

# Lost Children:

## An Annual Report about New Jersey Children Who Died from Abuse or Neglect

August 2008



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## Introduction

Each year, in New Jersey and across the country, children die or nearly die while in the care of people who are charged with caring for and protecting them.

In some cases, their deaths are caused by an isolated or single neglectful act. A great grandmother leaves prescription medication within reach of a toddler. A father becomes distracted for a few moments and his young child drowns in a friend's pool.

In other cases, people do the unthinkable. A mother stabs her child. A father strangles and drowns his children.

We struggle to understand these tragic early endings, but many times there are no clear answers. Many times, there is no one cause.

Still, it is important to examine these children's lives and deaths to understand, as best we can, the circumstances surrounding their deaths and search for ways to prevent future lives from being cut so tragically short.

This report marks the first time the New Jersey Office of the Child Advocate has documented in an annual report the deaths of all children who died or nearly died as a result of abuse or neglect. While the tendency has been to focus on the child protection system's involvement in these children's lives, the majority of these 29 children never had any involvement with the New Jersey Division of Youth and Family Services (DYFS).

In addition, measuring the overall functioning of the state's child protection system through a small number of cases with the worst outcome—a child death—is an unreliable measure of a system's operation on a larger scale. These cases, however, can steer us toward areas that may require deeper examination to determine whether other systemic changes could improve the safety of children.

It is important to note that four of the 12 DYFS-involved child fatality cases were opened and closed prior to June 2006 when the state entered into a modified settlement agreement that promised major reforms to the state's child welfare system. Since then, significant improvements have been achieved, including reducing worker case-loads and increasing the number of resource

homes. The state is now in the process of fundamentally changing the way families are served, with an increased emphasis on engaging families and providing relevant services to keep families safely together whenever possible.

The Child Advocate's extensive case reviews also identified issues that transcend these cases and may require a public policy response. For example, in one case, chronic, unaddressed truancy was an unheeded warning sign that a child was in serious trouble. This issue spans multiple government systems and solutions will require a broader, collective response.

In some cases, the Child Advocate identified medical issues that called for a more focused response. The Child Advocate personally met with some health professionals to discuss these concerns in an attempt to improve medical handling of cases involving child abuse or neglect.

The purpose of this report is to discover whether the data and information collected through our review might suggest measures that, if taken, would make injury or harm to a child through abuse or neglect less likely to occur in the future. The Office of the Child Advocate, however, has formed no conclusions or opinions on whether negligence or culpable conduct was present in any of the individual cases described, and nothing in this report should be construed as expressing any opinion by the Child Advocate on whether the incidents described were the result of any fault by any individual, agency or organization.

Lastly, the stories of these children remind all of us of the responsibility we share to ensure that New Jersey's children grow up safe and protected.

## Overview

In 2007, 29 New Jersey children died or nearly died as a result of confirmed abuse or neglect. This includes 23 fatalities and six near fatalities.

It should be noted that this report focuses only on these 29 children. Hundreds of children die or nearly die each year from accidental, intentional and natural causes. To be considered abuse or neglect, however, the perpetrator has to be acting as a caregiver. That means, for example, that a drive-by

shooting, while a homicide, would not be among these cases.

Most of the fatalities or near fatalities due to abuse or neglect were caused by one or both of the children’s biological parents. Blunt force trauma was the most common cause of death. More than half of these children were less than 1 year old.

**Figure 1**

<b>Rate of Child Death as a Result of Abuse/Neglect</b>		
<b>NJ vs. US</b>		
<b>Year</b>	<b>NJ</b>	<b>US</b>
2005	1.42	1.96
2006	1.53	2.04

Source: *Child Maltreatment*, U.S. Department of Health and Human Services, Administration for Children and Families, 2005 and 2006

In both 2005 and 2006, New Jersey’s rates of child death as a result of abuse or neglect were lower than national averages. In 2006, the national rate was 2.04 per 100,000 children, compared to New Jersey’s rate of 1.53, according to *Child Maltreatment 2006*, the federal government’s annual report on the maltreatment of children.

## Manner and Cause of Death<sup>1</sup>

In 2007, the manner of death, as determined by a Medical Examiner, was homicide for 17 of the 23 children who died as a result of abuse or neglect. Four deaths were deemed accidental by a Medical Examiner. For one child, the manner of death was determined to be natural causes, while another was determined to be suicide.

The most common cause of death was blunt force trauma. Of the 23 child deaths, 13 were victims of blunt force trauma, which includes the use of weapons. Young children under 3 years old were most likely to suffer injuries from blunt force trauma, which is often linked to “shaken baby syndrome,” or what is termed non-accidental head trauma. Some fatal blunt force trauma injuries were due to trauma to abdominal organs and/or other parts of the body. Children under 3 suffered injuries from blunt force trauma in 15 of the 21 child fatalities or near fatalities in this age group.

