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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

CHARLIE AND NADINE H., by and
through their next friend, Ellen
Kochler; JASON, JENNIFER and PATTI
W., by and through their next friend,
Yvonne Mitchell; DENNIS M. and
DENISE R., by and through their next
friend, Karol Corbin Walker, Esq.;
MARCO and JUAN C., by and through
their next friend, Dr. George Bigge;
RICARDO O., by and through his next
friend, Rosanne Maraziti, Esq.;
DOLORES and ANNA G., by and through
their next friend, Susan Dargay, Esq.;
KYLE J., by and through his next
friend, the Reverend Doctor Warren
Bouton; BARRY M., by and through his
next friend, Constance McManus, Esq.;
SHARON K., by and through her next
friend, Dr. Barbara Fleischer; on their own
behalf and on behalf of all others similarly situated;

Plaintiffs,

CHRISTINE TODD WHITMAN, as Governor of the
State of New Jersey; MICHELE K. GUHL, as
Commissioner of the Department of Human Services; and
CHARLES VENTI, as Director of the Division of Youth
and Family Services of the State of New Jersey,

Defendants.

Civil Action No. 99-3678 (GEB)
Hon. Garrett E. Brown, Jr., U.S.D.J.

Civil Action

AMENDED COMPLAINT FOR
DECLARATORY AND
INJUNCTIVE RELIEF

CLASS ACTION

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DISTRICT COURT

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PARTIES

Named Plaintiffs

1. Plaintiffs CHARLIE AND NADINE H.¹ are a brother and sister aged eleven and nine, respectively, who have been in DYFS custody for over five years.
2. Charlie and Nadine H. appear in this action through their next friend, Ellen Koehler, 702 Twin Rivers Drive North, East Windsor, New Jersey 08520.
3. Plaintiffs JASON, JENNIFER and PATTI W. are siblings aged ten, eight and six, respectively, who were removed from their mother's custody three years ago.
4. Jason, Jennifer and Patti W. appear in this action through their next friend, Yvonne Mitchell, 65 Edgerton Terrace, East Orange, New Jersey 07017.
5. Plaintiffs DENNIS M. and DENISE R. are a brother and a sister aged eight and seven, respectively, who were removed from their mother's custody in 1995.
6. Dennis M. and Denise R. appear in this action through their next friend, Karol Corbin Walker, Esquire, 2 Penn Plaza East, Newark, New Jersey 07105.
7. Plaintiffs MARCO and his brother JUAN C. are eight and ten-year-old boys, respectively, with special needs who were removed from their mother's care for a second time in 1995.
8. Marco and Juan C. appear in this action by their next friend, Dr. George Biggc, 90 Rainbow Trail, Pittsgrove, New Jersey 08318.
9. Plaintiff RICARDO O. is a 13 1/2-year-old youth who has been in DYFS custody since June 1997.
10. Ricardo O. appears in this action by his next friend, Rosanne Maraziti, Esquire, 50 Inwood Road, Chatham, New Jersey 07928.

¹ To protect their confidentiality, all named plaintiffs appear in this action by pseudonym and their addresses are not being disclosed herein.

11. Plaintiffs DOLORES and ANNA G. are two sisters who are four-years-old and seventeen-months-old, respectively, and have been in DYFS custody since August 1998.

12. Dolores and Anna G. appear in this action by their next friend, Susan Dargay, Esquire, 114 High Street, Mount Holly, New Jersey 08060.

13. Plaintiff KYLE J. is a one-and-a-half-year-old infant who has been in foster care since birth.

14. Kyle J. appears in this action through his next friend, the Reverend Doctor Warren Bouton, 79 Addison Drive, Short Hills, New Jersey 07078.

15. Plaintiff BARRY M. is a 17-year-old youth who has been in and out of DYFS custody since the age of four.

16. Barry M. appears in this action through his next friend, Constance McManus, Esquire, 50 Powder Springs Street, Suite 32E, Marietta, Georgia 30064

17. Plaintiff SHARON K., age four, has been in DYFS custody since birth.

18. Sharon K. appears in this action by her next friend Dr. Barbara Fleischer, 271A Route 516, Matawan, New Jersey 07747.

Defendants

19. Defendant CHRISTINE TODD WHITMAN is the Governor of New Jersey, and is sued in her official capacity. Her offices are located at P.O. Box 001, Trenton, New Jersey 08625-0001. Governor Whitman is responsible for ensuring that all New Jersey agencies comply with all applicable federal and state law, pursuant to Article V, § 1, cl. 11 of the New Jersey State Constitution.

20. Defendant MICHELLE GUHL is the Commissioner of the Department of Human Services ("DHS"), of the State of New Jersey, and is sued in her official capacity. Her offices are located at 222 South Warren Street, Trenton, New Jersey, 08625-0700. Commissioner Guhl is responsible for the welfare of all children in need of public assistance, care, support or protection who reside in New Jersey; for overseeing the administration of DHS; and for ensuring that DYFS,

and the private agencies with which DYFS contracts, comply with all applicable federal and state laws, pursuant to §§ 30:1-2 and 30:1-12 of New Jersey State Institutions and Agencies Law.

21. Defendant CHARLES VENTI is the Director of the Division of Youth and Family Services, and is sued in his official capacity. His offices are located at 50 E. State Street, P.O. Box 717, Trenton, New Jersey 08625-0717. Director Venti is responsible for the Division's policies, practices and operation, and for ensuring that DYFS and the private agencies with which it contracts comply with all applicable federal and state law pursuant to §§ 30:1-9 and 30:4C-4 of New Jersey State Institutions and Agencies Law.

JURISDICTION AND VENUE

22. This is an action pursuant to 42 United States Code § 1983, alleging violations of the United States Constitution and federal statutes. This court has jurisdiction over the federal claims pursuant to 28 United States Code §§ 1331 and 1343(a)(3).

23. Venue in this district is proper pursuant to 28 United States Code § 1391 (b) because the claims arise in the district.

INTRODUCTION

24. This is a civil rights action against officials of the New Jersey Division of Youth and Family Services (the "Division" or "DYFS"), the Department of Human Services ("DHS"), and the State of New Jersey (collectively, the "defendants"), on behalf of all children who are or will be in the custody of the Division (the "plaintiffs").

25. The defendants' systemic failure to protect these children and provide them and their families with legally required services has jeopardized their health and safety, and subjected them to significant harm, in violation of their rights under the United States Constitution and federal statutes.

26. Many children are being left by DYFS in homes where they are abused and neglected, and even killed, while those children who are removed from dangerous situations and placed in foster care spend a substantial part of their childhood growing up in government

custody subject to additional deprivations in a poorly managed and grossly overburdened child welfare system.

27. As a direct result of defendants' pattern of actions and inactions, New Jersey's child welfare system is rife with systemic deficiencies that prevent it from meeting constitutional and statutory requirements.

28. Defendants have not provided the leadership, resources and support necessary to ensure that the child welfare system complies with the law and provides adequate protection and services to New Jersey's most vulnerable children. Many DYFS administrators lack the ability, support and resources necessary to engage in appropriate problem-solving or long-term, strategic planning on the Division's behalf. They cannot and do not provide necessary, professional guidance and support to their subordinates. There has been turnover in both the leadership of the agency and the corps of front-line caseworkers, jeopardizing even the Division's most basic functions.

29. The plight of children served by DYFS and the Division's systemic deficiencies have been extensively documented. In response to mounting concerns that children were being victimized in a system required to protect them, defendant Governor Christine Todd Whitman appointed a Blue Ribbon Panel of professionals involved with the child welfare system, including social services administrators and service providers, lawyers and court personnel, children's advocates, and medical experts, to take public testimony around the state and to analyze documentary evidence concerning the New Jersey child welfare system. The Blue Ribbon Panel's Final Report (the "Blue Ribbon Panel Report") was issued on February 20, 1998, and concluded that New Jersey's child welfare system had been seriously damaged by years of cut-backs and neglect. The Report identified vast problems at every point in the child welfare process and concluded that the overall capacity of DYFS has been reduced to a crisis mode of intervention. The Report confirmed a decade of reports and child welfare data issued by such organizations as the Association for Children of New Jersey ("ACNJ") and the Child Welfare League of America ("CWLA"). DYFS failures have also been widely reported in the New Jersey press.

30. Defendants have thus been well aware of their systemic, ongoing failure to adequately serve the children who depend on them for their health, their safety, and their lives. Although defendants have engaged in superficial reform efforts, many areas for which aggressive reform is needed have not been addressed by management, and few meaningful changes have resulted. The deprivations experienced by New Jersey's most vulnerable children have only worsened significantly over time, leading to the unlawful and sometimes desperate conditions prevailing today.

CLASS ACTION ALLEGATIONS

31. This action is properly maintained as a class action pursuant to Rule 23 (a) & (b)(2) of the Federal Rules of Civil Procedure.

32. The plaintiff class includes the approximately 9,250 children who are in the legal and/or physical custody of the Division and children who will be in its custody.

33. The plaintiff class is sufficiently numerous. There are approximately 9,250 children in the custody of DYFS. Joinder of all class members is impracticable.

34. The questions of law and fact raised by the named plaintiffs' claims are common to and typical of those raised by the claims of the putative class members. Each named plaintiff and each putative class member is in need of child welfare services, must rely on defendants for the provision of those services, and is harmed by the Division's systemic failures to adequately provide such services.

35. Common questions of fact include:

- a. whether defendants fail to provide children in their custody with safe, secure foster care placements, as required by law and reasonable professional standards;
- b. whether defendants fail to provide foster children with legally required services, consistent with reasonable professional standards, necessary to prevent them from deteriorating physically and psychologically while in state custody, including but not limited to appropriate medical and educational services;

36. Common questions of law include:

a. whether defendants' actions and inactions violate plaintiffs' rights under the Fourteenth Amendment to the United States Constitution;

b. whether defendants' actions and inactions violate plaintiffs' rights under the Multiethnic Placement Act of 1994, as Amended by the Interethnic Adoption Provisions of 1996, 42 United States Code §§ 622(b)(9), 671(a)(18), 674(d).

