NEW JERSEY

CHILD FATALITY AND NEAR FATALITY

REVIEW BOARD AND

CITIZEN REVIEW PANEL

2005 ANNUAL REPORT

June 30, 2006

Table of Contents

New Jersey Child Fatality and Near Fatality Review Board
and
Citizen Review Panel Members
2005

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NEW JERSEY CHILD FATALITY AND NEAR FATALITY REVIEW BOARD/ CITIZEN REVIEW PANEL 2005 ANNUAL REPORT

Introduction

This is the seventh annual report of the Child Fatality and Near Fatality Review Board/Citizen Review Panel (CFNFRB). The report includes an overview of the activities and issues raised by the CFNFRB in 2005, as well as any actions that were taken to address them.

In August 1990, the Commissioner of the New Jersey Department of Human Services established the Child Death and Critical Incident Review Board by Administrative Order. In January 1991, the Child Death and Critical Incident Review Board began reviewing child fatalities. In December 1992, the status of the Board's authority was changed from a Departmental Administrative Order to State regulations that have the force and effect of law.

The Child Death and Critical Incident Review Board was mandated to review child deaths due to child abuse or neglect in which the family was currently or previously, within 12 months of the incident, receiving services from the Division of Youth and Family Services (DYFS). The Child Death and Critical Incident Review Board concluded its tenure in 1998 with the review of 1997 child deaths and critical incidents. The adoption of N.J.S.A. 9:6-8.88, the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA), on July 31, 1997, created the Child Fatality and Near Fatality Review Board which replaced the Child Death and Critical Incident Review Board. The Governor officially appointed the members of the CFNFRB in May 1998.

Although the CFNFRB is placed administratively in the Department of Human Services, it is statutorily independent of "any supervision or control by the department" or any of the Department's other "boards or officers."

The scope of incidents that are subject to review has changed to include child fatalities and near fatalities in the State of New Jersey as specified in N.J.S.A. 9:6-8.90. “Child” is defined as any person under the age of 18. The CFNFRB continues to meet monthly to fulfill this mandate. The principal objective of the CFNFRB is to provide an impartial review of individual case circumstances and to develop recommendations for broad-based systemic, policy, and legislative revisions for the purpose of preventing future child fatalities and near fatalities. According to CCAPTA, the purpose of the CFNFRB includes, but is not limited to, the following:

- To review child fatalities and near fatalities in New Jersey in order to identify the cause of the incident, the relationship of the incident to governmental support systems, as determined relevant by the CFNFRB, and methods of prevention;
- To describe trends and patterns of child fatalities and near fatalities in New Jersey, based upon its case reviews and findings;
- To evaluate the response of government support systems to the children and families who are reviewed and to offer recommendations for systemic improvements, especially those that are related to future prevention strategies;
- To identify groups at high risk for child abuse and neglect or child fatality, in terms that support the development of responsive public policy; and
- To improve data collection sources by developing protocols for autopsies, death investigations, and the complete recording of the cause of death on the death certificate, and make recommendations for system-wide improvements in data collection for the purpose of improved evaluation, potential research, and general accuracy of the archive.

Pursuant to N.J.S.A. 9:6-8.90, the CFNFRB's mandate requires the identification of fatalities due to unusual circumstances according to the following criteria:

- The cause of death is undetermined;
- Death where substance abuse may have been a contributing factor;
- Homicide, child abuse or neglect;
- Death where child abuse or neglect may have been a contributing factor;
- Malnutrition, dehydration, or medical neglect or failure to thrive;
- Sexual abuse;
- Head trauma, fractures, or blunt force trauma without obvious innocent reason, such as auto accidents;
- Suffocation or asphyxia;
- Burns without obvious innocent reason, such as auto accident or house fire; and
- Suicide.

In addition, the CCAPTA mandates the CFNFRB to identify children whose family was under DYFS supervision at the time of the fatal or near fatal incident or who had been under DYFS supervision within 12 months immediately preceding the fatal or near fatal incident. The CFNFRB is empowered to select cases from among these categories and to conduct a full review. The CFNFRB also examines and identifies approaches to achieve better coordination of efforts regarding child welfare and child protective services cases to promote prevention and the competency of response and investigation of reports of maltreatment.

Finally, CCAPTA requires the CFNFRB to establish regulations to govern its activities. CCAPTA stipulates that the CFNFRB submit an annual report to the Governor and State legislature. The CFNFRB is required to report as follows:

- Trends among unusual fatalities and near fatalities;
- The number of cases reviewed and specific non-identifying information regarding cases of particular significance;
- Risk factors and the governmental support systems available and responsible for support; and
- Recommendations for improving sources of data collection, achieving better coordination and collaboration among State and local agencies, and recommendations for system-wide improvements in services to prevent child fatalities and near fatalities.

This is the third report in which the activities of the CFNFRB are chronicled in a calendar year. The CFNFRB continues to set operational priorities, to standardize the case review process, establish protocols that will ensure as much information as possible is available during case reviews, and that the needs of its four Regional Child Fatality and Near Fatality Community-Based Review Teams are met.

Organizational Accomplishments/Issues

Regional Child Fatality and Near Fatality Community-Based Review Teams (Regional Teams)

A central and guiding principle of the CFNFRB's establishment of local teams, as permitted in N.J.S.A. 9:6-8.91(a), was to enable local communities to learn from each child fatality and to assume ownership of developing prevention initiatives and strategies at the local and regional level.