The second most common cause of death was suffocation or strangulation. Four children died from this cause. Three children died due to ingesting prescription medication. In two cases, the medications were unsafely stored or administered. One of these cases was a suicide in which the teenager overdosed on medications that her mother had given her. Two children drowned and another child died from natural causes.

In the near fatality cases, five children were severely injured through blunt force trauma, while another was suffocated.

<sup>1</sup>The cause of death/near death is based on Medical Examiner findings and hospital reports, and is grouped into broader categories consistent with the National MCH Center for Child Death Review’s method of compiling and presenting data on child fatalities. So, while a Medical Examiner may determine one cause of death to be “traumatic brain injury” and another to be “multiple sharp force injuries,” both of these causes would be categorized under “blunt force/weapon” for the purposes of this report.

Figure 2

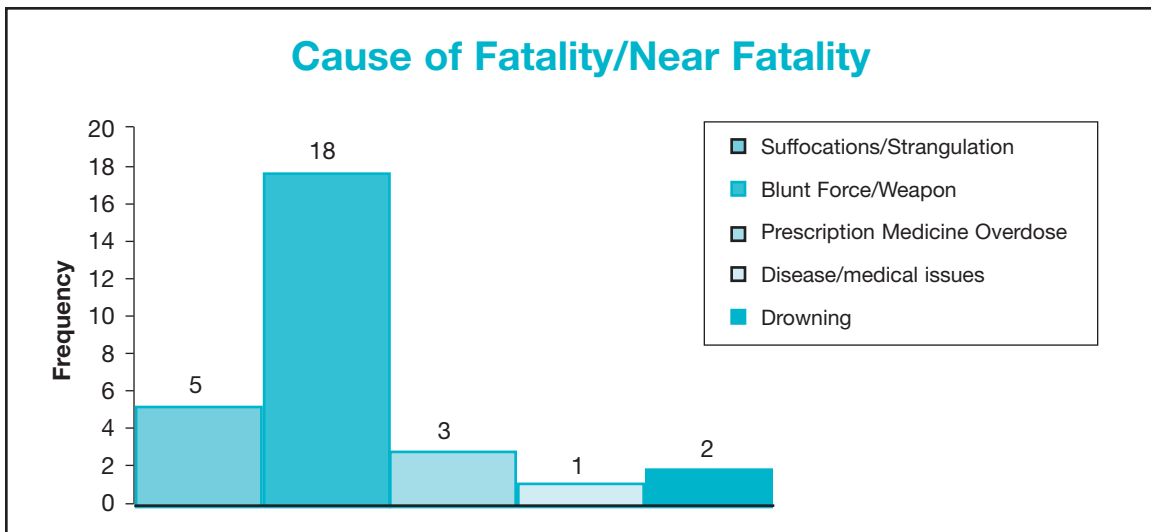
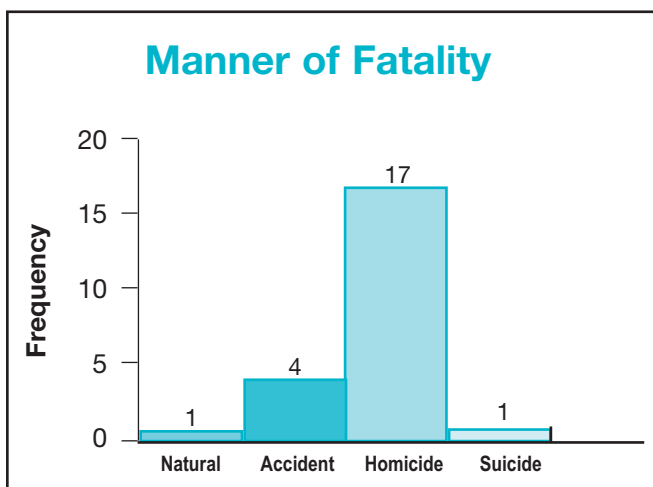


Figure 3



### Demographics of the Children

More than half of the children who died or nearly died from abuse and neglect in 2007 were under the age of 1 year. Children 3 and under comprised 22 of the 29 cases or nearly two-thirds of the total. Boys were the victims in 17 incidents. Girls were the victims in 12 cases.

In nine cases, the children were white. In 10 cases, the children were African American. In six cases, the children were multi-racial or race could not be determined. Two children were Hispanic and two children were Asian.

