New Jersey Office of the Child Advocate

Dr. E. Susan Hodgson, Child Advocate

Child Fatality Investigation Review

May 23, 2007

XAVIER JONES

OFFICE OF THE CHILD ADVOCATE
E. Susan Hodgson, M.D., Child Advocate
Joseph Suozzo, Esq., 1st Assistant
Teri Appelson, Esq., Chief Counsel
Maria McGowan, Dep. Director of Welfare and Health Policy Monitoring
Tiffany Ellis, Chief of Staff
Gianine Christiano, Senior Child Advocate
Alison Zuvich, Assistant Child Advocate

TABLE OF CONTENTS

INTRODUCTION

The independent Office of the Child Advocate (OCA) was created by statute on September 26, 2003. Public Law 2005, c.155 enables the Office of the Child Advocate to investigate, review, monitor and evaluate State agency responses to allegations of child abuse or neglect in New Jersey and make recommendations for systemic and comprehensive reform.

Since its inception, the OCA has reviewed child fatalaties due to abuse and neglect and has made recommendations resulting from fatality reviews to the Department of Children and Families' (DCF) Division of Youth and Family Services (DYFS) and other involved state systems.

Since December 2006, the Child Advocate has held a seat on the statewide Child Fatality and Near Fatality Review Board. Additionally, members of the OCA staff sit on each of the four Regional Fatality Review Teams.

Through these roles and other processes, the OCA will continue to independently review selected deaths of children who died while under the care of DYFS or who had a previously open DYFS case. Recommendations resulting from these reviews will continue to be made to involved state agencies.

In each review the OCA will focus on a few major questions:

- Was this a preventable death?
- Did the child welfare system fail in its mission to protect the child?
- Are there identified areas of concern in the prevision of and access to health services that need improvement?
- Were there systems deficiencies or issues, such as poor record keeping and insufficient documentation, that contributed to this fatality?

By attempting to answer these questions, the OCA hopes to identify deficiencies in systems, which if corrected, could prevent these untimely deaths.

Each report will focus on issues that contributed to the child's death and will provide recommendations and opportunities for systems improvement based on those concerns. An annual report summarizing those concerns and recommendations will attempt to identify trends and significant systems areas in need of discussion and improvement.

Upon releasing its recommendations, the OCA will initiate further collaborative efforts with the DCF and other involved parties to create lasting change and improvement.

The following review of the death of Xavier Jones is the first review from 2006.

Name: Xavier Jones

Date of Birth: 9/8/04

Date of Death: 6/7/06

Age: 21 months

Gender: Male

Summary of Death

Xavier Jones died on June 7, 2006 from complications resulting from an ingestion of methadone while in non-relative, resource family home care. He was a 21 month old African American child. Reportedly, early in the evening on June 3, 2006, Xavier found the methadone in a closet in the resource family home. The methadone was prescribed for the biological daughter of the resource parent. Xavier did not receive medical attention at the time symptoms of his methadone ingestion were detected. There is no evidence in the investigation records that the resource family ever tried to call poison control. By report, he received home treatment with an emetic and a suppository after his ingestion. He vomited and was then allowed to sleep. As expected after an opiate ingestion, he began to have depressed respirations and apnea (irregular breathing). He had a respiratory arrest while in the resource home and received some mouth to mouth CPR from an adult in the resource home and perhaps on the way to the hospital in the car.

Investigation notes indicate that Xavier had difficulty breathing and showed other symptoms at approximately 9:00 pm on June 3, 2006. EMS records show that there was an abandoned call from the resource home at 10:25 pm on June 3, 2006. His resource parent proceeded to take Xavier to the Columbus Hospital ER in her own vehicle where they arrived at 10:35 pm. At the time Xavier was admitted to the Columbus Hospital Emergency Room (ER) he had no pulse and no respirations.

Further resuscitation occurred in the Columbus Hospital ER, and the child was transferred via EMS transport to the Pediatric Intensive Care Unit at Newark Beth Israel Children's Hospital where he remained a patient until his death. On June 7, 2006, Xavier Jones was declared brain dead by neurological protocol and was removed from life support.

On June 6, 2006 the other foster children in the resource home were removed and placed in alternative settings. Neglect was substantiated against the resource parent by the DCF Institutional Abuse Investigation Unit (IAIU). The resource home was subsequently closed. The Essex County Medical Examiner called this child's Manner of Death a homicide. Discussion with the Essex County Assistant Prosecutor and others in the Prosecutor's Office between March

2007 and May 2007 indicates that the Prosecutor's Office is still weighing its decision as to whether to move forward with criminal charges.

This report focuses on issues that contributed to Xavier Jones' untimely death:

- Xavier Jones died because of delayed medical care after the discovery of his ingestion.

- Xavier Jones died from ingesting methadone that was prescribed for an adult who was spending significant amounts of time in the resource home and who frequently assisted with the care of the children living in the resource home.[1] This methadone dependent adult was assisting with the care of children in the resource home without clearance from DYFS.

- Xavier Jones was not under the direct supervision of his resource parent at the time he ingested the methadone.

- The methadone was not stored in a proper locked cabinet, even though this home had the capability for proper "storage of toxic substances" and "safety latches on cabinets and closets" as documented in a May 12, 2006 DCF Office of Licensing, annual licensing inspection report.

As the narrative summary winds through Xavier's life, and death, it also will focus on other systems and case-handling issues which presented both barriers to his care and risks to his well-being.

BACKGROUND

Materials Reviewed

The materials reviewed which have been used for this report are listed in the Annotated Appendix. All materials reviewed were received by the OCA by May 14, 2007.

[1] The DYFS caseworker's entry of May 23, 2006, documenting a Monthly Visitation Requirement, states that the resource parent "informed worker that her two daughters, J.S. and T.C., comes *(sic)* to her home on a regular basis to assist her." According to the DYFS Field Operations Casework Policy and Procedures Manual, "Intervals for Assessing Child Safety in Family-Based Substitute Care Settings," a caseworker shall "if the substitute care provider/foster parent has a significant other who frequents the home, obtain full details and identifying information" as "DYFS will want to meet this person, run checks on his or her name, and take action, as necessary, to assure that he or she does not pose a threat to the safety of the children placed there by DYFS." In this particular resource family constellation, the resource parent's adult daughter, J.S., was a significant member of the resource parent's home.

Division of Youth and Family Services Involvement:

Numerous DYFS field staff were involved with Xavier Jones' case and with the resource home. Following is a summary of the individuals responsible for management of each:

Division Local Office: Union County East Local Office (Cranford, NJ): Some of the DYFS case notes designate this office as the Union East Local Office, some as the Union Central Office, and some as the Union West Office. Both Xavier Jones and his older brother's DYFS cases remained with the same local office in Union County.

Case workers: J.O. was the designated worker from 2004 until April 2006. J.O. received some assistance from worker T.T. from 2004-2006. By May 2006 a new case worker, M.S., had been assigned to Xavier Jones' case and made her first monthly visit (MVR) to the resource family home on May 23, 2006.