The four Regional Teams continue to review cases that were formerly known or unknown to DYFS at the time of the fatal or near fatal incident and meet the established review criteria. The CFNFRB continues to review fatalities that are under DYFS supervision at the time of the fatal or near fatal incident. The CFNFRB established the following review priorities for the Regional Teams:

- Deaths due to maltreatment not under DYFS supervision;
- Deaths where the family received services from DYFS within the last 12 months;
- Suspicious deaths; and
- Sudden and unexplained deaths, including Sudden Infant Death Syndrome (SIDS).

The Department of Human Services provides professional staff support to the CFNFRB and its Regional Teams. Staff assures the CFNFRB and its Regional Teams have access to information required to conduct meaningful case review, maintains a running record of their respective activities and facilitates communication between the CFNFRB and the Regional Teams. The CFNFRB and its four (4) Regional Teams consist of volunteer members, and rely on staff to provide a variety of functions to support their activities.

In 2005, the Regional Teams continued to face challenges related to staffing, meeting attendance, diversity, and membership. The Central and Southern Regional Teams were only staffed from April through August due to staff changes. Therefore, they were not able to meet regularly. The CFNFRB reported in the 6/30/04 annual report that 146 fatalities had been reviewed, in 6/30/05 92 fatalities and near fatalities, and in 6/30/06 102 fatalities and near fatalities. The low number of cases reviewed in the last two years by these two Regional Teams as well as the CFNFRB is due in part to staffing.

Identifying a sufficient number of cases for the Northern and Central Regional Teams to review based on the NJ CCAPTA review criteria continues to be a challenge. However, in an effort to increase the number of cases reviewed by the Central and Northern Regional Teams, the CFNFRB has taken the redistribution of catchment areas for the Regional Teams under advisement.

Previous vacancies in local law enforcement and prosecutor representation on the Regional Teams have been filled. Each Regional Team now has the required

membership per NJ CCAPTA. Likewise, the CFNFRB, with the cooperation of the DHS Commissioner and the Attorney General, has filled public member vacancies and those in "hold over" status were reappointed.

Given the challenges associated with filling vacancies on the Regional Teams racial diversity has not been fully realized. The CFNFRB will consider asking the Regional Teams to develop a plan to actively recruit and achieve a meaningful level of racial diversity on each of the Regional Teams.

Administrative Reviews

During this review period the CFNFRB determined that certain case types may not warrant a full, in-depth review. The criteria for administrative review designation continue to be refined. However, the majority of cases that received an administrative review only in 2005 were cases that had active DYFS involvement and there were no allegations of child abuse or neglect related to the death. Generally, administrative reviews were conducted in incidents where the child was medically fragile and the death was expected. Unlike full reviews, the CFNFRB does not review related reports and records. Instead, the CFNFRB reviews a summary of the circumstances surrounding the death that is prepared by staff. Only the CFNFRB can determine if a case can receive an administrative review.

Homicides

The Board and regional Teams continue to face significant challenges in reviewing homicide cases as information is not readily obtainable from the Prosecutor, Medical Examiner or police when there is an active investigation. The CFNFRB, DHS Commissioner and Attorney General met to address this concern. The consensus was that the CFNFRB was entitled to obtain information on these cases at the point of discovery. The Attorney General agreed to address this at a Prosecutor's Association meeting. However, since the agreement was reached there has been a change of administration and a newly appointed Attorney General. In addition, it often takes more than a year to reach the point of discovery. The CFNFRB will decide how long it is willing to wait to review these cases, and consider exercising its subpoena power to obtain the information if necessary.

Perpetrator Unknown Cases

Eight cases were reviewed in which the investigation by the Prosecutor did not identify a perpetrator, despite the medical evidence and narrowing the possible perpetrator to two individuals in most cases. In one case, the CFNFRB had a prosecutor representative attend a meeting to discuss the medical evidence and its findings. As a direct result of the CFNFRB's involvement, the case is being actively pursued by law enforcement and in all likelihood there will be an indictment. The CFNFRB discussed this issue as well with the DHS Commissioner and Attorney General. There was consensus that forensic investigative practices may vary by county and that in some instances interviews may not be conducted per protocol or evidence secured as it should be. The Attorney General agreed to support training for investigators to be provided by the American Prosecutor's Research Institute, but to date this has not occurred.

Near Fatalities

Near Fatality means a serious or critical condition, as certified by a physician, in which a child suffers a permanent mental or physical impairment, a life-threatening injury or a condition that creates a probability of death within the foreseeable future. Nine near fatalities were reviewed during this reporting period. Clarification was provided by the CFNFRB to address issues raised by the Regional Teams with regard to how cases are identified and the purpose of the reviews. However, the CFNFRB will examine other alternatives to increase this pool since it believes there may be cases appropriate for review by the CFNFRB that are not reported to DYFS by hospital personnel.

National MCH Center for Child Death Review (Center)

The Center is part of the Michigan Public Health Institute. With the input of various states, the Center has developed a multi-state web-based Child Death Case Reporting System. To date approximately 12 states are participating in this project. Participation in this project will enable the CFNFRB to improve its understanding of child deaths in order to prevent harm to other children, and be consistent in how data is collected and reported. The CFNFRB has established a subcommittee to explore the possibility of participating in this project.

State Response Report

The New Jersey Department of Human Services (DHS) takes the lead in preparing the States' response to the recommendations of the Citizen Review Panels. The State response to the recommendations of the citizen review panels released on June 30, 2004 was due by December 30, 2004, but a response was not received until August 2005. The CFNFRB plans to review and discuss the response report, but anticipates in the future the response will be submitted within the timeframe prescribed by CCAPTA.