Figure 4

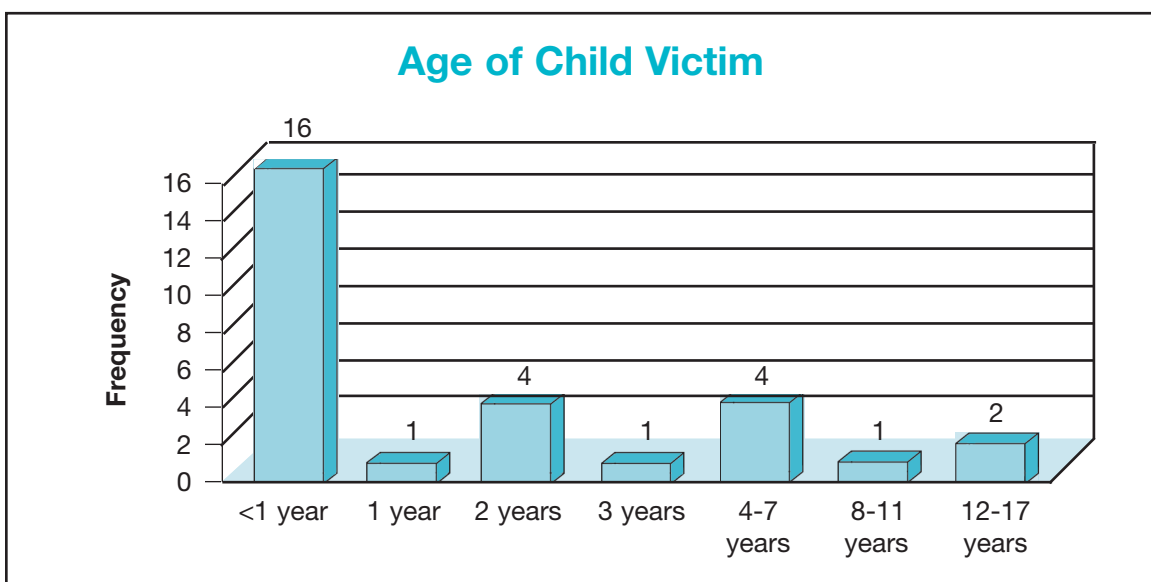
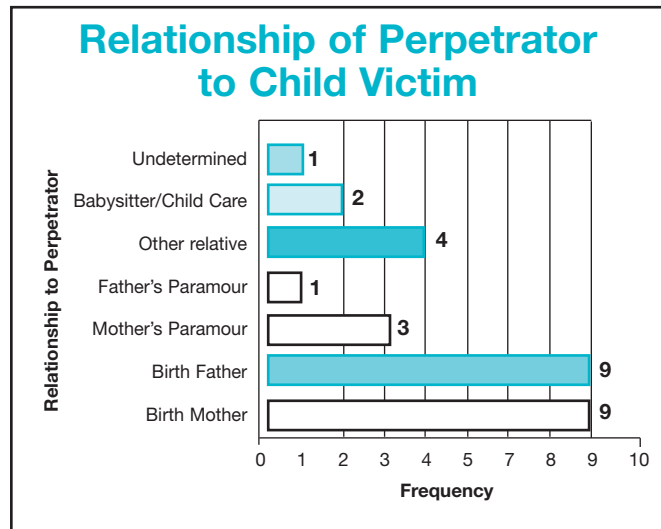


Figure 5



Figure 6



### Perpetrator Relationships to Children

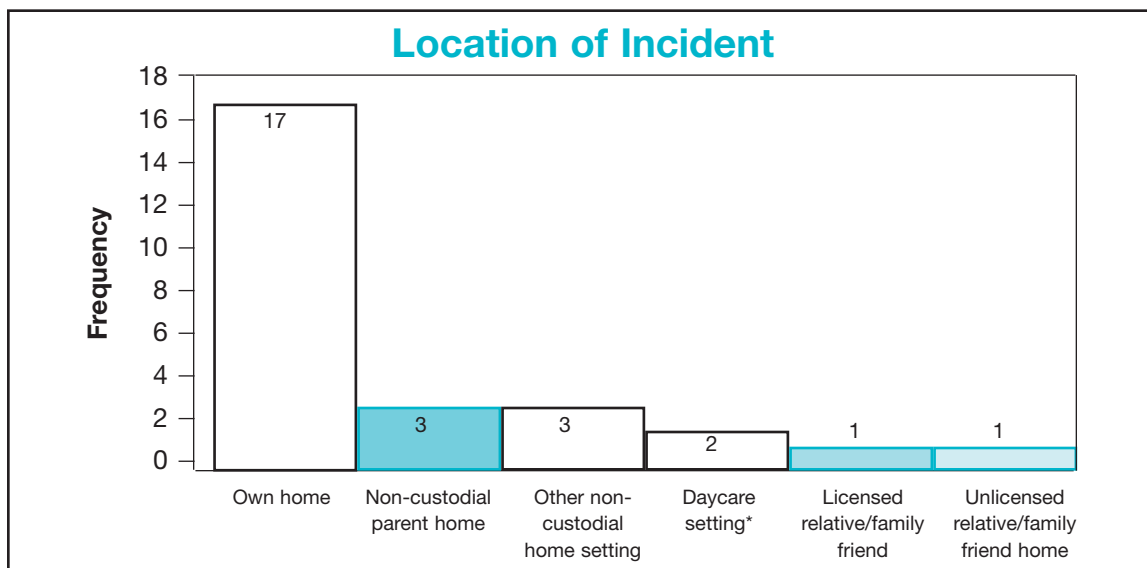
In most cases—18—the child’s natural parent or parents were the identified perpetrator. Roughly half of the mothers of all 29 children were under 26 years old.