Supervisors: J.K. 2004-2006, with some coverage from supervisor F.D. in 2004-2006. In 2006 some coverage by J.L; new supervisor P.R assigned by June 2006. Based on the documents received by the OCA, there were no case transfer summary notes between DYFS supervisors or completed DYFS forms formally documenting case transfer for any period of transition between new workers or supervisors. No documentation of case conferences between supervisory and case work staff were provided in the materials sent to the OCA.

Resource Family Unit: East Orange Local Office

Case workers/Supervisors: At least 23 different resource family unit staff interacted with Xavier's resource parent and placed children in her home between November 1996 and June 2006. Four different resource family unit supervisors were involved.[2]

Institutional Abuse Investigational Unit (IAIU):

C.T., Chief of Investigations for IAIU, issued a Findings Letter dated January 1, 2007 to the Western Essex Central Local Office. The IAIU Findings Letter was issued almost seven months after Xavier Jones' death.[3]

[2] The records clearly indicate that numerous staff from the Resource Family DYFS office were involved with Xavier Jones' resource parent over the years that her home was a licensed DYFS resource family home, authorized to have five children in placement at one time. Her home was initially licensed in 1996.

[3] DCF advised the OCA that the IAIU findings letter was held at the request of the Essex County Prosecutor's Office based on the fact that the Prosecutor's Office maintained an open investigation.

FAMILY CONSTELLATIONS:

Biological Family:

Biological Mother: Identified in this report as T.J (d.o.b. 1/16/84).

Biological Father: Identified in this report as D.P. (d.o.b. 9/4/84), D.P. was father to both Xavier Jones and to Xavier's older brother. Although D.P. did not live with T.J. and his children, he was involved with some of their care and visited them between the time of the births of his sons until 2005. By the time of the adoption permanancy hearing in 2005 D.P. was no longer involved.

Xavier Jones: (d.o.b. 9/8/04). Xavier was born a healthy, full term infant.

Brother: Identified in this report as tj (d.o.b. 4/17/03), tj was born when his mother was 19 years old. He remained in the nursery after birth from 4/17/03-5/12/03, when he was discharged home to his mother. He was born a 35 week premature infant.

Maternal Grandmother's Home:

For a short period after his birth, Xavier Jones, his mother, and his brother lived in the home of the boys' maternal grandmother, L.J. The maternal grandmother's family faced some significant challenges. There was an open DYFS case involving the maternal grandmother during the time Xavier Jones, his older brother and his mother, TJ, lived in the maternal grandmother's home.Six other maternal siblings ranging in age from 10-21 years old also lived in the home. In-home services contracted by DYFS were in place for at least two of the teen-age siblings.

Xavier Jones and his older brother, tj, were removed for good cause. They were placed together in an emergency resource family home from October 26-28, 2004. Then they were placed in separate, non-relative, resource family homes on October 28, 2004.

Maternal Grandmother: Identified in this report as maternal grandmother or L.J. (d.o.b. 7/29/65)

L.J.'s Husband: Identified in this report as K.M. (d.o.b. 2/26/65).

Xavier's Resource Parent: Identified in this report as J.H.

NARRATIVE SUMMARY: XAVIER JONES' LIFE AND DEATH

DYFS's involvement with Xavier Jones' mother and older brother began a few weeks prior to Xavier Jones' birth. DYFS was contacted on August 10, 2004, when a medical provider treating tj was concerned that tj's mother was not able to purchase the medications and bandages needed to care for injuries the child had recieved. On August 10, 2004, DYFS opened the case for services and substantiated lack of supervision against the birth mother for the injuries the child received while in her care.

DYFS placed services in the home shortly after their initial home evaluation following the August 10, 2004 referral. Around the clock in-home services through a DYFS contracted agency were provided. DYFS worked with the birth mother and maternal grandmother to provide follow up support services for the family. The birth father of tj and Xavier was also contacted and asked to participate in services. The initial case service plan was to have T.J. supervised at all times either by in-home service providers or by the maternal grandmother while caring for tj.

On September 8, 2004, Xavier Jones was born. He was a healthy 6 lb 8 oz. full term infant. His mother was 20 years old at the time of his birth. His mother started prenatal care late, after 5 months of pregnancy. Xavier and his mother remained in the hospital from September 8-11, 2004. Xavier had no medical complications at the time of birth or while he remained in the nursery.[4] The clinicians determined there were appropriate resources and support available for T.J. and Xavier to be discharged to the maternal grandmother's home. A Visiting Nurse Association (VNA) referral was made for follow up though there is no indication that a VNA visit ever occurred.

Xavier Jones had three appropriately timed visits with his pediatrician while he lived with his mother between September 8, 2004 to October 26, 2004. There was no indication of abuse or neglect at any of these visits. A pre-placement physical was provided on October 26, 2004 by his pediatrician when he and tj were placed into resource family care. This was an appropriately completed pre-placement physical and represented "best practices" whereby DYFS sought a pre-placement physical from the clinician who had been caring for these two children.[5]

Meanwhile, between August 10, 2004 and mid October 2004, the DYFS caseworker had been visiting the maternal grandmother's home and was collaborating with in-home service providers. The older brother, tj, was receiving follow up care for his injuries. The DYFS worker did a very thorough job in working with T.J. and the maternal grandmother in enrolling T.J. with some other services.

However, during a home visit in mid-October 2004, the worker discovered concerns around the birth mother's care of t.j. and the level of supervision that was occurring in the home. DYFS

---

[4] Xavier's state metabolic screening results were normal; he passed his newborn hearing screening. Records reflect he had no problems with bottle feeding. He had no neonatal jaundice.

[5] DYFS policy and child welfare best practice guidelines support the utilization of the child's health care provider whenever possible to conduct pre-placement health examinations prior to out of home placement.

became appropriately concerned regarding the family's compliance with the safety plan that had been implemented and in the ongoing care and supervision of tj.

For good cause, DYFS removed Xavier and tj, and placed them in emergency, non-relative, resource family care from October 26-28, 2004. No appropriate relative resource home could be found for either child. DYFS records indicate tj was in four different resource home settings before he was adopted by his final resource family. Xavier Jones was placed in J.H.'s resource family home on October 28, 2004. J.H. was interested in adopting Xavier should his permanency plan result in termination of parental rights. Xavier remained until his fatal ingestion of methadone on June 3, 2006.