Citizen Review Panels

In 1996, the Federal Child Abuse Prevention and Treatment Act (CAPTA) was amended to direct states receiving the CAPTA Basic State Grant to submit a five-year State plan and establish citizen review panels to evaluate the extent to which the agencies are effectively discharging their child protection responsibilities.

In July 1997, the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA) was enacted to comply with Federal CAPTA amendments. The NJ CCAPTA required the Commissioner of the Department of Human Services (DHS) to designate citizen review panels composed of volunteer members who are broadly representative of the community, as well as members with expertise in the prevention and treatment of child abuse and neglect. Because the CFNFRB's mandate was largely contiguous with the citizen review panel responsibilities, the CFNFRB was asked to also function as a citizen review panel.

A CFNFRB and staff member attended the National Citizen Review Panel (CRP) Conference held in Nagshead, North Carolina sponsored by the University of Kentucky Training Resource Center, from May 25-27, 2005. New Jersey had the most

representation (6) of any state. Funding was provided by the New Jersey Task Force on Child Abuse and Neglect. .

Citizen Review Panel Rules and Regulations (N.J.A.C. 10:16A) were adopted on December 5, 2005.

On December 8, 2005, the Chairs of the three panels and staff met to discuss common issues and how to maximize resources. The Panels decided to pursue establishing a web site and develop a brochure, to conduct a survey or take testimony from the public at the annual Child Abuse Neglect conference in order to satisfy the public outreach requirement. Other issues involved staffing, the need for timely response to the CRP recommendations by the State, and the National CRP conference.

Community Education

In 2004, the CFNFRB recommended continuing to promote and endorse public awareness campaigns about situations of high risk to children which could lead to death such as unsafe sleep practices, SIDS, water hazards, and home risk prevention such as fire and infant safety awareness. On July 1, 2005, the CFNFRB, DHS Commissioner, Northeast Spa & Pool Association and the American Red Cross promoted water safety around swimming pools.

Child Fatalities and Near Fatalities Reviewed

The CFNFRB continues to utilize child fatality data from the Office of the State Medical Examiner (OSME) and the Division of Youth and Family Services (DYFS). The CFNFRB prioritizes cases for full review based upon elements of suspicion related to the cause of death and whether or not the child or the family was known to DYFS. Each child fatality case that is suspicious of child abuse or neglect is prioritized for a full review. Cases in this category are further stratified, based upon whether the family is known to the DYFS (either the child's case was under DYFS supervision at the time of death, or had been open sometime within the previous twelve months). The CFNFRB continues to review fatalities where the family had an open case with the DYFS at the time of the fatality, and the Regional Teams review fatalities that were either previously known or unknown to DYFS.

In September 2004, the CFNFRB began reviewing near fatalities. The CFNFRB defined a "Near Fatality" as follows: "near fatality means a serious or critical condition, as certified by a physician, in which a child suffers a permanent mental or physical impairment, a life-threatening injury or a condition that creates a probability of death within the foreseeable future." DYFS utilizes the same near fatality definition therefore; the CFNFRB began by reviewing the cases identified by DYFS as near fatalities. Open DYFS cases at the time of the near fatality are reviewed by the CFNFRB and all other near fatalities are reviewed by the Regional Teams.

DEATH CLASSIFICATION

Data on child fatalities in New Jersey due to all causes can be obtained from the New Jersey Department of Health and Senior Services, Center for Health Statistics on the internet at www.state.nj.us/health/chs. The following definitions are nationally recognized by medical examiners and health professionals, and are provided to assure consistent interpretation of data presented in the tables that follow:

CAUSE OF DEATH: Disease or injury, or its combination, which initiates the sequence of physiological derangement's resulting in death. Examples include: Myocardial Infarction, Acute Bronchopneumonia, and Cerebral Vascular Accident.

SUDDEN INFANT DEATH SYNDROME (SIDS): The sudden death of an infant, one year or younger, which is unexpected and after a thorough postmortem examination including an autopsy, death scene investigation, toxicology, and review of the infant and family's medical history, fails to identify a cause of death.

SUDDEN UNEXPLAINED DEATH IN CHILDHOOD (SUDC): The sudden death of a child, one year or older, which is unexpected and after a thorough postmortem examination including an autopsy, death scene investigation,

toxicology and review of the child and family's medical history, fails to identify an adequate cause of death.

MANNER OF DEATH: A classification based on the circumstances bringing about the proximate cause that resulted in a fatal outcome, which include:

- **NATURAL -** If the proximate cause is a natural disease process;
- **UNDETERMINED –** Is used when the information pointing to one manner of death is no more compelling than one or more competing manners of death in thorough consideration of all available information.
- **ACCIDENTAL -** If the agency is an unexpected unforeseen event;
- **SUICIDE -** If the agency was intentionally caused by the decedent. Intent can be implied through the decedent's actions unless it is an altruistic act; and
- **HOMICIDE -** If the event was brought on directly by the actions of another human with express or implied intent to cause a fatal or near fatal outcome; or one that ordinarily results in a fatal outcome or is a felonious action that can be causally related to the fatal outcome.

CASE DATA: FATALITIES

The following analysis is based on incidents of child fatality and near fatality that occurred from 2002 – 2004, and were reviewed by the CFNFRB or the Regional Teams in 2005. There were 93 child fatality cases reviewed by the Child Fatality and Near Fatality Review Board (CFNFRB) and Regional Teams during this review period (2005). Of the 93 child fatalities reviewed 73 occurred in 2004, 13 in 2003 and 7 in 2002.