In four cases, a parent’s partner was the identified perpetrator. Relatives were the identified perpetrator in four cases, while in two cases a child care provider was the identified perpetrator. In another case, the perpetrator was undetermined.

### Location of Incidents

More than half of the incidents—17—occurred in the child’s own home. Incidents that caused the fatality or near fatality occurred in the home of a non-custodial parent in three cases. One incident occurred in a state-licensed relative placement. Another occurred in a privately-arranged relative placement. Two occurred in home-based daycare settings: one a state registered family daycare home, the other an unregistered home. Three incidents occurred in “other non-custodial home settings”: a friend’s pool, a friend’s home and a motel. In two cases, the location of the incident that caused the fatality or near fatality is unknown. In 2007, no children died of confirmed abuse/neglect while living in a non-relative foster care placement or a state-licensed or contracted facility.

Figure 7



\*Note: Day care setting can include both center- and home-based daycare. In this instance, both incidents occurred in home-based care.

Of the 2007 child fatalities/near fatalities, seven incidents occurred in Essex County. Four counties—Bergen, Atlantic, Ocean and Hudson—had three incidents each. Camden and Middlesex each had two incidents, while Cumberland, Gloucester, Monmouth, Morris, Union and Warren had one each. The other counties had no incidents of child fatalities or near fatalities as a result of confirmed abuse or neglect in 2007.

## Involvement with the Division of Youth and Family Services

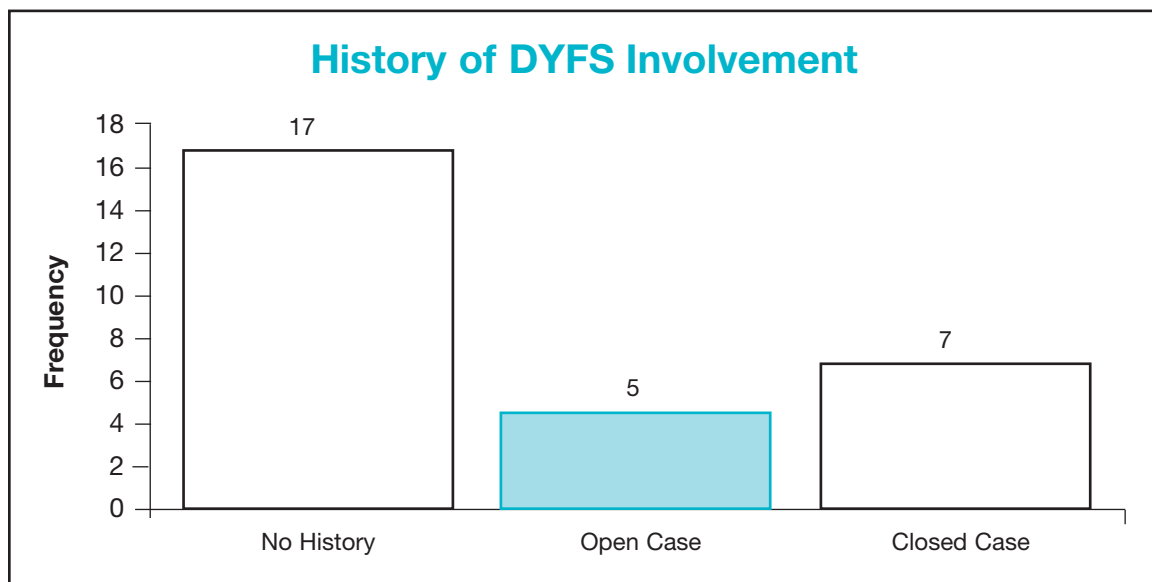
Twelve of the child fatalities/near fatalities involved children who had a history of involvement with the state Division of Youth and Family Services. Five of these children had an open DYFS

case at the time of their deaths. In seven cases, the child or family had previously been involved with DYFS but the case had been closed prior to the child's death.