37. The legal claims alleged by the named plaintiff children are typical and representative of those of the putative class. In addition, the harms suffered by the named plaintiffs are typical of the harms suffered by all class members.

38. The named plaintiffs will fairly and adequately protect the interests of the class. They are represented by attorneys employed by Children's Rights, Inc., a privately funded, non-profit organization with extensive experience in complex class action litigation involving child welfare systems, and by attorneys associated with the law firm of Lowenstein Sandler P.C. who have extensive experience in child welfare and civil rights litigation. Plaintiffs' counsel have the resources, expertise and experience to prosecute this action.

39. Each named plaintiff child appears by a next friend, and each next friend is sufficiently familiar with the facts and circumstances of the child's situation to fairly and adequately represent the child's interests in this litigation.

40. Defendants have acted or failed to act on grounds generally applicable to the class, making declaratory and injunctive relief with respect to the class as a whole appropriate and necessary. Counsel for the plaintiffs know of no conflicts among members of the class.

STRUCTURE OF THE NEW JERSEY CHILD WELFARE SYSTEM

41. The Division of Youth and Family Services ("DYFS") of the Department of Human Services ("DHS") is the agency established by the State of New Jersey to investigate reports of suspected child abuse and neglect; provide necessary services to children and families and protect children who are the subject of such reports; investigate and assess requests for child welfare services and, where appropriate, provide such services; manage cases accepted for service by developing, reviewing, revising, and implementing case plans, and provide services to children

and families in accordance with their case plan; provide proper care to children in state custody; and secure permanent placements for children in custody. Defendants Governor Christine Todd Whitman, DHS Commissioner Michele K. Guhl and DYFS Director Charles Venti are responsible for ensuring that DYFS carries out its mandates.

42. DYFS is legally required to maintain, on a 24-hour daily basis, an emergency telephone service for receiving allegations of abuse and neglect. These calls are answered by Child Protective Services "screeners" who are responsible to elicit relevant information from the caller, document it, and assess the response necessary. After hours, calls are screened by the office of Child Abuse Control.

43. When a screener determines that a report of abuse or neglect warrants a child protective service investigation, or a request for services warrants a visit by DYFS, the referral is forwarded to an Intake Unit, or, after hours, the Office of Child Abuse Control or a Special Response Unit ("SPRU"), located in DYFS district offices. DYFS has at least one district office in every county of the State. Intake workers are required to respond to reports referred to them by conducting an investigation within the time frame mandated by statute, and conducting a child welfare service assessment.

44. If a DYFS worker determines that a child's health and safety is in imminent danger, the worker may remove the child from his home with or without the consent of the parent. If the child is removed without consent, DYFS is required to immediately file an abuse or neglect complaint with the Family Part of the Chancery Division of the Superior Court ("Family Court"). A child may also be removed from the home, by order of the Family Court, or a parent may voluntarily place a child with DYFS under a voluntary placement agreement, which is required to be approved by the Family Court. Pursuant to such a voluntary agreement, DYFS is obligated to return the child at the parents' request or seek a Family Court order to continue the out-of-home placement.

45. If, following an investigation, an intake worker determines that a child is not in imminent risk of harm, but that the family is in need of child welfare services, the family's case is

"opened" and becomes a part of the "generic" case load of a district office caseworker. That caseworker is obligated to develop a case plan for the family, to ensure that the family receives the services identified in the case plan, to modify the case plan when appropriate, and to monitor the family.

46. If a child is removed from her home and placed in DYFS custody, her case is assigned to a district office case worker. A child may be placed in either a relative's home, a foster home, a shelter, a group home, or a residential treatment facility ("RTF"). In the event that an appropriate placement cannot be immediately located for a child because the child was removed after hours, he or she is placed in a temporary emergency placement on a nightly basis.

47. For a child placed outside her home, the district office in the county where the child is placed assumes case planning and case management responsibilities over the child and the placement. These responsibilities include developing and updating as necessary the child's case plan with the required elements; ensuring that the child and foster family are receiving services set out in the case plan within the time frames established by the plan; and, making face-to-face and other regular contacts with the foster child.

48. If a child is placed in a district different from where the child was removed, the case is then dually managed. The district where the child is placed assumes the duties described above, while the district where the child was removed has responsibility over providing services and supervision to the birth parent and in ensuring visitation between the child and the birth parent.

49. All children placed out of their homes under DYFS are monitored by citizen review boards called Child Placement Review Boards ("CPRBs"), overseen by the Family Courts and located in each county.

50. Once adoption is identified as a child's case goal, his case is forwarded from the district office to one of five regional Adoption Resource Centers ("ARCs"). An adoption caseworker then takes over the case management responsibilities. Regional ARCS are responsible for finalizing adoptions by pursuing termination of parental rights or voluntary surrenders of custody

and consents for adoption, and placing the child in an appropriate adoptive home. Complaints to terminate parental rights are filed with the court by Deputy Attorneys General.

51. The Division also has a Central office which includes a training and staff development unit, a quality assurance unit, a Bureau of Licensing newly responsible for certifying foster homes, and four Regional offices which include regional foster care units, and regional Institutional Abuse Investigation Units ("IAIUs") which investigate reports of abuse and neglect in DYFS placements.

LEGAL FRAMEWORK

52. Defendants are violating statutes and legal obligations that create an overall scheme to regulate the provision of child welfare services to children entitled to them.

53. The applicable constitutional standards and federal statutes establish a broad range of general and specific duties that defendants are failing to meet in administering the state's child welfare system.

The United States Constitution

54. The Fourteenth Amendment of the United States Constitution guarantees to each child in state custody the substantive due process right to be free from harm and the right to conditions of custody reasonably related to the purpose of custody. The right to be free from harm encompasses the right to treatment in accordance with reasonable professional standards, and the right to the services necessary to prevent children from deteriorating physically, psychologically or otherwise while in state care, including but not limited to safe, secure foster care placements, appropriate monitoring and supervision, case planning and management, permanency planning and medical, psychiatric, psychological and educational services.

The Multiethnic Placement Act of 1994, as Amended by the Interethnic Adoption Provisions of 1996

55. The Multiethnic Placement Act of 1994, as Amended by the Interethnic Adoption Provisions of 1996, requires that public agencies engage in aggressive efforts to recruit

potential foster and adoptive parents who reflect the racial and ethnic diversity of the children for whom such foster and adoptive placements are needed. The Act prohibits defendants from denying any person the opportunity to become an adoptive or a foster parent on the basis of the race, color or national origin of the child or adoptive or foster parent and prohibits the delay or denial of the placement of a child for adoption or into foster care on that same basis.

FACTUAL ALLEGATIONS REGARDING NAMED PLAINTIFFS

A. CHARLIE AND NADINE H.

56. Plaintiffs Charlie and Nadine H. are siblings from Mercer County, who will soon be eleven and nine years old, respectively, and who desperately want to be adopted. When they were removed by DYFS from their mother's custody because of abuse and neglect, they were placed by DYFS in a foster home where they were again neglected and abused, including being beaten with broomsticks and curtain rods. They remained in that home, under DYFS supervision, for close to five years. Although Charlie and Nadine's plan has been adoption for at least the last four years, DYFS has yet to seek or secure an appropriate permanent home and has currently suspended its adoption placement efforts. While Charlie and Nadine wait to be adopted, they have been placed in a "temporary" foster home, and are suffering continued emotional harm.

57. Charlie and Nadine's father is deceased. Charlie, Nadine and their older half-sister were removed by DYFS from their mother in 1994 after she attempted to drown three-year-old Nadine in the bathtub. Charlie and his half-sister were able to pull Nadine out from their mother's grasp.

58. DYFS placed Charlie and Nadine in foster care with their father's estranged wife, Mrs. H., in Trenton. DYFS planned to have Charlie and Nadine adopted by Mrs. H., even though Mrs. H. was ill-equipped to care for any child and it soon became obvious that she was also neglectful and abusive.

59. Mrs. H. had uncontrolled diabetes and ulcers in her feet, and had difficulty walking. She was also prescribed medication for psychiatric problems. She often screamed at the children and beat them with whatever was available.

60. By 1996, Mrs. H. also had an alcoholic and physically abusive live-in boyfriend who beat Charlie. The boyfriend previously spent six years in prison for a sexual offense involving his own child. When Mrs. H. was hospitalized for several weeks due to a diabetic coma, Charlie and Nadine were left by DYFS in the home with Mrs. H's abusive boyfriend.

61. Calls to DYFS reporting the deplorable condition of the home and that the children had nothing to eat were not adequately investigated by DYFS.

62. Mrs. H's home was consistently dark, malodorous and littered with garbage, cat feces and dirty laundry. When the only toilet in the apartment backed up, Mrs. H. never cleaned up the feces left in both the bathroom and the kitchen. The children slept on mattresses without bedding or sheets and with broken windows in their rooms, even in wintertime. The walls had gaping holes and the electrical wiring was exposed. Syringes for Mrs. H.'s insulin shots were littered all over the apartment. The children could not bathe in the bathtub because it was full of cockroaches. The Division's only response to numerous complaints made on behalf of the children was to conduct a home visit, before which Mrs. H. would enlist the help of others to clean her foyer and living room. No inspection of the rest of the home was ever made by DYFS, nor did DYFS ever offer Mrs. H. assistance in making the living conditions more appropriate, safer and less dangerous for the children.

63. Even though Mrs. H. was unable and unwilling to participate in therapy and failed to make progress regarding her poor parenting, the Division's goal for Charlie and Nadine remained adoption by Mrs. H. throughout 1997.