Cases Reviewed By

	2005 Frequency	2005 Percent	2004 Frequency*	2004 Percent
Central	14	16.5	18	19.6
Child Fatality & Near Fatality Review Board	20	21.5	7	7.6
Metropolitan	26	28.0	22	23.9
Northern	21	22.6	23	25.0
Southern	12	12.9	22	23.9
Total	93	100.0	92	100.0

** Includes near fatalities*

Of the twenty fatalities reviewed by the CFNFRB, 11 received an “administrative” review. Ten of the administrative review cases were substantiated abuse/neglect

fatalities, seven (7) occurred in 2002, and 6 of them involved fatalities where either the mother and/or child tested positive for drugs, and/or the child subsequently died prematurely, due to low birth weight, or some other medical condition.

The first part of the analysis focuses on child fatality data. In some instances and where appropriate for comparison purposes, results from the analysis of 2004 have been included. A simple review of 2005 near fatality data will follow.

Of the four regions, the Metropolitan Regional Team reviewed the most cases (28%) with the Southern Regional Team reviewing the least number of cases (12.9%). The CFNFRB increased its percentage of cases reviewed from 7.6% in 2004 to 21.5% in 2005.

CPS Status at Time of Fatality

	2005 Frequency	2005 Percent	2004 Frequency*	2004 Percent
Closed Longer Than 12 Months	9	9.7	12	13.0
Closed within 12 Months	10	10.8	10	10.9
Open	29	31.2	9	9.8
Unknown	45	48.4	61	66.3
Total	93	100.0	92	100.0

About one fifth (20.5%) of the cases were closed (longer than and within 12 months), about on third (31.2%) were open and almost half (50%) were unknown at the time of the child fatality. In 2004, a much smaller percentage of cases were open (9.8%) and nearly two thirds (66.3%) of the cases were unknown.

CPS Findings

	Frequency	Percent
Substantiated/Perpetrator Confirmed	26	28.0
Substantiated/Perpetrator Unknown	3	3.2
N/A	64	68.8
Total	93	100.0

More than two thirds (68.8%) of the cases were recorded as not applicable (N/A) when case findings were determined because the abuse/neglect was not involved. Of the remaining twenty-nine (31.2%) cases, 90% (26 of 29) were substantiated child abuse or neglect with the perpetrator confirmed.

DEMOGRAPHIC DATA

Gender

	Frequency	Percent	2004 Percent	State Percent
Female	30	32.3	38.0	51.5
Male	63	67.7	62.0	48.5
Total	93	100.0	100.0	100.0

Race/Ethnicity

	2005 Frequency	2005 Percent	2004 Frequency	2004 Percent	State Percent	*State Percent: Under 18
White	36	38.7	29	31.5	72.6	66.8
African-American	36	38.7	42	45.7	13.6	16.4
Hispanic	14	15.1	11	12.0	13.3	16.2
Arabic/Asian	4	3.2	4	1.1		
Multiracial	3	3.2	1	4.3		
Unknown	---	---	1	1.1		
Not Identified	---	---	4	4.3		
Total	93	100.0	92	100.0		

** Percentage of State Population Under 18 (0-17)*

In 2005, two-thirds of the children were male, similar to the gender distribution of child fatalities in 2004. More than 90% (92.5%) of the children were white, black or Hispanic children. As with the results in 2004, the percentage of Hispanic children who were fatalities approximated the statewide percentage for the Hispanic population in New Jersey - 15.1% (2004) and 12.0% (2003) to 13.3% (statewide) - as well as the percentage of the Hispanic population under 18 years of age (16.2%). Although the percentage of African-American children declined from 45.7% to 38.7% - the same percentage as the fatalities for white children - it continued to represent a large overrepresentation in the fatality data with a percentage (38.7%), more than twice the percentage of African-American residents less than 18 years of age in the state (16.4%). The percentage of fatalities that were white children increased from 31.5% for 2004 to 38.7% for 2005.

Age at death

Fatality before one month

Age in Days	Frequency	Percent of All Fatalities
1	3	3.2
3	1	1.1
4	1	1.1
7	1	1.1
9	1	1.1
11	1	1.1
14	1	1.1
20	1	1.1
Total	10	10.8

Age at death

Fatality after one month/before the age of 1

Age in Months	Frequency	Percent of All Fatalities
1	12	12.9
2	12	12.9
3	4	4.3
4	5	5.4
5	1	1.1
6	2	2.2
8	1	1.1
11	1	1.1
Total	38	40.9

Age at death

Fatality after the age of 1

Age in Years	Frequency	Percent of All Fatalities
1 – 5	11	11.8
6 - 10	4	4.3
11 - 15	13	14.0
16 - 18	17	18.3
Total	45	48.4

Child fatalities that occurred before the age of one month represent 10.8% of the 93 reported child fatality cases. Of these 10 cases, 30% of the fatalities (3 of 10) were in the first day of life. This represents 3.2% of the total child fatalities for 2005.