Of the five open cases, three had been open for less than one week. One had been open for 41 days and another had been open for more than seven years. Of the seven closed cases, one was closed 25 days prior to the date of the incident, two were closed less than one year prior to the incident, three were closed one to two years prior and another was closed for roughly four years. Of the seven closed cases, three had DYFS involvement that occurred prior to the child victim's birth.

The other 17 children had no history with DYFS.

Figure 8



The Office of the Child Advocate examined the circumstances of all 12 cases with DYFS history and determined that eight required a more extensive review. The other four cases did not receive a full review for the following reasons:

- The DYFS history consisted of only one unsubstantiated referral that had occurred several years before the child's death.

- The DYFS history was unrelated to the individual responsible for the child's death or to the child that died.
- One death was not confirmed by the state as a fatality due to child abuse/neglect case until March 20, 2008 and case records have not yet been received and reviewed.
- The Office did not undertake full reviews of near fatalities.



Several issues emerged in the review of the remaining eight cases. It should also be noted that several of these cases displayed evidence of sound case practice. To reiterate, the Child Advocate does not view these cases as being a reliable measure of the system's overall functioning. However, the case reviews identified issues that may require further investigation or issues that transcend these cases and require a broader public policy response.

A discussion of these issues follows, along with either recommendations for improvements or descriptions of steps the Child Advocate will take to further examine issues.

## Case Practice Issues

The Child Advocate identified other issues with the way DYFS handled some of these cases. Primary problems included inadequate safety and risk assessments and case plans, lack of documentation, insufficient engagement of family and relatives and ineffective efforts to provide relevant services.

As noted, the state is in the midst of major reforms and officials readily acknowledge that system changes continue to be a work in progress. However, as staff are trained in the new "case practice model," which emphasizes family engagement, it is vital that an evidence-based, best-practice quality improvement process be put in place. This is essential to achieving sustained child welfare reform. DCF officials, in discussions with the Child Advocate, said work has begun on a new quality assurance process that will focus in the fall on the four local offices that are "immersion" sites—the first to fully implement the new approach to case handling. This commitment is part of the federal court settlement agreement and is slated to be fully implemented by June 2009.

The Child Advocate will review this plan when it is developed to ensure key areas for measuring progress are identified. A system must also be put in place to concretely address the issues that are identified through internal quality assurance reviews.

## Investigations

In six of the eight reviewed cases, the Child Advocate identified issues concerning the thoroughness and accuracy of the abuse/neglect investigations. A thorough investigation is essential to determining whether a child is safe or whether state intervention is warranted.

These concerns included the use of Structured-Decision Making (SDM), a process designed to aid investigators in determining safety concerns and risk levels. To be effective, these tools must be completed with thorough and accurate information. In six of these cases, however, better use of the SDM process could have reduced the risk because investigators failed to record relevant, available facts in the assessment tools, thus skewing the risk and safety findings.

In addition, the rate at which New Jersey substantiates allegations of child abuse and neglect for many years was lower than national averages. In 2006, according to federally-released data, that trend reversed itself, with New Jersey substantiating nearly 28 percent of reports, compared to the national substantiation rate of 25.2 percent, according to *Child Maltreatment 2006*, an annual report from the U.S. Administration on Children, Youth and Families, Children's Bureau.

To provide further information in this area, the Child Advocate, in collaboration with the federal court-appointed monitor, will assess whether to undertake a deeper examination of child abuse investigations.



Figure 9

<b>Substantiation Rates, NJ vs. US</b>				
	<b>Total Investigations</b>	<b>Total Investigations Substantiated</b>	<b>Percent Substantiated</b>	<b>National Substantiation Rate</b>
<b>2002</b>	39,148	5,814	14.9	26.8
<b>2003</b>	42,762	5,872	13.7	26.4
<b>2004</b>	44,127	5,878	13.3	25.7
<b>2005</b>	34,806	6,796	19.5	25.2
<b>2006</b>	28,134	7,775	27.6	25.2

Source: Child Maltreatment, U.S. Department of Health and Human Services, Administration for Children and Families, 2005 and 2006

## Broader Issues

Other state and local systems are often involved with the children in these cases, including schools, police, hospitals and others. In reviewing these cases, the Child Advocate identified issues that extend beyond the child protection system.

