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

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Dear Colleagues:

I am writing to update you regarding the Department of Children and Families (DCF) work on reviewing the Ovilde matter. As you may recall, following my appointment and with Governor Chris Christie's support, I established the Executive Level Office of Continuous Quality Improvement (OCQI). In part, this office is responsible for internal case record reviews. As such, my intention is to provide you with as much information as I can about this ongoing review within the confines of the law.

We have completed our initial review of the Department's involvement with the Ovilde family from 2006 through 2008. It is important to note that numerous changes have been implemented to the child welfare system since this matter first arose and as such, many of the system's current policies, protocols, and training were not in place during the time period reviewed.

The Ovilde family originally became known to DYFS in March 2006, three months prior to the inception of the Modified Settlement Agreement, and nine months prior to the introduction of the DCF Case Practice Model, documents that laid the ground work for significant overhauls to DCF/ DYFS. OCQI found that the investigations conducted by and conclusions reached by DYFS were appropriate in all four referrals received. The review indicates that DYFS was responsive and supportive to the needs of this family, and did not detect any concerns related to recent reports. It appears that there was a seismic shift in this family sometime after DYFS closed its case in 2008. However, during the time of DYFS's involvement, the children were receiving positive reports from doctors, the children were in school, and the home was neat with plenty of appropriate food.

DYFS first learned of concerns regarding Ms. Ovilde's children on March 23, 2006, when we received a call at our hotline. The Essex County Special Response Unit (SPRU), the mechanism DYFS uses to respond to allegations of child abuse when its offices are closed, was assigned to respond to the matter immediately. SPRU was able to determine that the children were safe that evening, and recommended that the local DYFS office follow up with appropriate services. The local office in this case was the Essex South Local Office, which represents one of 47 local offices in the state where DYFS direct services are provided.

Following a visit to the home on April 5, 2006, the caseworker from the Essex South Local Office initiated a referral for parenting aide service. In addition, the caseworker reviewed medical records from the children's physician, which indicated that all were receiving routine required medical care, and made a referral for a psychological evaluation. Several phone contacts were made to various service providers to secure or confirm services through welfare between March 31, 2006 and April 6, 2006.

While the case was still open, DYFS received another call to our hotline from an anonymous reporter, who stated that the mother had been heard constantly yelling and cursing at the children, fighting, and screaming. Again, we assigned the investigation to the Essex South Local Office. A caseworker made contact with the mother at her home and also saw the children on this same date at their daycare. The children were observed to be clean, in good health, and with no observable marks or bruises. Because of their ages, the children were not interviewed.

The review notes that DYFS made several attempts to set up services for the family during this time. In addition, DYFS purchased beds for the children. Before closing the case, DYFS made an additional request for information from the pediatrician regarding the status of the children's medical treatment. The pediatrician's office indicated that all the children were receiving routine required medical care and that the parent was providing adequate and appropriate care. On March 7, 2007, our contact with the daycare indicated that the children were performing at grade level, their attendance was satisfactory, and there were no concerns. At that time, DYFS closed the case.

On January 20, 2008, just under a year after closing the case, the DYFS hotline received another allegation of child abuse at regarding the Ovilde children. An anonymous reporter called stating that the mother was physically disciplining one of her children with a belt. The reporter, however, could not recall seeing any marks or bruises on the child.

The Essex South Local Office was again assigned to respond to the allegations. The child was interviewed alone and denied being physically disciplined or abused. All three children and the residence were clean and neat, and the children all interacted positively with their mother. No observable marks or bruises were observed. The record indicates that DYFS again reached out to the daycare provider and pediatrician as collateral checks on the status of the family. On February 1, 2008 and February 28, 2008, the daycare and school both indicated that the children were performing at grade level with satisfactory attendance. These reports described the children as cooperative and loving. Additionally, medical reports received on February 25, 2008 indicated that all the children were receiving routine required medical care. Finally, two in-person contacts were made with the mother and her children in her home on February 20, 2008, and March 25, 2008.

However, on April 4, 2008, DYFS received yet another anonymous referral indicating that the mother beat her three children and left them unsupervised.

Again, Essex South Local Office was assigned to investigate. Contact was made with Ms. Ovilde and her children on the same date as the referral. During the interview, the child denied that she or her siblings were ever hit or left home alone. Because of the ages of the younger children, they were not interviewed, but were observed to be clean, neat, and healthy, with no visible marks or bruises. The caseworker then interviewed a neighbor, who denied ever hearing the children being beaten or screaming and who also denied ever seeing the mother hit her children or leaving her children unsupervised. At this time, Ms. Ovilde's three bedroom home was observed to be clean, with all utilities working and ample food. The beds previously purchased for Ms. Ovilde by DYFS were observed to be present in the home. As such, the Division closed its case on May 5, 2008.