Age at Death	Frequency	Percent
Before one month.	10	10.8
One month -- one year.	38	40.9
After one year	45	48.4
Total	93	100.0

Just over 40% (40.9%) of child fatalities occurred in the period of the child's life between one month and one year of age. Of these 38 fatalities, 63.2% (24 of 38) were children between the ages one and two months. This represents approximately 25% of the total child fatalities for 2005. Combined with the 10 fatalities for children under one month of age, 36.6% (34 of 93) of the total child fatalities were for children who were two months old or less at the time of death. Nearly half of the total child fatalities for 2005 were for children who died after the age of 1. The largest percentage of fatalities in this age group - 37% - was for 16-18 yr. olds. This represents more than 18% of the total child fatalities for 2005

Place of Injury: Municipality

Municipality	Frequency	Percent
Newark	9	9.7
Irvington	7	7.5
Jersey City	6	6.5
Linden	4	4.3
Atlantic City	3	3.2
East Orange	3	3.2
Piscataway	3	3.2
Elizabeth	2	2.2
Morristown	2	2.2
Asbury Park	2	2.2
Clifton	2	2.2
Lakewood	2	2.2
Magnolia	2	2.2
Paterson	2	2.2
44 Municipalities/One Fatality	44	46.2
Total	93	100.0

Child fatalities in the city of Newark accounted for 9.7% of the total child fatalities reviewed in 2005. Eleven municipalities with multiple fatalities (2-4) represented 29% of all fatalities reviewed. A single fatality in one municipality (44 fatalities) accounted for almost half (47.3%) of the reviewed child fatalities. Excluding the Newark, Irvington (7.5%) and Jersey City (6.4%) fatalities, 71 child fatalities (76.3 %) occurred in 55 different municipalities.

Approximately one fifth (19.3%) of the total child deaths reviewed in 2005 occurred in Essex County. Union (8.6%), Atlantic, Monmouth and Middlesex counties (each 7.5%) were the other most likely sites of child fatalities.

Place of Injury: County

County	Frequency	Percent	County % of State Population
Atlantic	7	7.5	3.0
Bergen	6	6.5	10.5
Burlington	2	2.2	5.0
Camden	4	4.3	6.1
Cape May	1	1.1	1.2
Essex	24	25.8	9.4
Hudson	6	6.5	7.2
Mercer	4	4.3	4.2
Middlesex	7	7.5	8.9
Monmouth	7	7.5	7.3
Morris	5	5.4	5.6
Ocean	5	5.4	6.1
Passaic	6	6.5	5.8
Sussex	1	1.1	1.7
Union	8	8.6	6.2
Total	93	100.0	

Cause of Death

Death Category	2005 Frequency	2005 Percent	2004 Frequency	2004 Percent
SIDS	22	23.6	28	32.2
Undetermined	15	16.1	11	12.6
Hanging	12	12.9	11	12.6
Medical Condition	11	11.8	6	6.9
Blunt Trauma	9	9.7	6	6.9
Drug Death	6	6.5	5	5.7
Gunshot Wound	5	5.4	3	3.4
Drowning	2	2.2	7	8.0
Asphyxia	2	2.2	4	4.6
Fire Deaths	2	2.2	4	4.6
Shaken Baby Syndrome	2	2.2	1	1.1
Sharp Force Injury	2	2.2	---	---
Child Neglect	1	1.1	---	---
Chemical Asphyxia	1	1.1	---	---
Gastroenteritis	1	1.1	---	---
Total	93	100.0	87	

** Information supplied by the Medical Examiner*

Generally, when comparing the categories for child fatalities between 2004 and 2005, there were few dramatic differences. The rate of incidence for those categories where the highest frequency of deaths were recorded (SIDS, undetermined, and hanging) were consistent with two exceptions. Medical Condition increased from 6.9% of the cases in 2004 cohort to 11.8% of the cases reviewed in the 2005 cohort. Drowning was a noticeably less common death category for the 2004 cohort when it accounted for 8.0% of the reviewed cases. It represented just 2.2% of the 2005 cases reviewed.

Manner of Death

	2005 Frequency	2005 Percent	2004 Frequency	2004 Percent
Accident	12	12.9	19	21.8
Homicide	18	19.4	9	10.3
Natural	35	37.6	35	40.2
Suicide	17	18.3	12	13.8
Undetermined	11	11.8	12	13.8
Total	93	100.0	87	100.0

From the child fatality recording periods of 2004 to 2005, there were two noticeable changes for Manner of Death. The category of Accident declined from 21.8% of the cases reviewed for 2004 to 12.9% of the cases reviewed in 2005. More dramatically, the incidence of Homicide as the Manner of Death, increased by 78% from 2004 to 2005, jumping from 10.3% to 19.4% of cases, as well as

Suicide (increased from 13.8% to 18.3%). Lesser change occurred for Undetermined (decreased from 13.8% to 11.8%).

Manner of Death X Gender

Manner of Death	Gender		Total
	Female	Male	
Accident	1	11	12
Homicide	5	13	18
Natural	15	21	36
Suicide	6	11	17
Undetermined	3	7	10
Total	30	63	93

A cross tabulation of the variables Manner of Death and Gender revealed several data patterns. As noted previously, the number of male fatalities more than doubled the number of female fatalities. Although Suicide and Undetermined were recorded as Manner of Death at a similar male/female ratio of approximately 2:1 (11:6 and 7:3, respectively), the category of Natural was used to record Manner of Death at a more equal rate by Gender (21:15) – females were more likely to fall into this category. Much of the overall difference in gender-related fatalities lies in the categories of Accident and Homicide. Ninety-two percent (11 of 12) of fatalities recorded as accidents were males. More than three quarters of the seventeen homicides (13 of 17 or 76.5%) were males.

