joe then transitioned into the recommendations from the review and opened up the discussion to the group for comments, suggestions and other recommendations. One recommendation from the review is looking at internal processes for better data collection- such as around educational data, health insurance data, social service data etc… Joe discussed modifying two Administrative Orders to help strengthen case review processes. Jey Rajaramam questioned if there were any LGBTQ issues relevant in the data for the older youth deaths. Joe reported that this was not an element that was looked at separately. Lori Morris discussed delving deeper into whether the children were seeing a pediatrician routinely and timely and not just for sick

visits. Rich discussion ensued about partnering with the medical professionals such as AAP regarding impactful ongoing education for parents of very young children regarding risk factors. Housing issues was also discussed regarding transient families and how that is a risk factor. Joe discussed having the broader system partners understand the Strengthening Families Protective Factors Framework to give them a basic framework of what a strong family is, how to identify those that are lacking protective factors and where to refer them so they can receive benefits. Commissioner Blake asked Marygrace Billek what she thought about making training available to BOSS staff on the Protective Factors. Marygrace suggested making the training available to receive licensing credits would be beneficial. Marygrace also suggested pulling in the staff at Onestop. Discussion was held around the other system partners such as law enforcement, education and other medical professionals like family practices besides AAP to have knowledge on how to assist families. It was suggested targeting home visiting and WIC staff for training as well.

Joe gave an overview on the campaigns and messaging the DCF does to include safe sleep, safe haven, water safety which needs to be expanded to bathtubs, summer safety issues such as not leaving children in cars. Joe opened it up to the group to discuss other campaigns or messaging for DCF and other system partners to employ.

Discussion followed around findings of lack of reporting to child welfare by law enforcement when children are present during DV calls. Marygrace suggested researching the reasons why calls were not made to determine causation such as lack of knowledge, bias, etc… before attempting to train AOC and law enforcement. Amy Fischer discussed the training that is available to AOC staff in how to handle and refer.

In terms of substance use, Joe reported that DCF in partnership with DOH is in the process of completing regulations around reporting to child welfare when newborns are substance exposed as well as safe care. There was also discussion about having an identified designated caregiver campaign similar to designated driver.

Recommendation around to be an effective caregiver you have to have a measure of self-care was discussed.

Joe also discussed some literature review recommendations on fatalities such as expanding the age of Safe Haven- NJ's age is 30 day. One service discussed was safe emergency respite for stressful parents. Another national literature recommendation which is noted as controversial is pairing birth data with CPS data to generate a referral was also discussed. Marygrace asked if this is done when there are active children in care and the parent gives birth. This was discussed as it is a case by case basis depending on the situation at the time of the birth. Commissioner Blake discussed referrals not necessarily being made to CP&P but for Central Intake. Joe discussed using birth data to target home visiting services such as those records that may have variables that would increase risk such as families receiving Medicaid and other targeted variables. Joe emphasized that these were literature recommendations and were not necessarily meant to be enacted by DCF but just brought up to discuss.

Joe ended by thanking the group and giving his contact information should they have any further questions/comments/ or ideas.

Other Business:

Membership was discussed. Three potential members were suggested. Dawn will submit their names to the task force for applications and invite. Dawn reminded members that the next meeting is scheduled for November 21, 2017 and Jey had offered to utilize her location in Edison. Jey confirmed that her location is not available as she and her staff will be at a conference that day. Dawn reminded the group that the DCF Professional Center is already reserved and will plan on that location unless another one is located. Dawn also announced that the SORS Annual Report has been submitted for final approval but that as of this date no word had been received on the progress.

Next Meeting:

Tuesday November 21, 2017
10am-12pm
Location: DCF Professional Center conference room 104
30 Van Dyke Ave.
New Brunswick, NJ

Announcements & Closure

None