Xavier Jones' Resource Family Home:

J.H. had been a licensed resource family home for DYFS since November 1996. Her home was licensed for up to five children. J.H.was a single parent during the time she provided resource family care. She also worked full time in her own business, running a beauty salon. The record reflects that on many occasions she stated to DYFS that she wished to care for children on a long term basis, and preferred to have boys since she already had one adopted son (who was almost 10 years old at the time of Xavier's death) and a teenage grandson whom she had been raising since birth. J.H.'s resource home was not a Special Home Service Provider (SHSP) resource home. DYFS records reveal that J.H. provided rather long term care for some developmentally challenged children.[6] In addition, DYFS regularly used J.H.'s resource home for emergency overnight and short term vacation placements for foster children, who frequently were in emotional crisis, and who frequently had significant behavioral issues. Indeed, between 1999 and May 2006, J.H. had cared for over 50 foster children. While Xavier was in her home she cared for 17 additional children at different times

J.H. had faced some family challenges prior to becoming a resource parent. She was personally involved with DYFS twice in her family's past when she became the supervisory custodian for her two grandsons, both of whom had been born drug exposed. She had raised her eldest grandson, who was still living in her home and was 19 years old at the time of Xavier's death. In 1999, J.H.'s eldest daughter, T.M., was living with J.H. DYFS found concerns as a result of T.M.'s background check, and would not issue a waiver[7] to allow her to continue to live in J.H.'s home along with the children in placement. DYFS records reflect that J.H.'s eldest daughter moved out of J.H.'s home as of June 6, 2000.

---

[6] During the time Xavier was in her home she had also cared for an autistic child, another female child with global developmental delays, incontinence and soiling, and was caring for her adopted son who was diagnosed with Attention Deficit Hyperactovotu Disorder (ADHD).

[7] During this period of time, DYFS policy required a waiver from the DYFS Assistant Director of Program Operations for foster homes or foster parent applicants when previous DYFS history was identified and/or criminal history checks revealed a conviction of a household member. Other situations, such as the presence of an adult in the home with a substance use issue, were also required to be reviewed by the DYFS Assistant Director in order for the home to be utilized or to remain open to placements.

In the spring of 2004, J.H.'s younger adult daughter, J.S., and J.S.'s 7 year old son came to live with J.H.. DYFS background checks on J.S. also raised concerns. The DYFS Resource Family Unit asked J.S. to document completion of a drug treatment program prior to DYFS' issuing a waiver to allow her and her son to live with J.H.. J.S. never provided DYFS with the requested documentation. By August 2004, DYFS Resource Unit records document that J.H. had called DYFS to inform them that J.S. and her son had moved out of the home.

During the time J.H. was a resource parent, there were two IAIU investigations of her home for allegations of corporal punishment with the children in her care.[8] There were no further IAIU referrals until the referral on June 3, 2006 when Xavier Jones ingested methadone.

On June 3, 2006, there were six unit dose bottles of methadone stored in the resource family home. One vial was empty, having been taken by J.S. just prior to storage of the box in the resource home. J.S. was managing her addiction problem through a methadone program.

Although a home visit was made on May 23, 2006 by a newly assigned caseworker, no documentation of a case transfer summary was completed before that date by the former caseworker/supervisor. Additionally, there is no record that a risk assessment was completed on other identified adult caregivers who frequented this resource home.

Xavier Jones' Medical Care while in his Resource Home

On June 7, 2005, when Xavier Jones was nine months of age, he was seen for a neuro-developmental evaluation at Children's Specialized Hospital. He was accompanied to this evaluation by J.H., his resource parent. No background medical information was provided to the evaluators by DYFS or by the resource parent. Xavier had been attending day care five days a week since his placement into resource care. By report, the daycare providers apparently had no concerns about his development. His physical exam revealed a right undescended testicle, and the clinicians at Children's Specialized Hospital recommended to the resource parent that this needed to be repaired and referred Xavier to pediatric surgery at Newark Beth Israel Children's Hospital. Xavier also was noted to have a small umbilical (belly button) hernia, which they recommended just needed monitoring by his primary care physician. His growth parameters were proportional, with weight at 50%, height at 90% and head circumfrence at 75%. No previous growth chart was sent for comparison. His developmental screening was normal in all parameters. He needed no referral at this point to Early Intervention or to any other services. They recommended that he continue to attend daycare.

Injuries while in the resource home: Review of DYFS, daycare center, and ER records indicate that Xavier had two minor injuries during the time he was in resource family placement:

1) On February 21, 2006, daycare records noted that Xavier fell off his chair while eating lunch and that he suffered a small laceration to the side of his eye from bumping the edge

[8] In 1998 unsubstantiated with concerns; in 2002 (with a different child) unsubstantiated with concerns. In 2000, J.H. was referred to Family Connections parent support services and completed an improvement plan for avoiding corporal punishment and for learning different types of discipline for children.

of a crib as he fell. His resource parent was notified immediately and took him to the ER where he had sutures. He was to have follow up with his pediatrician in 48 hours. There are no records to indicate whether he had that follow up visit. This was a documented minor accidental injury.

2) DYFS records contained two notations of another injury which may have been due to lack of appropriate supervision of Xavier while in his resource home. The DYFS record contains a one page handwritten note dated February 17, 2006 from his resource parent indicating that on or around that date, Xavier pulled a hot iron off of an ironing board and that he had a grazed "red line" on his cheek from the hot iron. This mild burn was treated at home by his resource home parent.[9] The note indicates that her son had been ironing when Xavier was present and that Xavier pulled the iron off the board.

   It seems that this second injury was also a minor injury but may have resulted from inappropriate supervision of a toddler. There is no notation in the DYFS case record of any case conferencing, formal investigation or home visit that occurred around the time of Xavier's iron burn.

Comprehensive Healthcare Evaluation of Children (CHEC) Exam

On April 17, 2006, both tj and Xavier Jones were seen for their foster care CHEC exams at the Metro Regional Diagnostic and Treatment Center. Both boys were at the CHEC site at the same time; both boys were accompanied to their evaluations by their respective resource parents. They had been referred for these evaluations in October 2004; exams were finally scheduled on February 1, 2006. At the time the boys were seen no medical records, past lab results, growth charts, hospitalization or ER records, or Early Intervention records had been provided to the CHEC evaluators by DYFS although such records had been requested by the CHEC site prior to the evaluations.

Xavier was in good health at the time of his CHEC exam. He was then 19 months old. His right undescended testicle remained untreated. CHEC medical providers documented that Xavier's undescended testicle finally had been scheduled for repair at Newark Beth Israel on May 6, 2006. He had a small asymptomatic umbilical hernia which could just be observed and would probably resolve on its own. The resource parent mentioned that Xavier had had some wheezing and that Xavier had needed some intermittent treatments with bronchodilators given by nebulizer machine. His developmental screening was normal in all parameters. His immunizations were delayed and were brought up to date at the CHEC exam. There is no notation of past results of lead and anemia screening. No lab work was done at the CHEC exam.

Final CHEC reports were sent to DYFS on June 7, 2006. DYFS records sent to the OCA for review did not contain the CHEC reports on either Xavier Jones or his brother.

[9] The DYFS record sent to the OCA for review also contains a first page only sheet of a DYFS 11-2 Pre-placement Exam form dated February 27, 2006, done by some unidentified clinical provider and at some unidentified location, which notes laceration to eye and "burn on (rt) [right] cheek (iron)...red line."