Manner of Death X Case Reviewed By

Manner of Death	Reviewed By					Total
	Central	Child Fatality & Near Fatality Review Board	Metropolitan	Northern	Southern	
Accident	1	1	2	5	3	12
Homicide	4	7	3	1	3	17
Natural	4	9	16	6	1	36
Suicide	5	2	3	6	1	17
Undetermined	0	1	2	3	4	10
Total	14	20	26	21	12	93

Another relationship that was examined was between Manner of Death and what region (or the CFNFRB) reviewed the case (Case Reviewed By). Two relationships stand out, as can be seen in this cross tabulation. The Manner of Death – Natural – represents more than double the number of child fatality cases as any other designation. Thirty-six fatalities were recorded as Natural. No other Manner of Death accounted for more than 17 cases. The Metropolitan region reviewed 26 child fatalities for 2005, 28% of the total cases. No other region

reviewed more than 21 cases (22.6% of cases). Of those 26 reviewed cases in the Metro region, 16 of them (61.5%) were recorded as Natural. No other Manner of Death choice accounted for more than 45% of cases for a reviewer. The CFNFRB classified 45% (9 of 20) of its reviewed cases as Natural. In addition, the Metro region reviews were responsible for 44% of the cases (16 of 36) that were identified as Natural. No other Manner of Death was so frequently used by a reviewer.

Unsafe Sleep

	Frequency	Percent
Yes	25	26.9
No	68	73.1
Total	93	100.0

Unsafe Sleep Factors

	Frequency	Percent
Co-sleeping	9	9.7
Stomach	8	8.6
Side	3	3.2
Bedding	2	2.2
Other	3	3.3
N/A	68	73.1
Total	93	100.0

Unsafe Sleep Factors involve the practice of placing infants to sleep on their stomach instead of their backs, in beds with adults or older children (co-sleeping) instead of a crib or the use of inappropriate bedding such as pillows and comforters that can obstruct their airway.

There were 25 recorded cases of Unsafe Sleep as a factor in a child fatality. In 2005, twenty-five (27%) of the ninety-three fatalities and in 2004, fifty (34%) of the one hundred forty-six fatalities reviewed involved unsafe sleep practices. The factor of co-sleeping accounted for the most frequent incidents of Unsafe Sleep - 9 - which is 36% of all Unsafe Sleep cases.

Suicide

	Frequency	Percent
Yes	17	18.3
No	76	81.7
Total	93	100.0

Suicide Factors

	Frequency	Percent
Hanging	11	11.8
Gun	3	3.2
Nonprescription Drugs	1	1.1
Blunt Trauma	2	2.2
N/A (Not Suicide)	76	81.7
Total	93	100.0

Suicides include deaths where the child intentionally caused his or her death by self-inflicting injuries or otherwise inducing loss of life. Seventeen child fatalities during this review period (18.3%) were attributable to Suicide. In 11 instances

(65%), the suicide was the result of hanging. There were 26 suicide deaths statewide reported to the Medical Examiner during the same review period.

Homicide

	Frequency	Percent
Yes	18	19.3
No	75	80.7
Total	93	100.0

Homicide Factors

	Frequency	Percent
Blunt Trauma	6	6.4
Shaking/Impact	2	2.2
Shooting	2	2.2
Stabbing	2	2.2
Undetermined	2	2.2
Asphyxia	1	1.1
Chemical Asphyxia	1	1.1
Child Neglect	1	1.1
Drowning	1	1.1
N/A (Not Homicide)	75	80.6
Total	93	100.0

Homicide accounted for 18 child fatalities for 2005. Blunt Trauma represented more than 35% (6 of 18) of Homicides. The percentage of child fatalities - 19.3% - for Homicide was an increase over the 2004 results where 10.3% of deaths were due to Homicide in cases reviewed by the Board.

Alleged Perpetrator

Perpetrator	2005 Frequency	2005 Percent	2004 Frequency	2004 Percent
Mother	13	14.0	7	8.0
Father	5	5.9	8	9.2
Husband/Paramour	5	4.7	1	1.1
Stepmother	2	2.4	---	---
Daycare/Babysitter	---	---	1	1.1
Other Relative	---	---	3	3.4
Unknown	4	4.3	---	---
Not Identified	64	81.2	67	77.0
Total	93	100.0	87	100.0

In the 2005 cohort of cases reviewed, in thirteen cases, nearly 45% of cases where an alleged perpetrator was identified, the mother of the deceased child was identified as the alleged perpetrator. For the 2004 cohort of cases reviewed, no one category of Perpetrator was dominant. Father (9.2%) and Mother (8.0%) were the most frequently identified alleged perpetrators.

CHILD MALTREATMENT FATALITIES

This category of cases includes deaths where the alleged perpetrator of the child maltreatment was the child's caregiver. Maltreatment fatalities can be found throughout the categories under Manner or Cause of Death, but are not categorized separately as maltreatment in other governmental reporting systems. For example, in a drowning death, "Drowning" would be the cause and the manner could be categorized as "Accidental" by a Medical Examiner. If there was lack of supervision on the part of a caregiver, the Division of Youth and Family Services would substantiate neglect. Maltreatment includes physical and sexual abuse, physical neglect, and medical neglect. Fatal injuries inflicted upon children by a person other than a caregiver are categorized under homicides. This child maltreatment category also includes infants that were exposed to drugs or alcohol during gestation and tested positive for these drugs at birth and where the mother tested positive or admitted to drug use.

In 2004, DYFS substantiated abuse/neglect in twenty-five (25) fatalities and identified 7 near fatalities. Twelve (12) of the fatalities and 3 of the near fatalities were reviewed. In 2006, the CFNFRB will review the remaining cases in addition to the 2005 fatalities and near fatalities.

In total, thirty-eight (38) fatalities and near fatalities involving allegations of abuse/neglect were reviewed during this reporting period. This included the remaining 2002 fatalities. The perpetrator was confirmed in twenty-nine (29) and unconfirmed in nine (9). Of the thirty-eight, twenty-one (21) were open with DYFS, 10 were not known to DYFS, 4 were closed within 12 months, and 3 had been closed longer than twelve months prior to the fatality or near fatality.