## Truancy

In one of the 2007 child fatalities, a 13-year-old had missed 66 days of school. This chronic truancy was clearly a warning sign that the child and family had significant problems. According to the National Center for School Engagement, “truancy has been clearly identified as one of the early warning signs of students headed for potential delinquent activity, social isolation, or education failure via suspension, expulsion or dropping out.” Other research has identified truancy as a possible indicator of child abuse and neglect.<sup>1</sup>

The New Jersey Legislature recently passed a law requiring schools to investigate suspected truancy if a student has unexcused absences from school for five consecutive school days. The law further directs the district to call the state’s child abuse hotline if the truancy investigation uncovers any “reasonable cause” to believe the child has been abused or neglected. (N.J.S.A.18A:36-25.2).

Current Department of Children and Families (DCF) policy directs child abuse hotline screeners to accept a report of educational neglect for a child protection investigation only if the school district has exhausted all avenues to compel a child to attend school, including filing charges against the parents. The expectation is that the school district should determine the reasons for a child’s truancy before reporting it as suspected educational neglect. DCF officials indicated that this is to ensure that routine and appropriate absences do not result in calls to the state hotline alleging child abuse or neglect, involving families unnecessarily with the child protection system. This refers only to truancy issues. State law mandates that schools officials, like all New Jersey residents, must report any reasonable suspicions of child abuse or neglect.

Both the new law and DCF policy require further examination. Truancy is a complex problem that demands a comprehensive response from educators, law enforcement agencies, courts, communities and families, according to Truancy Prevention, a web-based partnership among several federal government agencies, including the Office of Juvenile Justice and Delinquency Prevention (OJJDP), the Office of Safe and Drug-Free Schools (OSDFS) and the U.S. Department of Education.

The Child Advocate is considering further investigation of this issue to determine whether system changes are needed to ensure that children attend school to improve school success, reduce crime and improve efforts to keep children safe.

## Training Physicians to Recognize Abuse/Neglect

Emergency room doctors, pediatricians and all doctors who treat children are stakeholders in recognizing and reporting child abuse. A physician's opinion is powerful, often influencing how the state responds to an allegation of abuse or neglect.

In two of the reviewed cases, emergency room doctors rendered opinions about the nature of a child's injury that occurred weeks or months prior to their deaths and may have been warning signs that a child was not safe. In one case, it appears the doctor erred in determining that an injury was accidental. In the other case, it is uncertain whether the doctor was correct in determining the injury was accidental, but the records suggest the injury may have been related to abuse or neglect.

In both cases, the DYFS investigators lent significant weight to the doctor's opinion in their own decision-making process.

This highlights the need for all healthcare providers who come into regular contact with children and families to be thoroughly trained in child abuse recognition and response and to understand the resources available to assist in making these critical judgments. The Child Advocate will issue an advisory urging healthcare providers to participate in quality child abuse recognition, prevention and response training.

## Mental Health Screening Regulations

Mental health issues contributed to the death of a young teenager who committed suicide in 2007. Appropriately assessing a child's mental health status is critical in all cases.

Thousands of children in crisis receive screening services each year at one of 33 designated screening centers across the state. Existing regulations, however, are designed for adults rather than determining whether a child is in need of psychiatric hospitalization.

Child specification regulations would have several benefits. They could address issues including training for screeners, interviewing of parents and concerns that are critical to child safety, as well as foster consistency and provide quality assurance.

In the early 1990s, efforts were made to craft child-specific mental health screening regulations, but issues arose that were never resolved. Currently, a group of advocates is revisiting the issue of how to create these regulations. The Child Advocate will participate in those discussions, with the goal of identifying improved ways to meet the mental health needs of New Jersey children.

## Internal Reviews of Child Fatalities

Over the course of the year, child fatalities that are not due to confirmed abuse/neglect come to the attention of the Child Advocate. In 2007, the Child Advocate examined four such cases. Children in these cases were involved with various state systems and two were living in a state placement when they died. Because these cases are not considered the result of abuse and neglect, the details of the cases cannot be publicly disclosed under the state's Comprehensive Child Abuse and Prevention and Treatment Act.<sup>2</sup> It is clear, however, from the Child Advocate's review of these cases that they raise issues that warrant an internal examination by DCF. These cases present an opportunity for DCF to identify and address problems that may compromise children's safety while in out-of-home placement. Other states, such as Connecticut, review the circumstances of these cases to assess case practice and to identify ways to improve systems, policies and organizational structure.<sup>3</sup> New Jersey should explore ways to institute a similar process.

In addition, New Jersey's Child Fatality and Near Fatality Review Board and its regional teams analyze a broad spectrum of child fatalities and near fatalities. While the process has intrinsic value, going forward the Child Advocate will explore ways to collaboratively strengthen that process to more effectively advance efforts to ensure the safety of all New Jersey children.