Investigation of Xavier Jones' Ingestion and Death

Medical Examiner's Report: Final Report dated July 21, 2006.
Cause of death: Complications of acute methadone intoxication.
Manner of death: Homicide.
The child had been determined to be brain dead by neurological criteria in the hospital.
Premortem samples of urine and bile revealed methadone and methadone metabolites.
Date that samples were received : June 7, 2006, date of death.

Autopsy indicated that Xavier had undergone surgical repair of his right undescended testicle.

A form from the Essex Co. Medical Examiner's (M.E.) office and telephone conversation with the M.E.'s office (with the OCA on March 20, 2007 and March 22, 2007) indicate that the M.E. investigator documented a verbal report on June 7, 2006 from the hospital about Xavier Jones' death. The M.E. investigator's information from the hospital noted that the child was "playing in a closet on the first floor. He got methadone from a lock box in a bag with a child proof cap." The M.E.'s office was notified by Newark Beth Israel Children's Hospital on June 7, 2006 that Xavier met criteria for brain death and that the hospital wanted to withdraw life support, but that an autopsy would be needed.

Discussion with the M.E. and review of their scene photos obtained on June 7, 2006, by the M.E. investigator indicate that there had been 6 bottles of unit doses of methadone (50 mg each) stored in a metal box. By report, one bottle was empty. J.S.had taken a unit dose at the methadone clinic prior to bringing the rest of her week's doses home. The box was not locked. The bottle of methadone ingested by Xavier had a functional child-proof cap. This metal box with the six bottles for methadone was stored on a bottom shelf in an unlocked hall closet inside a backpack type of bag. This was a closet where Xavier liked to play.

The medical examiner stated to the OCA that he had determined this death to be a homicide due to the length of time it would have taken a 21 month old child to discover the metal box, negotiate its clasp, open the bottle of methadone by himself, and then drink all of it, if that is what occurred. The Medical Examiner's opinion was that clearly the child had been left poorly supervised for a significant length of time.

It is also clear from the finding of multiple doses of methadone in the box that J.S. was storing a few days of doses of her medication at this home. The IAIU investigator's reports and Special Response Unit[10] (SPRU) DYFS interviews with others present at J.H.'s home on June 3, 2006, revealed conflicting reports of whether J.S. and J.S.'s son were actually living with J.H.. An older teen-aged foster child stated that J.S. and her son were living in the home. This teenager later recanted his statement. Interview of J.S.'s son by the IAIU investigator indicated that J.S.'s son said they did not live there, yet he could not give the address of where he and his mother were allegedly living. The resource parent's adopted son, R.R.H., told the IAIU investigator that J.S. and J.S.'s son were living at the resource home at the time of the ingestion incident. J.S.

[10] The DYFS Special Response Unit is the after-hours unit of DYFS which conducts responses to and investigations of allegations of abuse or neglect.

provided the SPRU workers with a non-existent home address, a location which simply could not be found.

In late June 2006 when J.H. was interviewed by the IAIU investigator, J.H. stated to the investigator that she had been upstairs cleaning a bathroom during the time Xavier got into the methadone. Xavier Jones was not under the direct supervision by his resource home parent at the time he ingested the methadone.

SUMMARY OF DEATH INVESTIGATION FINDINGS

- Xavier Jones was 21 months old when he died from an ingestion of methadone.
- He ingested this opiate medication while he was living in a non-relative, resource family home that was licensed by DYFS. He had lived in this home since he was six weeks of age.
- The methadone was prescribed to one of the adult biological daughters of the resource parent. DYFS was aware that this biological daughter had addiction problems and had counseled the resource parent that her biological daughter could not live in the resource home without a waiver, and could not be left unsupervised with any of the children in the resource parent's home if she were visiting her mother and the children.
- Investigative reports suggest that this biological daughter and her nine year old son were frequenting the resource home and perhaps living in the home in June 2006.
- The daughter had placed five unit doses of her prescribed methadone on a lower shelf in an unlocked metal box in an unlocked closet in the resource home, a closet in which Xavier Jones reportedly liked to play.
- Xavier Jones was not under the direct supervision of his resource parent at the time he ingested the methadone.
- Adults in the household did not call poison control or EMS at the time they discovered that Xavier had ingested a bottle of methadone (50 mg), and had begun to have symptoms (wobbly gait and difficulty breathing).
- Adults in the resource home initiated home remedies, induced vomiting, gave Xavier a suppository, and then let him sleep.
- Xavier then, as might be expected after an opiate ingestion, had a respiratory arrest (stopped breathing).
- Around the time of Xavier Jones' respiratory arrest, estimated by a combination of various reports to be about one and a half hours after he had become symptomatic, the resource home made an abandoned call to EMS. They tried to initiate CPR, and carried him on their own to the ER at Columbus Hospital. By report Xavier was apneic (without breathing) and pulseless for over twenty minutes, perhaps longer. This amount of time without respirations and circulation forebodes almost no chance of recovery of any normal brain function if a child is resuscitated.
- Although a heart rate was re-established with resuscitation in the ER, too much anoxic (lack of oxygen) brain damage had occurred, and by June 7, 2006, in spite of extensive medical support in the Pediatric Intensive Care Unit at Newark Beth Israel Children's Hospital, Xavier Jones was declared brain dead and was removed from life support.

OFFICE OF THE CHILD ADVOCATE FINDINGS AND RECOMMENDATIONS

It is the opinion of the Office of the Child Advocate that Xavier Jones' untimely death was due to neglect and lack of appropriate supervision by his resource parent.

Immediate and appropriate medical advice and treatment, starting at the time Xavier became symptomatic from his ingestion, would have greatly improved his chances for survival. The adults in the resource home exhibited medical neglect when they did not seek medical advice and treatment immediately after discovering his ingestion. They exacerbated his medical condition and prognosis by treating him with home remedies and delaying getting Xavier into medical treatment for what appears to be at least one and a half hours after he had become symptomatic.

The resource parent demonstrated extremely poor judgment in her actions by not notifying DYFS or the DCF Office of Licensing of the fact that her adult daughter was frequently in the resource home in 2006 and that this adult was receiving treatment for addiction. The resource parent and her daughter had been counseled by DYFS about the need to inform them of such information and to obtain a waiver for allowing the daughter's presence and assistance in the home dating back to 2004.

Additionally, there is evidence that the resource parent violated numerous DCF Office of Licensing regulations for resource family homes through her action and inactions. The reckless storage of a prescribed, controlled drug in amounts that could be lethal to children was extremely neglectful. The presence of this inappropriately stored controlled medication in the household raises concerns over the safety for all children in this home. [11]

There is evidence of missed opportunities by DYFS in planning for and supervising this child throughout his life.

Xavier Jones' untimely death was preventable.