Of the twenty-nine confirmed cases, twenty-six (26) were fatalities and 3 were near fatalities. The Medical Examiner certified the Manner of Death "Homicide" in 14 of the fatalities, "Natural" in 7, "Accident" in 3 and "Natural" in 2. The tables below provide additional information on the twenty-nine cases where the perpetrator was confirmed. This does not include the history of the parent/caretaker as a child.

Age of Victim

Age of Victim	**Count**
Under 1 year	**13**
1-5 years	**9**
6-12 years	**4**
13-17 years	**3**
Total	**29**

Race of Victim

Race of Victim	Count
Black	**13**
White	**7**
Hispanic	**4**
Interracial	**2**
Arabic	**2**
Total	**29**

Gender of Victim

Gender of Victim	Count
Male	**22**
Female	**7**
Total	**29**

CPS History of Victim /Family

CPS History of Victim /Family	Count
Open Case	**18**
None	**5**
Prior Involvement	**6**
Total	**29**

Perpetrator's Relationship to Victim

Perpetrator's Relationship to Victim	Count
Mother	**12**
Father	**5**
Parent's Paramour	**5**
Unknown	**4**
Step Mother	**2**
Other Relative	**1**
Total	**29**

Disagreement with Cause of Death

	2005 Frequency	2005 Percent	2004 Frequency	2004 Percent
Yes	6	6.5	6	6.9
No	87	93.5	81	93.1
Total	93	100.0	87	100.0

There was no change in the degree of disagreement in 2005 regarding the determination of cause of death when compared to 2004.

The CFNFRB and Regional Teams determined that almost half (49.5%) of the total child fatalities reviewed from the 2005 cohort were definitely preventable (22.6%) or probably preventable (26.9%). In 2005, the cases ranged from infants that were substance exposed to children that drowned or died in a fire, and youth that had access to firearms and licit or illicit drugs. This represents an increase over the results for the cases reviewed from the 2004 cohort where 47.1% of the cases were similarly judged. The results for 2004 and 2005 differ markedly in two other categories – cases which were judged as probably not preventable and those where this factor could not be determined. For 2004, a large percent of cases reviewed (46%) were judged as probably not preventable. This percent decreased dramatically to 17.2% for 2005. However, the percent of cases where this judgment could not be determined sharply increased from 6.9% for 2004 cases reviewed to 33.3% in the 2005 cases reviewed.

Death Preventable

	2005 Frequency	2005 Percent	2004 Frequency	2004 Percent
Definitely Could Have Been Prevented	21	22.6	23	26.4
Probably Could Have Been Prevented	25	26.9	18	20.7
Probably Not Preventable	16	17.2	40	46.0
Cannot Be Determined	31	33.3	6	6.9
Total	93	100.0	87	100.0

The cross tabulation below (next page) examines the relationship between judgments regarding to what degree the death was perceived as preventable and the region (or CFNFRB) who reviewed the case. Generally, there are few differences between the reviewing regions judgments about preventing the death. However, both the Metropolitan and Northern regions demonstrated a high frequency of judgments that the possibility of preventing the child fatality *could not be determined*. More than half of the cases in the Metropolitan region (54%) and the Northern region (52%) fell into this category. Of the 31 child fatalities where the chances of preventing the death *could not be determined,* 81% (25 of 31) were from child fatality cases that were reviewed by either the Metropolitan region or the Northern region. The two remaining regions and the CFNFRB were more likely to reach a determination regarding preventability of the incident.

Degree Preventable X Race

To what degree was the death preventable	Race					Total
	Arabic/Asian	Multiracial	Black	Hispanic	White	
Definitely Could Have Been Prevented	0	1	8	1	11	21
Probably Could Have Been Prevented	0	1	6	3	15	25
Probably Not Preventable	3	0	6	4	3	16
Cannot Be Determined	1	1	16	6	7	31
Total	4	3	36	14	36	93

CASE DATA: NEAR FATALITIES

During the 2005 review period, a total of nine child near-fatalities were identified and reviewed compared to five in 2004. This small number of cases precludes anything other than some simple frequency tables. These tables follow below.

Case Reviewed By

	Frequency	Percent
Central	2	22.2
CFNFRB	2	22.2
Metropolitan	1	11.1
Northern	2	22.2
Southern	2	22.2
Total	9	100.0

Race X Gender

Race	Gender		Total
	Female	Male	
Black	2	1	3
White	1	2	3
Asian/Viet	1	0	1
Multicultural	0	1	1
Hispanic	1	0	1
Total	5	4	9

Gender

	Frequency	Percent
Female	5	55.6
Male	4	44.4
Total	9	100.0

County- Place of Injury

	Frequency	Percent
Camden	1	11.1
Cumberland	1	11.1
Essex	1	11.1
Hudson	1	11.1
Middlesex	1	11.1
Monmouth	1	11.1
Morris	1	11.1
Ocean	1	11.1
Union	1	11.1
Total	9	100.0

Race

	Frequency	Percent
White	3	33.3
Black	3	33.3
Asian/Viet	1	11.1
Multicultural	1	11.1
Hispanic	1	11.1
Total	9	100.0

Case Findings

	Frequency	Percent
Substantiated/Perpetrator Confirmed	5	55.6
Substantiated/Perpetrator Unconfirmed	1	11.1
Not Identified	3	33.3
Total	9	100.0

Alleged Perpetrator

	Frequency	Percent
Mother	4	44.44
Family friend	1	11.1
Paramour/Husband	2	22.2
Other Relative	1	11.1
Unknown	1	11.1
Total	9	100.0

Recommendations

Various themes were identified as a result of the reviews. The following recommendations are made in an effort to improve practice and prevent such incidents from occurring in the future.

