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Dear Colleagues:

I am writing today to provide an update regarding the Department of Children and Families' (DCF's) review of our involvement with the Benton family prior to the tragic death of Tierra Morgan in November. This review was conducted in accordance with DCF policy by the Department's Office of Performance Management and Accountability (PMA). As such, my intention is to provide you with as much information as I can about this review within the confines of the law.

This report and our work with the Benton family must be reviewed within the context of both child abuse and domestic violence. When the issues of child abuse and domestic violence co-exist in the same family, they present additional challenges for child protective services, domestic violence service providers, and law enforcement.

Over the past several years, DCF has taken significant steps to address these challenges:

- In collaboration with the New Jersey Coalition for Battered Women, we developed and implemented a Domestic Violence Protocol in 2009, which specifies appropriate and timely identification, assessment and intervention to promote successful outcomes regarding child safety, stability, and permanency. Overall this protocol has yielded positive outcomes for the children and families served by DCF and its system partners.
- Changed our practice so that we work in partnership with families experiencing domestic violence, understanding the complexities of these matters, and the expertise of the community agencies that provide shelter and services.
- In cooperation with the Domestic Violence Lead Agencies in each county, funded Domestic Violence (DV) Liaisons for each Area Office to work with the Division of Youth and Family Services (DYFS) staff in conducting assessments on cases where domestic violence is believed to be a factor, and to help identify safety and risk issues as well as service needs.
- Provided training on the protocol and other special topics related to domestic violence. These training programs have been offered continuously through the Division of Prevention and Community Partnerships and the DV Liaisons to DYFS staff.

Our review indicates that DCF's commitment to the guiding principles established through the protocol and the other actions identified above has resulted in a changing culture at the

Department and an improved skill set. However, it has also revealed that our work in this area is still developing, and further attention will be given in order to increase the safety of the children we are responsible to protect.

Background Information:

As I previously reported, the Benton family first became known to DYFS on October 29, 2010, when a call was received at the State Central Registry (SCR) hotline from Ms. Benton regarding an incident of violence between her and Arthur Morgan. After investigation, the allegations were determined to be unfounded and the case was closed on February 25, 2011. Since this referral, there were three more referrals made to SCR. On July 1, 2011, Mr. Morgan called to report concerns regarding his and Ms. Benton's daughter, Tierra's, safety and supervision in the environment in Ms. Benton's mother's home, where Tierra was staying. The allegations were determined to be unfounded and the case was closed on August 2, 2011. The next referral to SCR took place on September 23, 2011. Ms. Benton contacted SCR from a domestic violence shelter she went to following an altercation with a family member. This case was closed on October 17, 2011. The final referral on this family was received on November 9, 2011, when Mr. Morgan contacted SCR to report that Tierra was at a safe house with Ms. Benton. The case was still open when we received the last contact from Ms. Benton, which was a call on November 22, 2011, regarding her concerns about Mr. Morgan's visit with Tierra.

Conclusions:

The review of DYFS' handling of this case identified areas of strength that bear noting. Our child abuse hotline/SCR staff was thorough in their handling of these calls, and our Special Response Unit (SPRU) staff was thorough in their investigations as well. All demonstrated an understanding of the domestic violence protocol. It is also important to note that the law enforcement agencies worked with our staff cooperatively and provided necessary and timely assistance in each case.

As an organization dedicated to continuous improvement, we are always evaluating our practice and seeking ways to improve. One way we do this is by taking the opportunity to look systemically at our policies and procedures in situations where outcomes are not ideal. Our review has identified a number of opportunities to not only strengthen our practice, but to take DCF toward a position of leadership in the complex practice area of co-existing child abuse and domestic violence. In this case, our review revealed:

1. Relationship between SPRU investigation and "on-going" casework: The provision of services to this family could have been improved if there had been better coordination between them, and a greater effort to understand the issues and recommendations identified by the SPRU workers.

2. Relationship between DYFS and Domestic Violence Lead Agencies: The DV Liaison was not consulted to discuss the allegations of domestic violence. As a result, the caseworker(s) were unable to use this resource to evaluate the underlying needs impacting this family.

3. Assessment: Casework staff was unable to fully understand and assess the child/family's needs, as important collateral information was not gathered. DYFS risk assessment tools were not accurately completed, and the combination of "red flag" concerns of child abuse, substance abuse, and violence in the home were not considered as a whole when assessing safety for this child.

4. Supervision: Supervisors should have ensured that there was follow-up to recommendations made by SPRU or previous workers, which would have ensured a connection with resources such as DV and substance abuse services, as well as the completion of DYFS specific risk assessment tools. In addition, supervisors needed to hold case conferences to review and assess the status of the case, and ensure the development and implementation of a comprehensive case plan.

Following the completion of the review by the PMA, the matter was also referred to the New Jersey Child Fatality and Near Fatality Review Board, and to the Department's Office of Employee Relations with regard to the actions of individual staff.

The analysis also identified additional issues we are evaluating, including the need for supplemental training and policy clarification, specifically for cases involving domestic violence. DYFS leadership will be implementing steps to address these issues as we continue the improvement of overall case practice. These steps will include but are not limited to reviewing when workers should be required to consult with domestic violence liaisons, further training on integrating information gathered in all phases of an investigation to inform findings and outcomes, and a reemphasis of the importance of obtaining and analyzing collateral information as well as the appropriate use of Safety and Risk Assessments to make comprehensive assessments.

Additionally, we will be consulting with the Administrative Office of the Courts regarding the need to reconvene the Joint Task Force on the Co-occurrence of Domestic Violence and Child Abuse to review implementation of the Domestic Violence Protocol to date, and give consideration to additional areas for systems improvement. Similarly, the Division of Prevention and Community Partnerships, in conjunction with DYFS, will review for clarification the protocols, policies, and procedures for working with DV Liaisons in the local offices. Changes will be made as necessary to ensure proper utilization.

We are deeply saddened by the circumstances of this case and remain committed to working collaboratively with our system partners to improve our practice on cases where domestic violence and child abuse co-exist.

Sincerely,

Allison Blake

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