SYSTEMS CONCERNS AND OPPORTUNITIES FOR IMPROVEMENT

1. DYFS Case Handling Issues

While DYFS fulfilled its responsibility of monthly home visits to the resource family, documentation for the home visits and contacts that were made do not reflect that the child's safety and well-being were thoroughly and accurately assessed.

There is no written evidence in the DYFS records provided to the OCA to support that ongoing supervision of DYFS case work staff occurred. There is no documentation of any timely case transfer summary or conference, as required by DYFS policy, which might have alerted a new

[11] The resource family parent, J.H., knew her daughter had this medication.

caseworker to the risks posed by J.S.'s presence in the home and a subsequent evaluation of the adult daughter to ensure the safety of the children residing in the home. [12]

Recommendation:

- **DYFS must strengthen its implementation of case practice requirements and supervision of case work staff particularly at the time of case transfer.**
- **There is a need to strengthen adherence to policy regarding essential areas that must be addressed and documented during a home visit.**
- **At a minimum, there are numeerous areas that must be routinely assessed and documented by DYFS case work staff during each home visit.**
- **DYFS needs to strengthen and reinforce its policy that requires assessment of other individuals providing care in the resource home.**
- **DYFS supervisory staff must monitor worker compliance with MVR schedules, and the quality of the worker's documentation of home visits.** [13]

2. **Licensing**

The annual licensing evaluation of JH's resource home completed on May 12, 2006 cited "no violations" in her home, particularly no violations for the storage of toxic substances and medicines. It should be noted that the annual licensing inspection was delayed by two months, based upon the documented date that the resource parent's license expired on March 12, 2006.

---

[12] *N.J.S.A.* 30:4C-25 and *N.J.A.C.* 10:133D-4 require DYFS of Youth and Family Services to regularly visit all children under its care, custody, and supervision. Policy also states that visits occur, "At least once per month, regardless of the risk level, the children and parent(s)/caregiver(s) must be seen together in the home." Additionally, DYFS policy reflects that "In-person visits afford the worker the opportunity to observe the conditions in the home as well as the child's behavior, the parent or substitute care provider's reaction to and interaction with the child and the child's overall adjustment to placement out of his or her own home. From these observations, the worker can assess the appropriateness of the case plan and modify or change the services provided."

Additionally, this same policy cites as part of the purpose of the visitation requirement, "For a child in out-of-home placement, to determine the child's adjustment to and progress in the out-of-home placement and to obtain information and concerns about the child from the out-of-home placement provider and the child. (N.J.A.C. 10:133D-3.5)" DYFS policies clearly cite the importance of the MVR. Frequent contact with the child and his/her resource parent is critical to the protection and monitoring of the child in DYFS's care. Documentation of these visits allows supervisory staff to monitor the child's progress and the thoroughness of the assessment by the case worker. DYFS policy concerning Child Safety Assessment Field Visits further cites "if there are other adults present during the field visit to the home, ask who they are, whether they reside in the home, and whether they have a role in caring for the foster child."

[13] Much of the accountability for these issues rests with local office frontline supervisory staff. An expectation among supervisors must exist that the above-referenced areas are important to assess and will be discussed and verified at regular supervisory conferences.

Although the licensing report documents that this resource home had the capability to safely store medications, precautions were not taken by the resource family to safely store the methadone on June 3, 2006.

This tragic case points out the need for DYFS workers and licensing inspectors to be diligent during their home visits and safety assessments and to counsel resource parents at every opportunity about safe storage of medications, over the counter products, and other toxic substances. Resource homes in which there may be controlled drug medications deserve much closer scrutiny.

Inspectors and DYFS workers must acertain whether medications and other potentially toxic products are being left on table and bureau tops, in bathrooms, on low shelves, etc. to determine whether medications are being left within reach of young children and other children who may have cognitive limitations and/or behavioral disorders. Easy access to such medications places particularly vulnerable children at risk of ingestions or suicidal gestures.

3.Supports to Resource Parents

The DYFS records provided to the OCA reveal an ongoing lack of communication between the Union County DYFS office, the DYFS Resource Family Unit and the numerous other DYFS local offices that placed over 50 children in this home from 1999 to May 2006. Between October 28, 2004 and May 30, 2006, while Xavier remained in this home, 17 other children were placed with the resource parent at various times, including numerous children with special needs.[14] When fully implemented, NJ SPIRIT[15] should assist DYFS staff in readily accessing current information on resource families.

There is no documentation to evidence the fact that the children already present in this home were assessed for their adjustment to the many needy children that came and went during this time. There is further evidence to suggest that the resource parent frequently requested the removal of children from her home due to that particular child's presenting needs. It appears that DYFS did not always respond to this resource parent's requests for assistance or the removal of the child from her home. DYFS clearly over-utilized this resource home.

Recommendation:

- **NJ SPIRIT must be implemented as soon as possible. Until the system is fully functional, interim measures must be adopted to support needed inter-office communication and coordination of concerns regarding invididual resource homes. This communication and coordination should be done through the local office Resource Family Unit.**

4. Delayed Reports

[14] One child placed was autistic with a seizure disorder, one was globally developmentally delayed and had incontinence, and another was diagnosed with ADHD.
[15] NJ SPIRIT is the automated child welfare information system.

a. IAIU: Delayed Findings Letter

The Institutional Abuse Investigation Unit (IAIU) investigator provided comprehensive and timely interviewing of collateral contacts after Xavier's death. The IAIU Findings Letter was not rendered until January 11, 2007, seven months after Xavier's death. IAIU delayed rendering its findings letter at the request of the Essex County Prosecutor's Office, to allow the prosecutor's office further time to contemplate criminal charges.

Although IAIU did not render its Findings Letter for almost seven months, IAIU did appropriately determine that there had been neglect, closed this resource family home and placed the other foster children in new resource settings on June 4, 2006.

County prosecutor's offices and IAIU should be mindful that delays in rendering Findings Letters in child fatality cases may create significant disruptions in permanency and placement decisions for other children residing in a resource home.

b. Union County Local Office Child Death Report

The Local Office did not render its Child Death report until March 6, 2007. This report inaccurately lists the name of the biological father of Xavier Jones.

Recommendation:

- **Final child fatality summaries completed by DYFS local offices must be timely and accurate.**[16]

5. DYFS Medical Systems Issues

While these issues were not factors in Xavier's death, they warrant attention and discussion because of the systemic issues they present for all children in resource home care.

a. Gathering of Medical Information

The DYFS records sent to the OCA contained almost no medical records on either tj or Xavier Jones. Once DYFS obtained custody of tj and Xavier, inadequate and incomplete background medical information was gathered. Although the DYFS records contained numerous medical releases, it is unclear if the releases were ever sent to anyone.

The medical information that was gathered by DYFS on Xavier and tj was shuffled together with no dates of receipt nor any notation that these records were read or assessed for medical needs or follow-up.