## End Notes

<sup>1</sup>*Factors Contributing to Truancy*, National Center for School Engagement, [www.truancy-prevention.org](http://www.truancy-prevention.org)

<sup>2</sup>N.J.S.A. 9:6-8.83 Comprehensive Child Abuse Prevention and Treatment Act; 42 U.S.C.A. §5106g The Federal Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003.

<sup>3</sup>*Using the Special Review as a Program Improvement Tool*, Children's Voices, September/October 2007, Child Welfare League of America, [www.cwla.org/voice/0709eye.htm](http://www.cwla.org/voice/0709eye.htm).

## Recommendations

To improve child safety, the Child Advocate makes the following recommendations:

- The Department of Children and Families' quality assurance process currently under development should be crafted with input from the Child Advocate.
- A system should be put in place to concretely address the issues that are identified through the new quality assurance reviews.
- All healthcare providers who come into regular contact with children and families should be thoroughly trained in child abuse detection and response and understand the resources available to assist in making these critical judgments.
- The Department of Children and Families should institute an internal review process when a child dies while in their care. This should be used to identify ways to improve the care and safety of children in out-of-home placement.

The information presented in this report was obtained from reviews of state, medical and court records related to these children. In cases where there was a history of involvement with the state child protection system, the Child Advocate conducted an extensive review of the available state records, including Division of Youth and Family Services case records. A full source list is appended to this report.

## Profiles of Children Who Died Due to Abuse/Neglect Who Had DYFS Involvement\*

A.A.  
Age: 2 months

### Summary of Death

A.A. was nearly eight weeks old when his mother found him unresponsive, face down in the bassinet. The Medical Examiner determined the infant died from overdoses of alcohol, an adult medication prescribed for the baby's father and an adult over-the-counter medicine. His parents gave him the substances, presumably to help him sleep after he had injured his arm. In May 2008, the father pled guilty to manslaughter. The mother pled guilty to endangering the welfare of a child. Both were sentenced to seven years in prison.

### The Child's History

A.A. was a healthy baby boy who lived with his parents in his maternal grandparents' home. His father had served for eight years as a paramedic. After the father's discharge, the couple moved back to New Jersey with their oldest son who was 18 months old at the time of A.A.'s death.

The first sign of documented trouble in A.A.'s short life came when his father took him to the pediatrician 10 days before he died. The father told the doctor the infant had stopped breathing the day before for three to five minutes, according to documentation obtained by the Child Advocate. The physician believed the problem was related to overfeeding and choking and counseled the parents not to overfeed the baby and to place him on his back to sleep.

The next significant medical episode happened four days later when the father brought the baby to the emergency room with a broken arm. This injury was reported to the state Division of Youth and Family Services.

### DYFS History

The only referral to DYFS on this family prior to the infant's death came, just six days before A.A. died. The baby's father took the infant to the emergency room with a broken arm. The ER doctor became concerned because the injury was significant and unusual for a not-yet-mobile infant. Hospital staff reported the injury to DYFS.

It was nearing the hospital's shift change so the baby's care was handed off to another ER doctor. When the DYFS investigator arrived at the hospital, the second doctor documented that the injury appeared to be accidental.

The DYFS investigator interviewed the parents at the hospital and did not object when the hospital discharged the baby to the parents. The worker went to the family's home that same evening and did a brief evaluation of the home. No documentation exists that the worker interviewed various members of the household that night. This worker issued a finding of "unfounded" with regard to the allegation of physical abuse, without having conducted a full investigation.

\*Note: Identifying information regarding the children and families in this report has been omitted. Random initials have been substituted.

Even though the initial investigator found the allegation to be without merit, a second worker visited the home less than two days later. The worker spoke to the parents and an uncle who lived in the house. The worker noted that the baby's arm was still in a splint, not a cast. The worker recommended the parents consult the baby's pediatrician to identify an orthopedist or, if that failed, return to the hospital for the follow-up care. The baby's arm was still in a temporary splint when he died.

The worker also said she would need to speak with the grandparents, who also resided in the home. During that same week, however, the worker had a family emergency and was out of the office for 2-1/2 days. No other DYFS worker or supervisor continued the investigation during the assigned worker's absence.

Four days after the second worker visited the family's home, A.A. died.

B.B.  
Age: Three weeks

## Summary of Death

On the morning of the day he died, B.B.'s mother found her 3-week old infant in his crib unresponsive and not breathing. When EMS responded to the home they discovered that the baby had been dead for a number of hours.

The Medical Examiner determined the cause of death to be blunt force injury to the head and the manner of death as homicide. B.B.'s mother pled guilty to aggravated manslaughter and was sentenced to 12 years in prison.