64. In 1998, a sergeant in the Trenton Police Department who knew the children and Mrs. H. through his church, requested and attended a meeting with DYFS personnel to present information on the abuse and neglect Charlie and Nadine were suffering in Mrs. H.'s home. He presented photographs of the home, a sample of syringes that littered the home, and copies of

notes and documents he had begun to keep the previous year of his many interventions in the home on behalf of the children.

65. DYFS acknowledged that they were aware of some of these issues and agreed to have the sergeant meet with a DYFS supervisor regarding his concerns. The sergeant was later told that the meeting would not take place and that Mrs. H.'s planned adoption of Charlie and Nadine was proceeding.

66. Shortly thereafter, Mrs. H and the children were evicted and they moved into another apartment. The home quickly became as filthy as the last one. Mrs. H. continued to put off most home visits by DYFS and a therapist. Mrs. H. took the children to the dentist for the first time in more than four years under pressure from DYFS because of the pending adoption. In the meantime, DYFS continued to fail to protect the children from abuse and neglect.

67. That summer, neighbors repeatedly called the police to Mrs. H.'s home. Mrs. H. was often heard screaming at the children, and admitted beating them with curtain rods and a metal ruler. The Division's Institutional Abuse Investigation Unit ("IAIU") investigated the home, but took no action.

68. A few months later, in September 1998, Mrs. H. beat the children with a bucket. Nadine hit her head on the toilet seat, breaking the seat, while Charlie tried to protect his sister. Mrs. H. called the police sergeant and left a recorded message telling him repeatedly that she was going to kill the children if he did not come for them. When the sergeant arrived, Mrs. H. told him to "get them out of here; I can't stand to see them." The next day, DYFS placed both children in a "temporary" emergency foster home, where they have been for almost one year.

69. Five-and-a-half years after coming into DYFS custody, and two years after their mother's parental rights were terminated, Charlie and Nadine understand that their current placement can only be temporary. They are still waiting to find a stable and loving family that will adopt them.

70. DYFS has failed to take necessary steps to seek and secure an appropriate adoptive family for these children. The police sergeant and his wife have been involved in Charlie and

Nadine's lives for five years and are interested in adopting both of them. On March 1, 1999, they spoke to a DYFS adoption screener about doing so. DYFS has yet to take any action to investigate and approve them as a potential adoptive family, nor has it found another family for these children.

71. As a result of the defendants' actions and inactions, Charlie and Nadine have been and continue to be irreparably harmed. Charlie and Nadine both have significant emotional and behavioral problems due to their previous history of chronic abuse and neglect, both at home and in foster care. Both children are placed in special education classrooms because of their behavior. Charlie and Nadine do not know whether they will ever be placed with an adoptive family, or when that decision will be made. Although Charlie and Nadine have formed attachments in their present foster home, they know that the placement is temporary. Despite the fact that they have been the Division's responsibility for over five years, these young children continue to be deprived of the opportunity for healthy development and a normal childhood in a safe, permanent family, subjecting them to further emotional harm.

72. Defendants have violated Charlie and Nadine's constitutional and statutory rights by failing to protect them from harm; by failing to provide necessary services and an appropriate permanent placement to these children once they entered foster care; by failing to make timely and meaningful casework contacts and monitor their progress in foster care; by failing to investigate their foster home before approving their placement in that home and failing to annually evaluate and review that home; by placing them in a foster home that was not safe or secure; by failing to remove them from an abusive and neglectful foster home even though DYFS knew or should have known that they were being abused and neglected; by failing to treat them in accordance with reasonable professional standards; by failing to provide them with services necessary to prevent them from deteriorating while in state custody; by failing to ensure that they received proper medical attention or psychological or psychiatric or other foster care services while in DYFS custody; by failing to provide appropriate management and supervision while supervised by DYFS; by failing to provide case planning and management in accordance with

reasonable professional standards; and by failing to develop and implement a viable permanent plan that will allow them to leave foster care and secure a safe and appropriate permanent home, all of which are required by law and by reasonable professional standards.

B. JASON, JENNIFER and PATTI W.

73. Jason, Jennifer and Patti W., ten, eight and six years old, respectively, are siblings who were removed from their neglectful mother and have been in foster care for three years. During that time they have been in several different foster homes, and Patti has now been separated from Jason and Jennifer. DYFS is planning to have the children placed for adoption even though their father has had an ongoing relationship with his children and is able and willing to care for them.

74. All three children were initially placed by DYFS in a Cape May foster home where they resided for a year, during which time the children contracted ringworm and impetigo, a contagious skin condition. Following this placement, the children were moved first to one Burlington County foster home and then to another. Patti was removed from this second Burlington County home because of behavioral problems. She was subsequently replaced with the first foster family, but has been recently removed from that home as well.

75. DYFS has long been aware that Jason, Jennifer and Patti's father wants to provide a home and care for his children, and has told him that he could assume custody of the children if he did not live in a trailer that is too small to accommodate them. In the past three years, DYFS has simply advised the father to apply for federal housing, which he has done and for which there is a years-long waiting list. They also referred him to a program for homeless families, even though the program could not help him because he is not homeless.

76. In the last three years, DYFS has attempted to send Jason, Jennifer and Patti's case to an Adoption Resource Center ("ARC") on five separate occasions to terminate their father's parental rights. The ARC rejected the case the first four times, deciding that where housing was the only obstacle to reunification, termination of parental rights was unwarranted.

77. DYFS has again sent Jason, Jennifer and Patti's case to ARC, where it has now been accepted. The Division's current plan for the children is to terminate their parents' rights and to attempt to place the children for adoption.

78. Jason and Jennifer remain separated from not only their father, but also from their sister Patti. Despite the Division's long-standing plan to have these children placed for adoption, DYFS has taken no steps to secure an appropriate adoptive family for them. All three have been placed repeatedly with foster parents who are unable to adopt them.

79. Three years after Jason, Jennifer and Patti were removed from their mother, who was found to have neglected them and has since missed many visits with her children, DYFS has yet to file a petition to terminate her parental rights.

80. Jason, Jennifer and Patti visit with their father only once every two weeks, even though DYFS policy states that parental visits should occur at least once a week unless therapeutically harmful. Additionally, the visits arranged by DYFS require Jason and Jennifer to miss virtually one complete day of school every two weeks, even though reasonable alternatives are available.

81. Jason, Jennifer and Patti each have special needs. DYFS has taken no steps to ensure these needs will be met. Jason needs speech therapy which DYFS refused to take steps to provide. Jennifer suffers from adjustment disorder likely due to the instability of her situation, and also requires weekly treatment from a behavior therapist. She is not receiving these services because DYFS has not taken the steps to ensure they are provided. Patti is not only developmentally delayed, but also is speech and language delayed. Patti has been characterized by doctors as very apprehensive. Following a disruption in her placement, Patti began to vomit daily. All of these conditions require therapy, and DYFS has not taken steps to ensure that the needed therapies are being provided.

82. As a result of the defendants' actions and inactions, Jason, Jennifer and Patti have been and continue to be irreparably harmed. The children's special needs are not being met, causing them delay in their development and other physical and emotional harm. The children

do not know whether they will ever be reunified with their father, or, if not, if they will ever have a permanent, stable family. As a result they live in a state of constant anxiety and fear, and are being deprived of the opportunity for healthy development and a normal childhood, subjecting them to further emotional harm.

83. Defendants have violated Jason, Jennifer and Patti's constitutional and statutory rights by failing to protect them from harm; by failing to provide their father with services necessary to address their needs and facilitate their return to a parent; by failing to make reasonable efforts to prevent placement and then to make reasonable efforts after placement for the children to safely be discharged from foster care to a parent; by failing to conduct an adequate search for relatives willing and able to care for them after they had to be removed from their mother and within thirty days of the children's entering custody and failing to make its best effort to place the children with a relative; by failing to ensure they achieve permanency by the earliest possible date; by failing to develop and implement a plan that would provide the children with a permanency plan to either be returned to their parent or be adopted within a reasonable period of time; by failing to provide appropriate services and supervision while the children are in DYFS custody; by failing to support the family relationship by not providing parent-child visits as frequently as required, all of which are required by law and by reasonable professional standards.

C. DENNIS M. and DENISE R.

84. Plaintiffs Dennis M. and Denise R. are siblings who are eight and seven years old, respectively. They have been under DYFS supervision since at least 1995, and in DYFS custody since at least 1997. Their mental health has deteriorated due to the Division's failure to provide for their special needs. Successive inappropriate DYFS placements have continued to jeopardize Dennis and Denise's mental health.

85. DYFS did not remove Dennis and Denise from their grandparents' home, however, until 1997, when DYFS finally concluded that the children were unsafe, poorly supervised and being neglected. DYFS petitioned the Family Court for custody, and placed both children in foster care. Later that year, DYFS placed Dennis and Denise with their father.

86. Both Dennis and Denise have learning disabilities and severe emotional and behavioral problems. Both children have been attending special schools for the emotionally disturbed. Dennis started exhibiting fear of returning to his father's home after school. On several occasions, his hands had to be pried from a school railing to get him on the school bus home. Professionals familiar with Dennis' case repeatedly expressed concern to DYFS regarding the care Dennis was receiving in his father's home. Dennis also disclosed that another adult in his father's home was placing Dennis at serious risk of physical injury. The Division's investigation into Dennis' allegations, however, was inadequate, and that report of suspected abuse and neglect was unsubstantiated by DYFS.

87. Dennis and Denise were left in their father's home for over one year by DYFS, until their father was arrested in November 1998 for sexually assaulting a minor. He was later convicted of the crime. Dennis has since also reported that his father made him vandalize automobiles by breaking their windows.