A DYFS form for gathering background medical information was developed several years ago and was never implemented. That form was to be completed with the biological parent(s) by the DYFS worker and/or the DYFS nurse consultant at the mandatory meeting that occurs after the

[16] According to current DCF policy, as of April 2007, fatality summaries are now completed by DCF Central Office, no longer at the local office level.

placement of the child into out of home care. This meeting now must occur within 72 hours of the child's entry into out-of-home placement.

Completion of a background medical information form would provide the worker with information for where to gather necessary records, indicate any need to alert resource caretakers about immediate and chronic treatment needs of the child, and create the ability for DYFS and caretakers to communicate with specialists and other clinicians involved in the child's ongoing care.[17]

Once DYFS takes legal custody of a child, DYFS is responsible for overseeing the child's well-being and for creating a medical care plan for the child while the child remains in DYFS's custody. Medical information must be gathered by DYFS and cannot be gathered by resource parents or treating physicians since neither has the legal right to sign releases.

Recommendation:

- **The organization of medical records in DYFS charts must be improved.**
- **The medical chart of each child needs to have an individual tab under which his/her medical records are collated and chronologically ordered. When medical records are received they must be dated and include documentation that the records were read and that appropriate action was taken.**
- **Additionally, a medical problems sheet for each child should be included in the child's DYFS chart. The needs identified on this chart should be addressed in the case service plan.**
- **A form for gathering background medical information needs to be implemented. Background medical information forms must be completed at the 72-hour family meeting.**

b. Xavier's Medical Care

There were troubling lapses in Xavier's medical care while he was in the resource family home that were due to a lack of communication between his resource parent and his DYFS worker.

Although CHEC evaluations are ideally done within 60 days of a child's out-of-home placement, Xavier's was not completed until 18 months after he was removed by DYFS. A CHEC site was readily available in this county. The exam was finally scheduled by the DYFS in February of 2006, after it was mandated by a second court order. It was then completed within 60 days.

DYFS's failure to provide the CHEC providers the requested and necessary medical information prior to Xavier and tj's CHEC exams led to less comprehensive evaluations.

[17] Background records might include past birth records, growth charts, lab results, primary care records and immunization records. This would enable the case worker/DYFS office to start to gather the medical records needed for the CHEC evaluation.

Additionally, the DYFS office did not track the resource parent's ongoing medical care of Xavier. Xavier had an unexplained delay of nearly a year in getting his undescended testicle repair done and had delayed well care/immunizations. No consultation from the DYFS nurse about Xavier's care was ever requested by DYFS.

DYFS must monitor the timeliness of a child's healthcare and follow up on health issues and treatment needs while the child resides in out-of-home placement. DYFS needs to take appropriate steps to correct inaction when care is not being provided by the resource parent.

Recommendation:

- **The OCA strongly recommends that the Divison strengthen and expedite additional medical resources in all DYFS local offices to ensure timely coordination of medical care and follow up services for children in out of home placements.**

c. Preplacement Medical Exams

Xavier Jones' and tj's pre-placement exams on October 26, 2006 were done by their primary care physician, who had seen them since birth. Xavier's pre-placement exam was an appropriate and complete exam, well documented, and consistent with DYFS policy and "best practice" recommendations for obtaining a pre-placement health exam from a physician who actually knows the child and who has records on the child. Subsequent pre-placement exams on tj, Xavier's brother, were incomplete and done by four different providers. It is unclear whether Xavier's pre-placement exam was ever shared with the pediatrician to whom he was taken by his resource parent. [18]

The pre-placement medical exam form is cumbersome and antiquated, and requires clinicians to provide unobtainable medical information and/or medical information that is no longer used (e.g. such the date of oral polio or smallpox vaccines).

Shifting to a web based form that could be reviewed by subsequent medical providers would help in beginning to develop a medical passport for children under DYFS supervision. All attempts should be made to have a child's pre-placement exam completed at a medical home where the child has received some previous primary care.

Recommendation:

- **The Department of Children and Families and the Deparment of Human Services, Division of Medical Assistance and Health Services (Medicaid) should audit the quality of pre-placement physical exams to ensure these exams meet the designated standard of care as stipulated in DCF's original requirements. Improvement plans for DYFS offices and medical providers should be implemented as needed.**

[18] The four pre-placement physical exams on tj were incomplete, were conducted by multiple physicians, and were not shared with each subsequent physician.

d. Medical Safety Plan
There is no documentation from DCF Office of Licensing or DYFS to indicate that Xavier's resource parent followed *N.J.A.C.* 10:122C-4.3 and *N.J.A.C.* 10:122C-7.2, which describes medical emergency requirements for resource homes.

Recommendation:

- **DYFS and the Office of Licensing need to review and document that resource parents have an appropriate emergency medical care plan and exhibit an understanding that they are to seek immediate medical treatment for the child in the event of a serious illness or accident involving the child.**

e. Other Safety Concerns
Although Xavier Jones' death was not due to a burn, review of N.J.A.C. 10:122C-4.1 (e-4) and licensing forms used in re-licensing Xavier's resource home reveals another worrisome licensing standard.

The licensing forms indicate that hot water in resource homes should be between 120-140° F. However, this water temperature is too hot, and poses a safety risk for elderly persons and/or infants and toddlers.

The American Academy of Pediatrics recommends that water temperatures in homes with small children should be below 120° F.

Recommendation:

- **Licensing standard for hot water temperature in resource family homes should be lowered to less than 120° F.**

6. Medical Examiner's Office:

The M.E.'s Office investigator did take photographs of the scene/closet area where Xavier allegedly got into the methadone; photos were taken on June 7, 2006. However, the investigator did not provide a written Report of Investigation by the Medical Examiner (RIME) of the scene evaluation nor of any interviews obtained by the M.E.'s office with the others in Xavier's foster home.

Recommendation:

- **All Medical Examiners' offices must follow state standards and issue RIME Reports along with their investigations.**

7. Prosecutor's Office/DYFS Communications:

Records reveal that there were barriers in communication between DYFS workers and law enforcement in trying to obtain addresses and locations of the adults that were in the household at the time of Xavier's incident on June 3, 2006.

This made it extremely difficult for DYFS to develop a timely safety plan for the other children in the resource home and particularly for the other birth children of the adults in home at the time of this incident.

Recommendation:

- **Opportunities should be explored through the Essex County Multi-Disciplinary Team meetings and/or other interagency forums for improving communication among professionals at the time of an acute, life-threatening incident involving children.**

ANNOTATED APPENDIX:

Summary of Xavier Jones' Medical History

1. Full term appropriate for gestational age infant at birth

2. Normal state metabolic and genetic testing results

3. Two minor injuries by 17 months of age - one small laceration by the side of one eye from falling on an edge of furniture at daycare; small first degree brush-by burn to right cheek from an iron falling on him while in his resource home.