It has since come to my attention that the ongoing investigation into this child fatality revealed an additional anonymous call to the Division of Youth and Family Services (DYFS) on May 13, 2011 related to this matter. The anonymous referent provided no names, and scant identifying information, and the State Central Registry (SCR) – our child abuse call center - subsequently determined that a field referral was not warranted. Although our inquiry is incomplete, the possibility that this call was not linked to the prior case, or coded for investigation by the field, raises concerns that will be at the center of our continuing analysis of this matter. In the meantime, however, I have requested that the OCQI conduct an additional, post-2008 review of the Ovilde matter. DYFS has already taken immediate steps to increase supervisory presence and oversight on all shifts.

Under this Administration, New Jersey has continued to make sustained progress in reforming our child welfare system, improving performance and enhancing our capacity toward long-term stability. As mentioned earlier, we established the internal capacity through our OCQI to review and monitor our own work, identify issues and areas for improvement, and integrate real practice changes accordingly in real time.

Further, engaging stakeholders continues to be an integral part of the work that we do to help ensure that we remain on the right path. We launched a Department-level Office of Advocacy to better address constituent concerns and gain additional stakeholder feedback. The Office of Advocacy provides information, referral, and advocacy services. To further engage stakeholders, we have been holding Parent Focus Groups with parents around the State to receive feedback on their interactions with New Jersey's child welfare system. We plan to use this feedback as part of our Continuous Quality Improvement and strategic planning work.

This case provides yet another opportunity to critically examine our system and make strategic and meaningful adjustments in the way we interact with the families we serve. While this review supported decisions of unfounded allegations with regard to the four Child Protective Services (CPS) intake reports in 2006 and 2008, as well as DYFS' decision to close the case in May 2008, given our case practice expectations today, we have identified opportunities for additional improvement. It is my expectation that all OCQI reviews will include recommendations for improved practice. Ultimately, the record confirms that the basic necessary and required steps were performed by DYFS field staff in accordance with the DYFS policy manual in 2008.

These steps include, but are not limited to:

- Interviews, observations, and face to face contacts with the family and children in the home and at the children's child care center, for several months exceeding the minimum visitation requirement;
- Community collateral contacts, including interviews with persons of interest to the investigation, medical, and child care providers; and
- Keeping the case open for supervision during the first year of contact with the family despite the investigation finding allegations were unfounded.

Additionally, it is important to note that, unless allegations are found to be "substantiated," a parent is not obligated to accept our services or intervention. However, we are often able to work with families voluntarily, as we did here, to provide services. It is clear from my above description that partnering with families and engaging with them in a strength-based way is a critical, cultural shift in our agency. My staff and I are committed to this process.

The review did, however, identify areas, in addition to the reforms already underway, which warrant further improvement. Specifically, the reviewers noted that there are opportunities for better family engagement, more thorough information gathering, and appropriate supervisory conferences. These recommendations are summarized as follows:

Training:
A review and revision of the current training for investigators with emphasis on interviewing skills is necessary, along with the engagement of family and community providers. This will help staff to gain an understanding of the family's dynamics, as well as have the ability to verify information provided by the family and service providers. This will assist investigators in making informed decisions regarding case outcomes. The Chief of Staff will work with the Director of Training and all training outlets to review relevant training, including training for investigators, to meaningfully incorporate this

recommendation and to provide recommendations for areas requiring practice enhancements and updates to curriculum and retraining.

Supervision:
Supervisor training and engagement of staff during case conferences is necessary to ensure best case practices are being exercised. Documentation of supervisory conferences in New Jersey Spirit by supervisors must be reinforced as well. With assistance and support from community providers and advocates, I have established an executive level workgroup to develop additional clinical supports and a mentoring program for front line supervisors. This workgroup will also explore the importance of case conferencing and how best to engage staff in the case conferencing process. This will help to ensure thorough and timely reviews of all cases open with DYFS, and will assist workers in decision-making and case handling.

Risk Assessments:
The review identified concerns regarding how workers assess risk to children and the extent to which family history is incorporated in that assessment. Therefore, a clarification to field staff on risk assessment will be forthcoming.

Family Engagement:
We will reinforce with field staff the importance of searching and identifying fathers, regardless of their current role in the family or their previous history. In addition, specific guidance will be provided on how to search and locate fathers and identify other system partners that can assist DYFS in these searches.

Screening:
We look forward to additional recommendations regarding screening in the next review by OCQI, and will address those recommendations in their totality at that time.

This letter underscores the Administration's support for New Jersey's ongoing child welfare reform and DCF's continued effort to become a transparent learning organization. Thank you for your continued partnership in our service to children and families.

Sincerely,

Allison Blake

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