88. After a one-week stay in an inappropriate placement, in November 1998, Dennis was placed with his sister Denise in the emergency foster home where they currently live. Both children continue to have serious emotional and behavioral problems. The current foster parent is unable to meet their needs. While DYFS has recently acknowledged that the children should be in a therapeutic foster home that could provide specialized care, DYFS has failed to secure such a home for them or to otherwise provide adequately for the children's special needs.

89. No adequate permanency planning has been initiated on behalf of these two young siblings. Although DYFS has recently acknowledged that adoption should be their goal, upon information and belief none of the steps necessary to prepare and transfer their case to the ARC, or to terminate parental rights, or to find them adoptive resources, have been completed.

90. As a result of the defendants' actions and inactions, Dennis and Denise have been and continue to be irreparably harmed. They remain seriously emotionally disturbed due to the Division's failure to protect them, keep them safe, place them in an appropriate home, and provide them services for their special needs after their abuse was discovered. The Division's

repeated inappropriate placements and failure to address the needs of these young children, which continue to this day, has caused them further deterioration and has exacerbated their emotional and behavioral problems. Their lack of permanency causes them further anxiety and stress and they are being deprived of the opportunity for healthy development and a normal childhood in a safe, loving, permanent family, subjecting them to further emotional harm.

91. Defendants have violated Dennis and Denise's constitutional and statutory rights by failing to protect them from harm; by failing to treat them in accordance with reasonable professional standards; by failing to provide them services necessary to prevent them from deteriorating physically, psychologically or otherwise while in foster care; by failing to provide safe, secure and appropriate placements; by failing to provide appropriate monitoring, supervision, case planning and management; by failing to provide appropriate psychiatric and psychological and other appropriate services; by failing to conduct adequate investigations of abuse and neglect reports; by failing to conduct comprehensive assessments of the children; by failing to ensure foster care placements that are appropriate to the individualized needs of the children; by failing to ensure that the children were being provided safe and appropriate care while being supervised by DYFS; by failing to ensure the homes in which the children were placed were appropriately investigated, reviewed and evaluated; by failing to ensure that the children achieved permanency at the earliest date by which it was safe to do so; by failing to ensure that they receive proper care while in state custody and that they or their foster parents receive the services necessary to address the children's needs and to assure their placement into a permanent home; and by failing to ensure they receive all the benefits of the Division's child welfare program without discrimination for their handicaps or disabilities, all of which are required by law and by reasonable professional standards.

D. MARCO and JUAN C.

92. Plaintiffs Marco and his brother Juan C., eight and ten years old, respectively, have spent half their young lives in DYFS custody. During that time they have been repeatedly shifted from one placement to another, sent out of state with the promise of adoption to a family

whose home was so bad it was closed by local authorities, and returned to New Jersey only to be placed by DYFS with foster parents who could not adequately communicate with them because the boys only speak English and the foster parents speak almost exclusively Spanish. The brothers have now been separated, and Marco's condition is deteriorating in this inappropriate foster home where his needs are not being met. Even though these children will never be returned to their parents, DYFS has not taken reasonable and timely actions to seek and secure a permanent home for them.

93. In the last four years that Marco and Juan have been in DYFS custody, each has been in ten different placements. Both boys suffer from neurological and behavioral problems.

94. Marco and Juan lived together in a therapeutic foster home in New Jersey for two years until January 1999, when DYFS sent them to live in a pre-adoptive home out-of-state.

95. DYFS sent these two young children out-of-state without conducting an adequate investigation of the potential adoptive family and home, and without taking necessary steps to ensure that Marco and Juan would be safe or would receive appropriate care, and without adequate supervision, despite the fact that these children remained in the Division's legal custody.

96. After Marco and Juan had lived in this new placement for only a few months, local authorities closed the home and sent the boys back to New Jersey, having discovered that the family to whom defendants had entrusted Marco and Juan had adopted over 20 special needs children. Many of the children in the home were filthy and heavily medicated, and were being abused.

97. When Marco and Juan were returned to New Jersey, DYFS placed them in a foster home with parents that speak almost exclusively Spanish, despite the fact that the boys speak only English. These foster parents were unable to communicate adequately with the boys or with professionals involved with their care. The foster parents also have had no training in caring for children with the neurological and behavioral problems the boys are experiencing, nor did DYFS provide them with the training to do so.

98. Juan is now placed in a foster home with an English-speaking foster mother who has extensive experience in the care of special needs children. Juan's behavior is improving and he is thriving in this placement. However, DYFS is failing to take necessary and timely action to ensure a permanent placement for him.

99. Marco's behavior has deteriorated markedly since his return from the failed pre-adoptive home out-of-state and separation from his brother. Marco now exhibits severe signs of distress, such as excessive rocking, mutilating himself by scratching his neck until his skin is raw, and smearing his mucus over walls. DYFS has failed to take reasonable steps to end the continuing harm to this eight-year-old child.

100. Although the goal that DYFS has set for Marco is adoption, the defendants have failed to take reasonable and timely steps to accomplish that goal. Instead, defendants have left Marco in a home that is an inappropriate permanent placement for him and have failed to take steps to protect the only permanent relationship this child has had, with his brother Juan.

101. For most of the time that Marco and Juan have been in defendants' custody, the supervision of their case and contacts with DYFS caseworkers have been inconsistent at best.

102. As a result of defendants' actions and inactions, Marco and Juan have been and continue to be irreparably harmed. Both boys have serious psychological and neurological problems which have been exacerbated by defendants' failures to fulfill their legal responsibilities to them. As a result of defendants' actions and inactions, these young children have been subjected to the serious emotional trauma of repeated movements while in foster care, further abuse and instability while in DYFS custody, and separation from each other, the only family member with whom each has had an ongoing relationship. In addition, defendants' failure to take reasonable steps to seek an appropriate adoptive home for Marco while he has deteriorated in DYFS custody, and defendants' failure to provide permanency for Marco and Juan, are depriving them of their only opportunity for a permanent family, and for healthy development and a normal childhood, subjecting them to further emotional harm.

103. Defendants have violated Marco and Juan's constitutional and statutory rights by failing to protect them from harm while they have been the Division's responsibility; by failing to provide them with proper care and treatment in accordance with reasonable professional standards; by failing to provide appropriate foster care services once placed outside their home; by failing to develop and implement appropriate permanent plans for them; by failing to conduct adequate assessments of the appropriateness and safety of their placements and obtain appropriate placements for them; by failing to appropriately screen and supervise their placements; by failing to provide services necessary to prevent their deterioration while in DYFS custody; by failing to ensure contact with their case workers in accordance with their case plans; by failing to ensure they receive medical, psychological and psychiatric services; by failing to develop and implement appropriate case plans; by separating these brothers unnecessarily and failing to ensure contact and visitation between them when they were placed separately; by failing to provide planning and services that would permit them to be placed in a suitable permanent home; and by failing to ensure they receive all the benefits of the Division's child welfare program without discrimination for their handicaps or disabilities, all of which are required by law and by reasonable professional standards.

E. RICARDO O.

104. Plaintiff Ricardo O. is a 13 1/2-year-old boy from Hudson County who has been in DYFS custody since June 1997, when he and his four siblings were removed from their mother's home. Ricardo had been sexually abused by his mother's boyfriend and, consequently, has serious mental health problems. Since he became the Division's responsibility, DYFS has failed to place him in a safe setting. As a result, Ricardo was sexually abused again while he was in state custody, and his mental health has deteriorated.

105. Before going into foster care, Ricardo lived with his divorced mother. The four oldest children, including Ricardo, have all since disclosed that they were sexually abused by their mother's boyfriend. Ricardo was approximately ten years old when he was molested and

threatened by his abuser. When Ricardo told his mother about the incident, she told him that she did not believe him. Ricardo was also beaten with a belt by his mother's boyfriend.

106. When Ricardo was removed from his mother's home and placed in DYFS custody, he was already prescribed Prozac. Defendants knew or should have known that Ricardo had serious psychological problems because of what he had experienced, and was in urgent need of treatment and a specialized therapeutic placement. However, DYFS failed to conduct an evaluation of his needs, or to secure an appropriate placement or necessary services for him.

107. Instead, all five children, and a later-born sixth sibling, were placed by DYFS with Ricardo's maternal aunt in Camden. DYFS made this placement without determining whether such a placement was appropriate for him and without providing necessary supervision or services to keep Ricardo from deteriorating while in DYFS custody.

108. While living in his aunt's home under DYFS supervision, Ricardo's behavior became increasingly disturbed, making clear his need for immediate treatment and help. He attempted to drink Clorox, stuck his fingers in electrical sockets, tried to throw himself in front of a moving car, and ran away from his aunt's home, hitchhiking on the New Jersey Turnpike. He said that he heard voices telling him to do things and also saw monsters.

109. While living with his aunt in DYFS custody, Ricardo had to be hospitalized on three separate occasions, each time for dangerous behaviors. DYFS was aware of these hospitalizations and of Ricardo's worsening condition but took no steps to help him or to provide services or a therapeutic placement. After each hospitalization, he returned to his aunt's home.

110. Ricardo was so troubled that his aunt hid knives in the house so that Ricardo could not get them.

111. In approximately September 1998, in the middle of the night, Ricardo cut his penis with a dull knife. He also disclosed to his aunt that he had recently been sexually molested by an adult male. He was again hospitalized.

112. Ricardo ultimately required psychiatric commitment, and in September, 1998 was placed in the Arthur Brisbane Child Treatment Center ("Brisbane"), New Jersey's only children's psychiatric hospital.

113. DYFS referred Ricardo to nine residential facilities, each of which rejected him, because DYFS allows the facilities with which it contracts to do so without challenge.

114. While waiting for DYFS to find a less restrictive placement, Ricardo was housed with older boys and was sexually assaulted by three older youths at Brisbane in March, 1999. He was subsequently forced to sleep in a seclusion unit for several weeks before being transferred to Brisbane's Coed unit for younger residents.