4. Normal growth and development when examined at 9 months of age and again at 19 months of age.

5. Delayed repair of congenital right undescended testicle. The finding of a right undescended testicle was noted in Xavier's developmental assessment at Children's Specialized Hospital on June 7, 2005 when Xavier was 9 months old. Usually it is recommended that an undescended testicle be brought down (surgically repaired) on or before one year of age, to best preserve future testicular function. The resource family parent was advised of this by the clinicians at Children's Specialized Hospital (CSH) on June 7, 2005 and recommendation was made to get Xavier's surgery at Newark Beth Israel Children's Hospital. However, by the time of the CHEC exam when Xavier was 19 months old on April 17, 2006 this elective surgery still had not been done, though it had been scheduled for May 6, 2006. It is unclear from the records why there was an almost one-year delay in getting this surgery done.

6. Delayed immunizations: At the time of the CHEC evaluation when Xavier was 19 months old, his immunizations were delayed and the record suggests that he must have missed his 15 months old routine Well Child exam. The CHEC evaluators outlined for the resource family parent when routine exams should be obtained from Xavier's primary care pediatrician.

7. History of mild wheezing and intermittent use of a nebulizer

8. Out of home non-relative placement since October 26, 2004. One emergency placement with his brother October 26, 2004-October 28, 2004; one long term placement, without his brother, October 18, 2004 - June 3, 2006.

9. Untimely death from ingestion of methadone, ingestion June 3, 2006; death June 7, 2006.

A. Materials from DYFS of Youth and Family Services

1. Central Screening Report – June 3, 2006 5 pages

2. IAIU Findings Report from C.T., Chief of Investigations, Date of Death June 7, 2006; Date of Findings Letter January 11, 2007, 6 ½ months after incident 4 pages

3. DYFS Internal Placement Review Report dated March 21, 2006 Children removed from mother and maternal grandmother who failed to adequately supervise children 9 pages

4. DYFS 2C-81e Report, dated April 27, 2006 20 pages

5. DYFS 2C-52 Contact Sheet, dated 4/27/06 – 6/4/06, Union Central LO Worker J.O., Supervisor J.L. Contact visits dated 10/17/05, 11/21/05, 11/28/05, 3/8/06, 3/17/06, 4/10/06, 4/27/06 5 pages

6. DYFS 26-52 contact sheets, dated 9/10/04, 9/17/04, 9/21/04, 10/7/04, 10/21/04, 10/22/04, 10/27/04, 10/29/04, 10/31/04, 11/1/04, 11/3/04, 11/5/04, 11/15/04, 11/29/04, 12/13/04, 1/3/05, 5/9/05, 8/22/05, 9/17/05, 9/21/05, 10/17/05, 11/21/05 42 pages

7. Psychological report on D.P., biological father, date of report 2/1/05 7 pages

8. Psychological report on T.J., biological mother, date of report 1/27/05 9 pages

9. Treatment summary, Family and Children's Services on T.J., Summary dated 9/19/05, after T.J. had attended 8 out of 10 sessions, (1 session cancelled by the clinician). Report mentions that T.J. also had started cognitive therapy on 7/21/04 and had attended 8 sessions so far. 3 pages

10. Letter to D.P. from the Supervisor of Family and Children's Services, letter dated 9/16/05. D.P. failed to attend the first session of parenting classes, thus his case was closed. 1 page

11. Parent enrichment project monthly report and daily logs. Of note, 9/1/05 T.J. still had not organized or secured housing and/or employment and had permanency hearing for 9/29/05. 6 pages

12. Jones family treatment summary of supervised visitations from 7/26/05 –8/23/05, involving 4 visits with T.J., L.J. (mgm), tj, X.J. (children) and D.P. (bio. Father)

13. Individual Educational Plan for T.J. 5/19/04 29 pages

14. Request for CHEC exam from Xavier 10/28/04 1 page

Request for CHEC exam for tj 10/28/04 1 page

15. Supervised visitation summary for T.J. Xavier Jones, and tj from Family and Children's Services 9/6/05 – 11/29/05 (6 visits) 1 page

16. DYFS 9-7 Referral Response Report and interviews of children in the household around the time tj was burned by hot soup
[date of incident on or around 8/7/04]. Date of 9-7 8/10/04 11 pages

17. Treatment Summary from Family and Children's Services for tj, individual cognitive sessions, 7 sessions, 1/05 – 3/06, date of report 3/24/06 3 pages

18. Family and Children's Services Treatment Summary for service 9/05 –12/05, report dated 12/28/05 for cognitive therapy for T.J. By this time of report, T.J. had attended 18 individual therapy sessions 4 pages

19. Possible IAIU handwritten investigative note dated 2/28/06 concerning Xavier Jones' fall at daycare on 2/21/06, while eating lunch at a table and falling from his chair, hitting edge of left eye on nearby crib – small laceration. Resource parent took him to [Columbus Hospital] ER right away, 2 sutures were placed 1 page

20. DYFS Perpertrator Request and Finding check list and SIS reports for D.P., dob 9/4/84, biological father of Xavier Jones, incomplete assessment. 7 pages

21. DYFS Resource Family assessment file 12/13/96-5/30/06. License most recently updated 3/12/06. 3 inches of records

22. IAIU Supervisory Conference Forms from 6/5/06, 6/13/06, 6/14/06, 6/19/06,7/18/06, 7/25/06, 8/22/06, 9/21/06, 10/25/06, 12/6/06, 12/15/06, 1/8/07 14 pages

B. Legal Materials

1. Letter from Assistant Public Defender to Union County East Local Office, notification of bonding evaluation for biological mother, T.J., letter dated 2/21/06 2 pages

2. Civil Action Case Management Order in the matter of guardianship of tj and Xavier Jones, Docket No. 20-39-06F, May 8, 2006 6 pages

3. DYFS litigation court review 1/23/06 4 pages

4. Civil Action Complaint for Guardianship, 1/4/06 Order for termination of parental rights 16 pages

5. Order to Show Cause 1/9/06 3 pages

6. Affidavit of Service 1/9/06 6 pages

7. DYFS litigation contact summary sheet and support documents for Termination of parental rights 9/29/05 21 pages

8. Compliance Review Order 9/22/05 re: mgm L.J. and her children 4 pages

9. Civil Action Order to Show Cause, granting DYFS custody 10/26/04 (5 pages); Verified complaint 10/26/04 (25+ pages)

10. Custody and Services 11/4/04 5 pages

11. Preadoption court hearing 10/6/05 7 pages

12. Out-of-home permanency assessment/court report 11/04 10 pages

13. Out-of-home permanency assessment/court report 3/16/05 39 pages

14. In person contact litigation hearing 11/4/04 8 pages

15. Law Guardian Investigator's report on the minor children of mgm L.J.: Children - H., L., A. and I., date of report 1/31/06 6 pages

16. Letter from L.J. to Judge Spatola re: T.J. and Xavier Jones and tj – letter dated 12/6/05 5 pages

17. East Orange Police Department Incident Report, dated 6/4/06, (2 pages).
East Orange Police Department Supplemental Incident Reports, dated 6/3/06, (3 pages); 6/3/06, (2 pages); 6/5/06, (1 page); 6/506, (3 pages); Arrest Report 6/4/06, (1 page)