Suicide Deaths

- The CFNFRB recommends that school staff, students, parents, police, DYFS staff and others who interact with teenagers need continuing education on the signs of depression and services that are available, as well as more thorough awareness of the impact of phenomena in the lives of adolescents which, while appearing insignificant to adults, might trigger thoughts of helplessness, hopelessness, or despair in adolescents.
- The CFNFRB recommends that the Department of Education expand publicizing the State resources to school districts as well as prevention efforts.
- The CFNFRB recommends that the Department of Education expand its substance abuse education program to include information on the correlation between substance abuse, depression and suicidal behavior.
- The CFNFRB recommends that the Office of the Attorney General develop an education campaign on the dangers related to maintaining fire arms in the home and effective measures to secure them.

Safe Sleep

- The CFNFRB recommends the Department of Human Services, NJ Task Force on Child Abuse and Neglect, Division of Prevention and Community Partnerships, SIDS Center of New Jersey and the New Jersey Hospitals Association continue a Statewide Safe Sleep campaign.
- The CFNFRB recommends the education of parents and other caregivers on Safe Sleep practices by hospital staff in newborn units and by pediatricians at well-baby visits.
- The CFNFRB recommends the NJ Task Force on Child Abuse and Neglect continue supporting/expanding EPIC SCAN and Practicing Safety efforts programs.
- The CFNFRB recommends a partnership between the American Academy of Pediatrics and the Association for the Advancement of Retired Persons to educate grandparents on Safe Sleep practices.

Medical Examiner System

- The CFNFRB continues to strongly recommend the immediate need for the Office of the Attorney General to give the Office of the State Medical

Examiner the necessary additional authority to improve County Medical Examiner offices.

- The CFNFRB recommends the State Medical Examiner continue reinforcing compliance with the American College of Radiology standard for autopsies in children.

- The CFNFRB recommends the State Medical Examiner implement the investigative protocol for evaluation of child deaths under the age of three recommended by the Death Scene Investigation Subcommittee of the Sudden Child Death Autopsy Protocol Committee. The protocol consists of three sections for utilization by the medical examiner including sections for Emergency Medical Services, Medical Examiner offices and the SIDS Resource Center of New Jersey. This approach will provide a very extensive understanding of the circumstances involved in these types of cases.

Division of Youth and Family Services

- The CFNFRB recommends that DYFS expand its safety and risk assessments to better weigh a prior history of DYFS referrals in current investigations.

- The CFNFRB recommends DYFS reinforce with its staff the importance of identifying and completing background checks on all adults living in the home or who frequent the home.

- The CFNFRB recommends DYFS reinforce with its staff the importance of collateral contacts (with the caller, etc.) in gathering/corroborating information.

- The CFNFRB recommends DYFS establish as protocol requiring the referral of all cases of alleged sexual abuse and near fatalities to the Regional Diagnostic and Treatment Centers (RDTC).

- The CFNFRB recommends the DYFS Office of Program Operations provide the CFNFRB with reports (at least quarterly) on substantiated abuse/neglect fatalities and near fatalities.

- The CFNFRB recommends DYFS incorporate into its training curriculum information on safe sleep practices for all direct service staff.

Department of Human Services

- The CFNFRB recommends the Department of Human Services submit a timely response to the recommendations of the Board.

- The CFNFRB recommends the Department of Human Services continue to provide State funding and staffing to support the activities of the citizen review panels.
- The CFNFRB recommends the Department of Human Services Commissioner arrange a meeting between the CFNFRB and the Attorney General to discuss addressing at a Prosecutor's Association meeting the issue of releasing information on homicide fatalities and near fatalities to the CFNFRB, and follow through on child abuse investigation training for law enforcement investigators by the American Prosecutor's Research Institute.

- The CFNFRB recommends the Department of Human Services and the Office of the Attorney General partner to conduct a statewide public awareness campaign on the dangers (such as fires) of leaving children home alone.

- The CFNFRB recommends the Department of Human Services continue its annual "Hot Cars" campaign to educate the public about the dangers of leaving children alone in a locked car during the hot summer months, and broaden the campaign to address the dangers of children being allowed to enter into or remain unattended in cars or other similar places which they may not be able to evacuate in an emergency, on account of immaturity, disability, etc.

Cross Cutting Systemic Recommendations

- The CFNFRB recognizes the efforts by the Department of Human Services to develop a cohesive child welfare reform plan. It is also clear that during the planning process communication and collaboration among the Department of Human Services, Office of Children's Services and its Division of Youth and Family Services, Child Behavioral Health Services and Division of Prevention and Community Partnerships, and the Department of Health and Senior Services and the Juvenile Justice Commission has been less than optimal. This has resulted in incomplete child fatality investigations and limited interventions by secondary and tertiary prevention programs. Therefore, the CFNFRB recommends the Department of Human Services increases the number of intergovernmental stakeholders in its planning process.

- The CFNFRB recommends the Office of the Attorney General and the Department of Human Services partner to educate and train first responders (Police, EMT's, ME Investigators) on contacting SCR, per DYFS policy, in child deaths where there is a surviving sibling, or other children in the home. It is further recommended that, as part of interdepartmental training between the Office of the Attorney General and

Division of Youth and Family Services, educating or reinforcing the practice of police and DYFS investigators interviewing children separately and alone, not in the presence of their parents or caregivers while conducting a child abuse investigation.

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