115. A tenth facility finally accepted Ricardo in early April 1999. He was placed there in June 1999. He reports that he does not feel safe there, and that he was just sexually assaulted and threatened by his roommate on August 2, 1999.

116. Ricardo currently suffers from Post-Traumatic Stress Disorder ("PTSD"), Attention Deficit Hyperactivity Disorder ("ADHD"), Impulse Control Disorder, depression, and psychosis, and has a learning disability. He has been on several medications including Prozac, Depakote and Mellaril.

117. DYFS has never developed an adequate permanent plan for Ricardo. When discussing his life and his future, this 13 ½ -year-old boy states: "I've got nothing to live for."

118. As a result of the defendants' actions and inactions, Ricardo has been and continues to be irreparably harmed. He has suffered continued physical and sexual abuse while in DYFS custody. He does not know whether he will ever have a permanent family or any hope of a secure childhood.

119. Defendants have violated Ricardo's constitutional and statutory rights by failing to protect him from harm; by failing to provide services to prevent him from deteriorating while in DYFS custody; by failing to provide appropriate placement and services to meet his needs; by failing to meet his medical needs; by failing to place him promptly in the least restrictive placement appropriate for his needs; by failing to provide appropriate supervision; by failing to

develop and implement appropriate permanent plans; by failing to ensure his placement in a permanent home; and by failing to ensure he receives all the benefits of the Division's child welfare program without discrimination for his handicap or disability, all of which are required by law and reasonable professional standards.

F. DOLORES and ANNA G.

120. Plaintiffs Dolores and Anna G. are sisters who are four years old and 17 months old, respectively.

121. Dolores and Anna have now spent a year in foster care. Even though parental rights were terminated as to three previous children, and despite a history of neglect of Dolores and Anna and the fact that the home and parenting circumstances had not changed, the Division's plan is to send Dolores and Anna back home. However, DYFS has made no plans as to when it would be appropriate to do so or what services would be necessary to ensure that the children could be returned home safely.

122. Almost one year after they came into DYFS custody, DYFS is still planning for Dolores and Anna to be reunified with their parents, even though DYFS previously terminated these same parents' rights for three other children. DYFS has made no reasonable determination that the parents will ever be able to care for Dolores and Anna. Dolores and Anna's parents repeatedly miss their scheduled visits with the children.

123. Although DYFS knows or should know that it is highly unlikely that Anna and Dolores can safely be returned to their parents' custody, DYFS has taken no action to place the children into a foster home that can also be a potential adoptive placement. Instead, the children have been living for the last eleven months with a foster family with which they have formed emotional attachments, despite the fact that DYFS is aware that this family cannot provide a permanent home for the girls.

124. In the spring of 1999, Dolores and Anna were assigned a new caseworker, who has visited the foster home on only one occasion. Meanwhile, Dolores and Anna's family court hearings have had to be adjourned due to the Division's lack of preparation.

125. Although both these children have significant physical and emotional needs because of their early deprivations, DYFS is failing to provide appropriate treatment, services and supervision necessary to address those needs.

126. As a result of the defendants' actions and inactions, Dolores and Anna have been and continue to be irreparably harmed. Dolores and Anna both have significant developmental delays due to their previous home environment. Dolores, at the age of four, functions like a two-and-one-half to three-year-old child and attends a pre-school class for the disabled. 17-month-old Anna is just learning to walk. Dolores and Anna do not know whether they will be reunified with their biological parents or placed with an adoptive family, or when that decision will be made. They are likely to be removed from the foster family to whom they have formed attachments and moved to yet another family home, subjecting them to further emotional harm. Despite the fact that they -- as with their siblings before them -- have long been the Division's responsibility, these young children are being deprived of the opportunity for healthy development and a normal childhood in a safe, loving permanent family, subjecting them to further emotional harm.

127. Defendants have violated Dolores and Anna's constitutional and statutory rights by failing to protect them from harm; by failing to make timely and meaningful casework contacts and monitor their progress; by failing to provide necessary services and an appropriate long-term placement to these children once they entered foster care; by failing to provide appropriate monitoring and supervision while in state custody; by failing to develop and implement a permanent plan that would allow them to leave foster care and secure a permanent home; by failing to provide planning services to facilitate adoption or another permanent home; by failing to file timely petitions to terminate parental rights; and by failing to develop and implement appropriate permanency plans, all of which are required by law and by reasonable professional standards.

G. KYLE J.

128. Kyle J. is a one-and-a-half-year-old infant from Essex County who remained in the hospital for over two months after birth, but who was discharged to DYFS foster care after being deemed healthy by his doctors. Kyle's mother is a homeless substance abuser who has never visited her son or shown any interest in his welfare since his birth. Her current whereabouts are unknown. Kyle's six-year-old brother is also currently in foster care. DYFS has yet to place Kyle in a pre-adoptive home.

129. Although Kyle's doctors deemed him to be healthy, DYFS placed him in a foster home for medically fragile infants. DYFS was made aware that Kyle's foster parents are only interested in providing temporary care for infants, and cannot adopt Kyle. Despite this, DYFS listed them in Kyle's record as a pre-adoptive resource. One year and three months later, Kyle remains in this "temporary," non-adoptive home.

130. Although DYFS has concluded that adoption is the appropriate goal for Kyle, it has done nothing to further that plan. While Kyle has been in DYFS custody since birth and his mother has never visited him, DYFS has not yet begun a proceeding to terminate his mother's parental rights.

131. DYFS has failed to place Kyle, who has been described as a beautiful, healthy, bright, curious boy, in an appropriate pre-adoptive placement. As a result, Kyle has become emotionally attached to his foster parents, although DYFS knows that they cannot adopt him.

132. During the fifteen months that Kyle has been in his foster parents' care, his caseworker has visited the home only three times.

133. At one point, DYFS was alerted to a potential adoptive home for Kyle. DYFS never called this family, which adopted another infant through a private agency.

134. As a result of the defendants' actions and inactions, Kyle is being irreparably harmed. He is growing up in foster care without a permanent family and is becoming emotionally attached to a family with whom he cannot live permanently. Kyle is being deprived of an

opportunity for healthy development and a normal childhood, subjecting him to further emotional harm.

135. Defendants have violated Kyle's constitutional and statutory rights by failing to protect him from harm while in state custody; by failing to provide required caseworker contacts; by failing to provide appropriate monitoring, supervision and case management; by failing to develop and implement an appropriate permanent plan; by failing to achieve permanency by failing to terminate parental rights and arranging for his adoption within appropriate time frames; and by failing to implement his permanent plan and allow him to leave foster care and enjoy a permanent and secure home, all of which are required by law and by reasonable professional standards.

J. BARRY M.

136. Plaintiff Barry M. is a 17-year-old teenager from Camden County who has been in DYFS custody repeatedly since he was approximately four years old. Barry was removed from his mother's custody because of neglect as well as sexual abuse by her boyfriend. His mother is a former DYFS foster child. Although Barry has been the Division's responsibility for most of the last thirteen years, defendants have never provided Barry with appropriate services to address his problems or to cope with the many losses that have been inflicted on this youngster throughout his childhood. Barry's latest DYFS placement is in a residential treatment facility in Georgia, far from his only remaining family, because DYFS has not developed sufficient facilities in New Jersey for youngsters with mental illness and behavioral problems.

137. Barry's father died when Barry was an infant, and his step-father died when Barry was eight years old. Barry's mother died in December 1994. Shortly after her death, Barry lost contact with his only sibling, Natalie, who is 14 years old, when her adoptive family moved out-of-state.

138. When Barry was first removed from his mother's custody at the approximate age of four, DYFS initially placed Barry with a foster family. He was later placed with an aunt and then with his maternal grandfather. At that time, DYFS failed to assess Barry's mental health

needs related to his history of neglect and sexual abuse, or to provide appropriate and necessary services to address those needs. Barry remained with his grandfather for several years, until 1991, when Barry's grandfather suffered a stroke. DYFS then placed Barry with a foster family, once again without doing an adequate assessment of Barry's needs or providing services that were appropriate to address those needs.

139. In reaction to the losses in his family and the instability in his life, Barry began to exhibit the signs of serious emotional and behavioral problems. Barry has now been diagnosed with paranoid-schizophrenia with psychosis and conduct disorder. He is currently prescribed Haldol, Cogentin and Zyprexa.

140. At the end of 1993, when Barry was eleven years old, he was arrested for burglary and placed by DYFS in a residential program. In December 1994, while he was placed there, Barry's mother died, and shortly thereafter, Barry ran from the program and was subsequently arrested again.

141. Since then, Barry has repeatedly alternated between detention, unsuccessful DYFS placements, and incarceration. In 1995, DYFS placed Barry in another residential program from which he ran, then in a temporary therapeutic foster care home for a month, and then sent him to live with a relative out-of-state. That placement lasted approximately one month before Barry was sent back to New Jersey.

142. After several incarcerations, the Family Court ordered DYFS to identify an appropriate residential program for Barry.

143. In September 1998, Barry's grandfather signed a voluntary Residential Placement Agreement with DYFS and Barry was placed by DYFS at a residential treatment program out-of-state, far from his grandfather, because there is no adequate program in New Jersey. Barry was dismissed from that program after an altercation with a teacher in February 1999.

144. Barry was then held at a lock-up county detention center in Blackwood, New Jersey, awaiting another DYFS placement.

145. The Family Court ordered Barry into DYFS custody for residential placement, but DYFS did not have any appropriate program for Barry in New Jersey that would accept him. Meanwhile, Barry was held in the secure detention facility for three and a half months, without adequate psychiatric and other treatment services. At least four scheduled dates for his move out of detention lapsed before Barry was moved out-of-state again to a treatment program in Georgia on July 7, 1999.

146. Contact with his grandfather, the only family he has left, is now limited. The program he is now in will not keep him past his eighteenth birthday in June of next year.