18. Telephone consultations with the Essex County Prosecutor's Office: 3/22/07, 5/9/07, 5/10/07, 5/11/07, and 5/15/07.

C. Medical Materials

1. Neurodevelopmental evaluation of Xavier Jones done on 6/7/05 when Xavier was 9 months of age. Evaluation done at Children's Specialized Hospital, Dr. Rosemary Merola, Lori Ioriatti, CPNP 3 pages

2. Preplacement physical exams: Xavier Jones, exam done 10/26/04 by Dr. Viswanathan, MD, Pediatrician. Exam done on date of first out of home placement. 2 pages

3. Preplacement physical exam: tj exam done 10/26/04, 10/28/04, 11/10/04, 11/12/04. Of note: All 4 exams were done at 4 different sites, by 4 different practitioners. The 11/12/04 evaluation, done at Kids Docs in So. Orange, NJ had no recorded vital signs, height, weight or head circumference and no notation of his burn patterns. He was started on inhaled steroids (Pulmicort) for his wheezing and continued on Albuterol 25 pages

4. Numerous requests for DYFS collateral medical information (DYFS forms 5-50) 4/13/05: Request to Occupational Therapist (OT) for tj – no information returned (4 blank pages); Second request from OT at Newark Beth Israel Children's Hospital– tj had been evaluated there on 11/19/04 and seen again on 4/21/05 3 pages
   There were 37 blank pages of requests for collateral medical information

5. Early Intervention assessment and summary on tj from Children's Specialized Hospital, Fanwood, NJ date of evaluation 5/7/04, when tj was 13 months. tj qualified for services especially for gross motor and cognitive skills 5 pages

6. Special Approval Requests for services for tj and Xavier Jones +39 pages

7. Records from St. Barnabas Burn Center on tj when he was 16 mos old. 5% total body surface area, mixed 2nd and 3rd degree burns were treated at St. Barnabas 9/10/04 – 10/29/04. Follow up 3/05; 4/05 for re-measuring for Jobst garments for scar compression 12 pages

8. Preplacement Physical Exam on Xavier Jones, done by his pediatrician 10/26/04 at time of placement into foster care. No background medical history provided on form 11-2 2 pages

9. DYFS case service history 10/04 – 9/05 85 pages

10. Accident/Injury Report from "First Class Learning Center" in Bloomfield, NJ, where Xavier Jones was a student on 2/21/06. Xavier then was 17 months of age. By report, Xavier cut his eye on a crib in the classroom. 1 page

11. Incomplete Preplacement form 2/27/06. No 2nd page of form 11-2 sent. This incomplete preplacement record notes "Burn on RT check (Iron) and sutures (LT) eye (fell)" [date of eye injury 2/26/06] 1 page

12. Immunization record for Xavier Jones. Unclear if immunizations were up to date for age since DYFS did not stamp date of receipt of immunization records 1 page

13. Early Intervention Family Service Plan (EIFSP) for tj, date 5/21/04. tj was still living with his mother and maternal grandmother. He was 13 months old at the time of the E.I. service plan. 7 pages

14. Three outpatient specialty clinic visits for tj from University Hospital Pediatric Specialty Practice, dates of visits 10/5/05, 10/20/05, and 11/29/05. Presumptively he was seen by a Pulmonologist since he was seen for an exacerbation of asthma and asthma follow up. Contract DYFS physician, Dr. Raksha Gajarawala, referred tj for his specialty evaluation. tj was 2 5/12 years old when seen for these evaluations. He was brought to these appointments by his foster care provider who had had him since 11/04. (presumptively his 4th foster care provider)

15. UMDNJ Early Intervention Program Summary of Evaluation and Care of tj at 1 year and 5 months of age (12/05). At 2 ½ years old (2 months prior to summary), tj's speech therapist was no longer available. As of 12/05, EI still did not have a speech therapist available in Essex County. 2 pages

16. DYFS collateral information from First Class Learning Center on Xavier Jones, dated 12/19/05, Xavier was 15 months old. No concerns, "perfect attendance." 2 pages

17. One-page handwritten note from Resource Family parent, J.H., to Xavier Jones' case worker describing how, on 2/11/06, Xavier bumped an ironing board reportedly while one of the foster mother's grandson's was unplugging the iron. The iron fell and grazed Xavier's check, leaving a "red line." Letter dated 2/17/06. Treated at home, topical care 1 page

18. CHEC reports on both tj and Xavier Jones, reports dated 4/17/07, 16 pages. *N.B.:* The OCA received these reports directly from the RDTC on 3/14/07 after discovering that they were not part of the DYFS records sent for review. On 3/19/07 the OCA reveiwed the whole IAIU investigative file and these CHEC reports were part of the IAIU investigative file.

19. M.E.s Report on Xavier Jones, case number 07060975AUT, final report dated 7/21/06. The OCA finally received this M.E. report as part of the IAIU investigative files which were delivered to the OCA on 3/19/07. 12 pages

20. Medical records from Dr. Uma Viswanathan, MD, who was Xavier's pediatrician from 9/13/04 (seen for hospital newborn exam, at 5 days of age, discharged from Trinitas Hospital 9/11/04; seen again 10/8/04 for one month old Well Care Exam; 10/26/07 seen for DYFS pre-placement physical. Dr. Viswanathan's office notes did include copies of the CHEC evaluations done on tj and Xavier Jones from 4/17/06 even though she had sent the Medicaid HMO (Americhoice) a letter dated 11/4/04 stating that she was no longer the pediatrician for these children. Clearly neither DYFS nor Xavier's resource family parent, J.H., told the CHEC providers that Dr. Viswanathan was no longer Xavier's pediatrician. 18 pages

21. Pronouncement of Death Report form Newark Beth Israel Children's Hospital, and transport notes from Columbus Hospital ER. Died: 6/7/06 12:22 am. 22 pages

22. Newark Beth Israel in-patient hospital consultations from Dr. Patricia Morgan-Glenn, RDTC child protection MD, consult dated 6/6/06, 3 pages, who concluded that this child's impending death was due to neglect from inadequate supervision, medical neglect for resource parent's lack of seeking appropriate medical care after Xavier's methadone ingestion, and overdose with a controlled substance. PICU SW note 6/4/06 on date of transfer of patient to PICU. Neurologist's consult 6/4/06 3 pages. Intensivist chart notes 6/6/06 and 6/7/06, with declaration of brain death 8 pages.

23. Inpatient medical records on Xavier Jones from the Newark Beth Israel Children's Hospital from 6/4/06-6/7/06 over 2" of records

24. Birth records on tj from Trinitas Hospital 4/17/03-5/12/03. Received by OCA 3/21/07 through subpoena of records 180 pages.

25. Birth records on Xavier Jones from Trinitas Hospital 9/8/04- 9/11/04. Received by the OCA 4/1/07 through subpoena of the records. 53 pages.