147. Because of the defendants' actions and inactions, Barry has been and continues to be irreparably harmed. Barry has been placed out-of-state again, far from his only remaining family, and he will need to be moved again in less than one year due to his age. DYFS has not made any plans for Barry's transition back to New Jersey and into adulthood. The uncertainty of his situation and his placement in an out-of-state facility is detrimental to his mental health and proper development.

148. The defendants have violated Barry's constitutional and statutory rights by failing to protect him from harm; by failing to provide an appropriate placement that can manage Barry's psychiatric and behavioral problems; by failing to provide him with a written plan, reviewed annually, to prepare him for self-sufficient living; by failing to ensure that the services he received were designed to maintain and advance his mental and physical well-being; and by leaving him for months without adequate psychiatric and other care in a secure detention facility which was not the least restrictive placement to which Barry was entitled and which was inappropriate for his individual needs; failing to provide Barry, who has a disability, with the least restrictive placement and services appropriate to his particular needs; and by failing to ensure Barry receives all the benefits of the Division's child welfare program without discrimination for his handicap or disability, all of which are required by law and by reasonable professional standards.

K. SHARON K.

149. Plaintiff Sharon K., who is four years old, was born in Middlesex County and within days of her birth entered DYFS custody directly from the hospital. Her mother was abusing drugs and alcohol, and her father's identity was unknown. She has remained in DYFS placement since birth. Her current permanency planning goal is adoption.

150. Sharon K., who is African-American, was placed with Caucasian foster parents, Mr. and Mrs. K. at six days old, and remains with them to this date. Sharon K. has never known any other home and considers Mr. and Mrs. K. to be her mother and father. Even though she is bonded to Mr. and Mrs. K and will suffer grave harm if she is separated from them, Defendants are delaying or denying her adoption in this home because her foster parents are of a different race and color than Sharon K.

151. Within a year of Sharon K.'s placement in DYFS custody, her case was transferred to the DYFS Metro Adoption Resource Center ("ARC") in Edison, New Jersey. In early 1998, her foster parents expressed to DYFS their interest in adopting Sharon K. and signed a letter of intent affirming that they would adopt Sharon K. when she was free for adoption.

152. Sharon K.'s foster parents had already successfully adopted six DYFS children with special needs during the previous ten years. Mr. and Mrs. K. have received recognition awards for dedication and outstanding service as foster and adoptive parents from DYFS's Middlesex District Office, DYFS's Metro ARC office, and the DYFS Central Office. The six children they adopted are all Caucasian.

153. Sharon K. was legally freed for adoption on June 24, 1998.

154. A DYFS homestudy approving Sharon K.'s foster parents to adopt Sharon K. was not completed until May 1999.

155. By June 1999, the petition to finalize Sharon K.'s adoption by her foster parents, Mr. and Mrs. K. was finally ready for submission to the court. DYFS, however, never proceeded with the adoption petition and, beginning in June 1999, repeatedly informed Sharon K.'s foster

parents that the adoption was "on hold," even though a DYFS manager admitted that there is no such status.

156. In fact, Sharon K.'s ARC worker was instructed to stop the adoption by the DYFS worker who had completed the homestudy because DYFS had some unspecified concerns about the placement. This same worker inquired of the ARC worker whether Sharon K.'s skin was "ashy" and whether Sharon K.'s hair was properly groomed -- questions clearly related to her race and color.

157. When Mr. and Mrs. K. had previously taken in a biracial foster child, a DYFS social worker told them on or about March 1995 to "be careful, because they [DYFS] don't always let you adopt a black baby." Shortly thereafter, that child was removed from this foster home and placed with a relative.

158. Defendants have delayed and denied Sharon K.'s adoption by her foster parents because of Sharon K.'s race. This is part of a policy, pattern and practice of racial discrimination and racial matching in foster and adoptive placements by DYFS and of delaying and denying adoptions because of the race of the child and/or the adoptive parents. These policies, patterns of conduct and practices are not consistent with reasonable and accepted professional standards and do not constitute professional decision-making with respect to selecting appropriate adoptive parents for children in DYFS custody for whom adoption is determined to be appropriate or expediting the adoption of such children. Defendants have been aware of and deliberately indifferent to these policies, patterns and practices that delay and deny adoption on the grounds of race and color.

159. As a result of the Defendants' actions and inactions, Sharon K. has been and continues to be irreparably harmed and deprived of the security of a permanent, loving home, because of her race and color. She also risks serious psychological and emotional harm from further denial of that security.

160. Defendants have violated Sharon K.'s statutory rights pursuant to MEPA, by delaying or denying her placement for adoption on the basis of her race and color. Defendants

have also violated her substantive due process right to be free from harm while in Defendants' custody by subjecting her to the uncertainties of a temporary foster care placement and the risk of an arbitrary removal from the only family she has known, as well as the emotional and psychological damage she will suffer as she ages and becomes aware that her adoption has been delayed and denied because of her race and color.

FACTUAL ALLEGATIONS REGARDING SYSTEMIC DEFICIENCIES

161. The experiences and current circumstances of the named plaintiffs are typical of the class. They illustrate defendants' long-standing pattern and practice of not meeting the needs of the children in the plaintiff class and reflect deliberate indifference to and failure to exercise professional judgment regarding the health, safety and welfare of the plaintiff class. Because of the failures in decision-making at every level, as well as the lack of placements and services, the lack of planning for children, and the absence of accountability, plaintiff children are not receiving adequate protection, care, treatment and services as required by law. This system's chronic dysfunction is hurting the very children defendants are obligated to protect.

162. The Governor's own Blue Ribbon Panel concluded in 1998 that "New Jersey's child welfare system has been seriously damaged by years of neglect[,] and has reached "a state of crisis," as previously described in numerous other reports such as the Association for Children of New Jersey's ("ACNJ") 1997 "Children First" report, 1996 "In Their Own Words" report, 1994 "Stolen Futures" report and 1988 "Splintered Lives" report. Despite their long-standing awareness of the need to redress systemic problems in the child welfare system, however, defendants have refused to exercise their authority to ensure that adequate funds are available and used appropriately to ensure compliance with their legal responsibilities to plaintiff children.

163. Little has changed since the Blue Ribbon Panel Report was issued more than 17 months ago. Over one year ago, on June 30, 1998, DYFS issued a Strategic Plan in response to the Blue Ribbon Panel's recommendations, but it ignored the Blue Ribbon Panel's "unequivocal conclusion that continued sustained investment of resources will be required to achieve the

essential changes in the child welfare system." The Strategic Plan contained only non-specific goals and lacked any discussion of the key problem areas identified by the Blue Ribbon Panel, including the lack of resources, unmanageable caseloads and inadequate staffing that are a result of a decade of defendants' willful neglect of the Division and repeated cuts to its budget. The Division's resources and staff have been decimated, but there has been little, if any, reform made in these areas, as acknowledged in the Division's 1999 Report Card, issued on July 23, 1999. The ensuing violations of plaintiffs' rights, detailed below, continue.

Out-of-Home Placements

164. When children are removed from their families, DYFS is failing to ensure that they are placed in safe settings that can meet their needs. Case workers first have to transport children in old, unsafe automobiles without appropriate child car seats. Regional Foster Care Units are in disarray and children are shuffled in and out of inappropriate placements. Many are diverted to informal placements and their cases closed without any DYFS services or judicial oversight.

Lack of Appropriate DYFS Foster Homes

165. When children are taken into DYFS custody, they are being placed wherever there is an available bed regardless of their particular needs, because defendants have not developed a sufficient quantity of proper placements to meet the needs of children in DYFS care and custody. In addition, insufficient safeguards exist to assure that children are not actually suffering harm in foster care. As a result, many children who have already suffered the effects of abuse or neglect in their own homes are further deteriorating in the Division's custody.

166. DYFS has failed to recruit sufficient numbers of foster homes to meet the needs of the steadily increasing number of children coming into DYFS care. As reported by the Home News Tribune, in an Associated Press article, on November 30, 1998, New Jersey state officials estimate that they need 500 more foster homes to provide a safe place for every abused and neglected child who needs a home. According to the Division's own 1999 Report Card, since July 1998, it has only been able to increase its net pool of foster homes by 93. The number of

available foster homes has since declined, however, and the Division expects to lose more homes as it finally implements a program to certify foster homes.

167. Newly regionalized Home Finding Units, responsible for matching children with available foster homes, are understaffed and overwhelmed, so that when a child is removed from home, district office caseworkers are often left to find available foster homes themselves. The disarray in the Home Finding Units is so extreme that one unit even arranged for a young child to be placed in a foster home in Ocean County even though the home was closed to younger children because an older child in the home had sexually abused a young child in that very home.

168. There are so few placement resources that in some DYFS district offices it is a daily occurrence for several children to be awaiting placement at the office all day and well into the night, sometimes staying until midnight. Repeated overnight emergency placements are often resorted to, and many children experience daily changes in placement. One child was brought in daily to the Perth Amboy district office for two consecutive weeks waiting for a placement and was exposed there to a janitor masturbating as a result.

169. Due to the lack of available placement resources, workers also frequently place children in foster homes beyond their allowable capacity -- the maximum number of children a particular home is allowed to care for at any given time. Waivers of DYFS placement policies are routinely being granted for emergency overnight placements even though placing more children in a home than the foster family can manage places all the children in the home at greater risk of harm.

170. Many foster homes are not safe. Foster homes have been subject only to a perfunctory approval process with insufficient standards to ensure that children will be safe. DYFS then fails to monitor foster homes providing care to children in DYFS custody and fails to make the required annual assessments of these homes. Upon information and belief, only 275 of the 2,686 foster homes state-wide have been certified by DYFS as part of the Division's new certification protocol. At the current rate it will be more than a year before existing foster homes have all been inspected for certification.

171. Some foster homes are filthy, offer poor child supervision and have consistently violated DYFS policies and regulations. Workers do not have time to check up on children within the first week of placement as required.

172. Caseworker complaints of abuse or neglect by foster parents are often not reported by DYFS, because the Division tolerates behavior from foster parents which would be unacceptable if exhibited by birth parents. Despite notice of foster child abuse, the Division routinely delays any action, thus jeopardizing children's safety in foster care. Some foster homes that repeatedly have had children removed because of social worker complaints of abuse are still receiving DYFS children.

173. When formally filed, reports of children being abused or neglected while in a foster home are referred to the Institutional Abuse Investigation Unit ("IAIU") for investigation. Instead of being fully investigated or assessed as independent protective investigation cases as required, however, many of these investigations are simply referred on by the IAIU to the ongoing caseworker. District offices are instructed to handle these reports of child abuse or neglect as contract performance problems with the foster parents instead of child protection cases. Foster homes are so scarce that some children remain placed in foster homes where the Institutional Abuse Unit has substantiated reports of physical abuse by the foster parents.

174. Children who suffer multiple movements, effectively severing over and over again attachments they have formed, become increasingly unable to love and trust their caretakers, exhibit higher levels of problem behavior, and are more difficult to place in permanent homes as a consequence. Such movement also disrupts children's education as they move from school to school.

175. 54% of New Jersey children in regular foster care have had multiple placements. Children who experience multiple placements typically spend more time in care before returning home or achieving an alternate permanent plan than children who experience one placement. In New Jersey, the average time in regular foster care for children with multiple placements is 41.14

months, or over 3.3 years, compared to 32.47 months, or approximately 2.7 years for all children in regular foster care.

Inadequate and Harmful Adolescent Placements

176. Because of the lack of foster or group home placements available for teenagers, many youth are placed in emergency shelter care facilities for extended periods of time. The average stay in some short term shelters that are only intended to house youth for 14 days is approximately six months. As a result, these youth are denied necessary therapeutic treatment by qualified professionals because the shelters are not designed to provide such treatment services.

177. Some teenage girls who give birth while in foster care are separated from their infant children solely because of a lack of appropriate mother-child placements. Teenage mothers and their babies are thus unnecessarily deprived of their opportunity to develop and nurture an emotional attachment while in separate DYFS placements.

178. Other youth, who have been adjudicated delinquent and ordered by the Family Court into DYFS care and custody for placement, wait for months in county detention centers before being placed by DYFS, although detention is intended to be temporary only. Meanwhile, specialized treatment is not provided nor are county detention center staff trained to meet the needs of those youth who need specialized care. For example, while many DYFS youth in detention centers need special education and psychiatric help, the county detention centers are not equipped to address special education or therapeutic needs.

179. In addition, some youth waiting for DYFS placement are in severely overcrowded detention centers such as those in Atlantic, Camden, and Hudson counties. Some youth in county detention centers awaiting DYFS placement do not even have basic toiletries such as soap, or clean underclothes.

Inadequate and Harmful Special Needs Placements

180. Many children with special medical or psychiatric needs are inappropriately placed, which results in additional, harmful deterioration of their condition. The reduction in

available residential treatment facility placements in particular has resulted in children being referred later in a much more traumatized and fragile state, often after years of inappropriate movement through the foster care system.

Services to Foster Children

181. Defendants fail to provide foster children with the services necessary to keep them free from harm while in foster care and to prevent their stay in foster care from being longer than necessary.

182. DYFS caseloads are too high to allow for professional foster care services for every child entitled to such critical services. In Essex County, for example, caseworkers carry caseloads of 70 to 90 children each, far above reasonable professional standards.

183. Because of high caseloads, case workers do not have time to visit children in their foster homes or procure services necessary to support the children's behavioral and emotional needs. In addition, many services needed by children are simply not available, further compromising case workers' ability to function effectively.

184. While in DYFS custody, children suffer a myriad of substantial deprivations, such as inadequate physical and mental health care and inadequate educational services.

Health Care and Related Services

185. Although DYFS is required to ensure that children in its custody receive adequate health care, the Division does not adequately track children's health care needs and records. As a result, many foster children's physical and mental health care needs go unaddressed.

186. Besides an initial medical screening before placement, which usually only consists of a visit to a hospital emergency room, foster children do not routinely receive medical care. Many foster children are behind on their immunizations. The failure to provide health services to foster children is particularly egregious in that foster children tend to have heightened health care needs as a result of their background of abuse and/or neglect.

187. DYFS routinely expects foster parents to assess and coordinate their foster children's health care needs, as caseworkers do not have the time to do so themselves. While children in DYFS custody are eligible for Medicaid, DYFS often fails to make children's Medicaid cards available to foster parents. Thus, when a foster child needs medical care, the foster parent is often required to pay the costs out of pocket. DYFS then fails to reimburse the foster parents for these out-of-pocket medical expenses.

188. Children in DYFS care with parents known to be HIV positive are not routinely tested for the HIV virus themselves, jeopardizing their effective treatment if they are in fact infected.

189. DYFS does not provide children with needed counseling or therapy after traumatic removals from their parents' homes. DYFS does not explain to the children what is happening to them.

190. For those children with mental health care needs, there is a critical lack of appropriate services. The Division's failure to develop and provide an adequate range and quantity of mental health care services -- from out-patient counseling to in-patient psychiatric care -- deprives children of necessary health care. According to figures analyzed by ACNJ, psychological and therapeutic services, including evaluations and on-going treatment, were cut 21.6% in the FY 98 budget.

191. The Blue Ribbon Panel Report recommended that DYFS "[m]ove to eliminate the considerable variability in determining the need for and extent of diagnostic and treatment services within District offices by developing minimal standards and assuring adherence to such through a monitoring process." However, the Division's Strategic Plan does not address these recommendations and, upon information and belief, the recommendations have not been implemented.

192. Defendants have failed to develop a functioning children's mental health system. DYFS is routinely unable to access the services provided by the Division of Mental Health Services ("DMHS") and the Division of Developmental Disabilities ("DDD") for the children in

DYFS custody because of a long-standing lack of coordination and access among these various divisions of the Department of Human Services.

193. There are approximately 1500 to 2000 children on waiting lists for placements with Division of Developmental Disabilities programs. Many times DYFS social workers cannot even get personnel at DDD to answer their phone calls.

194. As a result, many foster children do not receive the mental health care they need, which often results in disrupted placements and the movement of these children from one foster care placement to another, causing further problems. Ultimately, these children often end up hospitalized or involved with the juvenile justice system because their mental health problems have gone unaddressed for too long.

Educational Services

195. DYFS systemically fails to ensure that all children in foster care receive an education appropriate to their needs and in accordance with state education laws. This includes, but is not limited to, ensuring that all foster children receive appropriate academic and vocational guidance.

196. Children being moved between placements are kept out of school for days at a time. Children are also often taken out of school for an entire day each time they attend visitation with their parents and/or siblings, rather than having these visits scheduled during non-school hours.

197. Children in need of special education who are in county detention centers or temporary shelters awaiting DYFS placement for up to six months are not receiving appropriate educational services.

Adoption Services

198. DYFS has also delayed or blocked the adoption of some African-American foster children by their non-African-American foster parents because of race, thus limiting adoption opportunities for many children. Meanwhile, the children languish in foster care, awaiting

permanent families despite the fact that in many instances, families already taking care of them are available to adopt them.

Caseworker Screening, Training, Retention and Support

199. Even though DYFS staff are entrusted with protecting the well-being of the most vulnerable children in the State, DYFS suffers from insufficient and inadequately trained and supervised staff, excessive caseworker workloads, and inadequate support staff and supplies. This has made worker professionalism almost impossible and contributed to low worker morale, worker burnout, and high attrition rates. As a result, defendants are not providing a workforce that can protect plaintiff children from harm, or provide them with necessary services, or ensure compliance with applicable legal and professional standards.

200. Staffing levels have not kept pace with increased referrals to and demands on DYFS. While the number of children and families needing DYFS services continues to increase, DYFS has eliminated hundreds of positions since fiscal year 1991, with most cuts coming from direct service staff positions. Staff additions in the last two years have not made up the chronic shortfall, so that even non-case carrying staff are being assigned to cover cases.

201. In addition, DYFS has never achieved full staffing of existing positions. The burden on remaining staff is even greater because DYFS vacancy rates do not include its numerous personnel on leave, many for stress-related health problems. Also, inappropriate or incompetent staff are retained because otherwise additional positions would be left unfilled.

202. Additional vacancies in the district offices are being created by the improvident transfer of case workers to the regional offices and ARCS.

203. Meanwhile, the hiring of several hundred additional caseworker trainees over the past two years has had little impact on the provision of direct services as most new workers are unqualified, inexperienced, poorly trained, and many have already resigned.

204. New caseworkers being hired by DYFS are only required to have a bachelor's degree in any subject without any related work experience. In addition, applicants are not adequately screened for their ability to succeed in such challenging and critical positions.

205. There is inadequate training for new workers, so that inexperienced new workers have to rely heavily on whatever informal training they can get from more experienced co-workers. New workers are also being assigned complex and difficult cases that should be reserved for experienced staff.

206. CPS screeners and intake workers in particular are poorly supervised and lack the guidance of any uniform or clearly applied policies or adequate training regarding screening criteria and when removal of the child or provision of in-home services is appropriate.

207. There is inadequate in-service training for experienced workers. Workers do not have the time to avail themselves of training provided in any event because of high caseloads. Training manuals are not readily available to staff. Computer training is minimal.

208. Because many promotions are now based on a worker's ability to close cases instead of on quality of social work practice, an increasing number of DYFS supervisors do not have the appropriate skills and experience to direct and be accountable for a workforce required to make critical life and death decisions. In addition, such inappropriate promotions demoralize experienced caseworkers and supervisors.

209. Because supervisors are responsible for too many workers and do not all have the necessary skills, experience and education, caseworkers do not receive needed supervision, guidance or support. Much of the supervision received is "hallway" supervision when a crisis occurs. One case worker in the Central Passaic district office has only had one formal supervision meeting in the past two years. CPS supervisors are also either unqualified or untrained to perform the requirements of their positions, or are too overworked to perform their duties adequately. Supervisor to caseworker ratios exceed the 1:5 ratio recommended by the Child Welfare League of America. Some units have up to eight workers per one supervisor, and some days there is only one supervisor in a DYFS district office responsible for up to eight separate units of workers.

210. While the Child Welfare League of America ("CWLA") recommends that workers be responsible for no more than 12 family cases in intake and 17 families in ongoing

services, for DYFS workers individual caseloads of over 80 children are not unusual. With average caseloads well over reasonable professional standards in all units, adequate casework is not possible.

211. The Blue Ribbon Panel Report confirmed that case worker staffing levels are woefully inadequate, staffing goals are unrealistically low and even then still unmet, and case worker hiring requirements must be increased in order to develop a qualified and motivated staff. The Blue Ribbon Panel Report recommended that DYFS should conform its caseload standards to established national standards as recommended by the CWLA, to enable workers to effectively provide services to children and their families.

212. The DHS Critical Incident and Child Death Review Board, created in 1992 to examine cases in which a child under DYFS supervision (currently or within the past 12 months) dies or is critically injured due to abuse or neglect, released a report in 1998 covering deaths in 1995-96, and a final report covering deaths in 1997. The Board noted in these fatality reports that inadequate staffing levels throughout DYFS contributed to work overload for many caseworkers and all levels of supervision and had a negative impact on the staffs' ability to effectively manage daily tasks and protect children.

213. However, the Division's Strategic Plan does not address this issue and, upon information and belief, the Blue Ribbon Panel's recommendation has not been implemented.

214. The Division's response has been to put enormous pressure on supervisors and case workers to keep caseloads down by closing cases. Case workers are told to close cases if no services are available for a family, even though the need for ongoing services is apparent and the case will most likely come back as a new intake case. So that caseloads will appear lower, siblings of abused and neglected children are also closed out from active cases if they are not imminently at risk, without consideration of their need for preventive services.

215. DYFS provides case workers with inadequate clerical support and supplies, also affecting their ability to perform their jobs competently. Case workers are expected to do their own typing and data entry. Copy machines routinely do not work. Case workers have had to

wait for an available car to be returned to the office before they could respond to emergencies. In order to respond to simultaneous emergencies, workers compete over whatever car is available. Needed supplies as simple as blank copies of voluntary placement agreements are often unavailable.

216. When a case worker has to work after hours on an emergency, management in some DYFS district offices imposes mandatory flex time, requiring the case worker to report to work late the next day, so as to avoid paying overtime, even though the workers' caseloads need immediate attention. Case workers with too many cases have to complete much necessary case work, such as parent/child visits, on their own time or not at all.

217. With high caseloads and a lack of adequate training, support and supervision, a large number of DYFS caseworkers are resigning. As a result, the front-line staff is frequently young, inexperienced and poorly trained, putting an even higher burden on the remaining experienced over-worked staff. Many cases remain unassigned or uncovered for weeks and even months.

Accountability Throughout the System

218. The current level of accountability in New Jersey's child welfare system is inadequate. The diminished capacity of DYFS to carry out many basic management functions has resulted in weak internal assessment and oversight functions. External oversight of DYFS by DHS and Governor Whitman has also been inadequate.

219. DYFS has no accurate or timely system for the measurement of case management and outcomes. Management cannot track individual case progress and only has periodic case totals to rely on.

220. DYFS has no operational or effective quality assurance program. The Governor's Blue Ribbon Panel Report estimated that DYFS only reviewed 0.0035% of its cases for quality assurance purposes.

221. Nor does DYFS have a functioning system for monitoring the quality of foster care and related services. The Blue Ribbon Panel Report noted that "[f]oster care has never

officially been reviewed ... and thus, there is no baseline of what the status of practice and quality of care is in order to address the areas of needs or gaps."

222. DYFS has no functioning system for monitoring contracted services provided by private agencies that include most residential and group home placements as well as preventive services.

223. Field staff are unfamiliar with the services available, various contracts, or changes in policy and practice within DYFS. Central office senior officials are remote and uninformed. Management staff do not know what is actually happening to children and families in the field.

224. Prior to the Blue Ribbon Panel Report, the DHS Critical Incident and Child Death Review Board had reviewed and reported on cases through 1994 to determine if the cases were handled appropriately and what if any changes in practice were needed. According to the Governor's own Blue Ribbon Panel Report, however, the identified concerns and recommendations regarding DYFS case practice in the two reports covering cases through 1994 had still not been adequately addressed by DYFS.

Insufficient Resource Development and Maximization

225. Assuming a modest 3% inflation rate from FY 1992 to FY 1998, the DYFS FY 1998 budget fell \$47 million short of providing the same level of services that was provided in FY 1992. Recent additions to the state appropriations for DYFS have not closed the gap, especially in light of the increase in cases over the past seven years.

226. DYFS fails to ensure that the New Jersey child welfare system receives the maximum amount of possible federal financial support to which it is entitled and which could be used to enhance services for children and families. For example, despite the obvious need for training, New Jersey has requested and received one of the smallest amounts of Title IV-E federal funds earmarked for training in the country, with only four other states requesting less, according to the most recent comparative data available.

227. The Blue Ribbon Panel Report recommended that DYFS "[c]onduct a complete budget analysis of every aspect of the Division's operations." The Blue Ribbon Panel also recommended that DYFS "[a]llocate sufficient resources for appropriate staffing levels," for "administrative support, equipment, cars and technology to carry out functions that have been compromised by shortages in each of these areas," and for "improved training." The Panel also recommended that the Division "devote more resources to preventive and family support, preservation, and reunification services."

228. However, the Division's Strategic Plan does not address these recommendations and, upon information and belief, the recommendations have not been implemented.

229. DYFS is currently running a deficit of approximately \$40 million for money owed to residential treatment facilities for prior services rendered.

Lack of Planning and Failure to Prioritize Systemic Improvements

230. Although long-term strategic planning is necessary to resolve the problems confronting the child welfare system in New Jersey, the defendants have only managed to respond episodically to crises with ineffective short-term fixes.

231. The cumulative effects of a decade of neglect, budget cuts and minimal maintenance of New Jersey's child welfare system now require a drastic restructuring and infusion of resources. Additional emergency allocations to the Division's budget in recent years have only restored a fraction of the budget losses the Division suffered throughout the last decade. Moreover, few of the resources that had been cut in the past ten years have been restored.

232. The Strategic Plan DYFS issued in response to the Blue Ribbon Panel's recommendations contains only very non-specific goals and is inadequate to address the long-term disintegration of the Division. As set forth throughout this Complaint, many of the Blue Ribbon Panel's Recommendations went ignored in the Strategic Plan and, upon information and belief, the recommendations have not been implemented. As acknowledged by the data in the Division's 1999 Report Card, the Division's recent attempts at reform have resulted in little meaningful change.

233. DYFS does not operate in a manner consistent with reasonable professional standards or applicable legal standards, and, as a direct result, plaintiffs are being denied their legal rights and subjected to unnecessary harm by state officials legally responsible for their care and protection.

CAUSES OF ACTION

First Cause of Action - Substantive Due Process

234. The foregoing actions and inactions of the defendants are inconsistent with the exercise of reasonable professional judgment and also amount to a pattern, practice and custom of deliberate indifference to plaintiff children's constitutional rights. As a result, plaintiff children are being deprived of their substantive due process rights conferred upon them by the Fourteenth Amendment to the United States Constitution. These rights include, but are not limited to, their right to protection from harm; their right not to be harmed -- physically, emotionally, developmentally or otherwise -- while in state custody; their right to treatment; their right to treatment related to the cause of their confinement; their right to receive care, treatment and services consistent with competent professional judgment.

Second Cause of Action - The Multiethnic Placement Act

235. As a result of the foregoing actions and inactions of the defendants, the plaintiff children are being deprived of the rights conferred upon them by the federal Multiethnic Placement Act of 1994, as amended by the Interethnic Adoption Provisions of 1996. These rights include, but are not limited to the right not to have adoptive or foster placements delayed or denied on the basis of the race, color or national origin of the foster or adoptive parent or of the child.

PRAYER FOR RELIEF

WHEREFORE, the plaintiff children respectfully request that this Honorable Court:

- A. Assert jurisdiction over this action;
- B. Order that plaintiffs may maintain this action as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure;

C. Declare unconstitutional and unlawful pursuant to Rule 57 of the Federal Rules of Civil Procedure defendants' failure to provide for plaintiffs' safety and freedom from harm, consistent with the exercise of reasonable professional judgment and failure to comply with the federal Multiethnic Placement Act of 1994, as amended by the Interethnic Adoption Provisions of 1996;

D. Permanently enjoin defendants from subjecting members of the plaintiff class to practices that violate their rights;

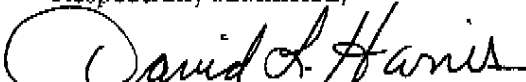
E. Order appropriate remedial relief to ensure defendants' future compliance with legally mandated services to plaintiffs;

F. Appoint an expert panel with full access to defendants, their records and their personnel, to develop and oversee the implementation of a plan for reform, to ensure that defendants protect the constitutional and federal statutory rights of the plaintiff class;

G. Award plaintiffs their reasonable attorneys' fees and costs pursuant to 42 U.S.C. §§ 1988 & 1920; and

H. Grant such other and further equitable relief as the Court deems just, necessary and proper to protect the plaintiff class members from further harm by defendants.

Respectfully submitted,

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