## The Child's History

At the time of B.B.'s death, the baby was living with his 23-year-old mother, his 3-year-old half sister, his mother's ex-boyfriend and the ex-boyfriend's 20-month-old son. Prior to B.B.'s birth, the ex-boyfriend and his son had moved back in with B.B.'s mother to help with child care and bills. The ex-boyfriend was the father of B.B.'s half-sister. The two also had some support from relatives.

B.B.'s mother had only one prenatal visit, just six days prior to his birth. At that visit the mother expressed a desire to place the baby for adoption. Clinical staff gave her phone numbers for adoption agencies. After delivery, the mother apparently chose to keep her baby.

When B.B. was discharged from the hospital after birth, the hospital arranged for a public health nurse to visit the family because the mother had not received regular prenatal care and was diagnosed with high blood pressure at the time of delivery. She was also hearing impaired, although she heard normally with the help of a hearing aid she wore during the day, according to case records.

The public health nurse visited the family three times after B.B.'s birth, over the course of six days. During the last visit, the nurse noticed the baby was coughing and recommended the infant be seen by his pediatrician. When the mother brought the baby to the doctor, the physician recommended the child be hospitalized. B.B. was hospitalized for four days for poor growth (possibly failure to thrive) and for diagnosis and management of an unexplained right hand injury that had become infected (cellulitis).

## DYFS Involvement

There was one referral to DYFS on this family. It was made one week prior to the baby's death. A hospital staff person called the child abuse hotline on to report concern over the 2-week-old infant's cellulitis of the right hand, an infection of the skin that is typically caused by an injury. The referent told the hotline screener that the mother had said the baby fell while with the mother's ex-boyfriend.

The reporter also said B.B.'s pediatrician believed the child was suffering from "failure-to-thrive," although the cause was unknown. The hospital requested DYFS accept the case for investigation and assess the family for services. The referral was coded as a Child Protective Services case with an immediate response time.

A full review of the DYFS records indicates that on the day of the referral, the DYFS investigator began an investigation. Prior to seeing the family, the investigator placed several collateral calls to the child's pediatrician, hospital social worker and the public health nurse who had been working with the family.

The investigator visited the mother and infant twice in the hospital that same day and also met the maternal grandmother and the baby's sibling. The investigator met with the hospital floor nurse to discuss the baby's condition and treatment, the mother's interaction with the baby and the mother's ability to hear the baby when he cries since the mother was hearing impaired. The investigator also spoke via phone to the ex-boyfriend later that afternoon. The investigator documented three supervisory conferences at various times throughout the day.

The next day, the DYFS investigator completed a Safety Assessment, which was based on seeing all these individuals at the hospital, rather than in the home. The investigator documented a supervisory conference that included the DYFS nurse consultant and reflects the nurse reviewed medical information on the baby from key sources, including the pediatrician, the current hospital and the public health nurse. The worker was advised to refer the family to Head Start, Early Head Start and a Family Success Center, which could provide support services and referrals to community agencies. The worker was also to ensure the mother followed up with the Women, Infant and Children (WIC) program, which provides nutritional supports to mothers and their babies.

The DYFS investigator placed several collateral calls to the hospital social worker to check the baby's status and learned that B.B. was to be discharged. The hospital again provided a referral for a public health nurse. DYFS placed additional calls to obtain the baby's hospital birth records.

On the afternoon of the infant's discharge from the hospital, the DYFS investigator visited the mother's home and saw all family members, including the ex-boyfriend and his 1-year old son. The home was found to be "very clean and decorated nicely" and the kitchen was "stocked with food."

The worker also completed a Family Risk Assessment for the mother and her two children, which found a moderate risk for neglect and low risk for abuse, with an overall assignment of moderate risk. The ex-boyfriend and his child are not listed, despite the fact that they resided in the home. Child and Caregiver Strengths and Needs Assessments were completed on the mother and her two children, but again not for the ex-boyfriend and his son. No needs were identified.

Three days later, the worker confirmed that the hospital had contacted the nursing agency. A date for initiating the service and frequency of the visits is not documented. The worker also made a referral to the Family Success Center program on the mother's behalf and faxed a request to the pediatrician to obtain immunization and pediatric records on B.B. and his sibling. The worker also requested via fax the birth records for B.B. and hospital records for his sibling. The investigator concluded that the allegation of neglect was unfounded.

After B.B.'s death, his siblings were placed in foster care.



C.C.  
Age: 2-1/2 years

## Summary of Death

C.C. was brought to the hospital after she was found unresponsive. The mother said she found the child blue and unconscious sleeping next to the child's father on the sofa with her face buried in a cushion. The father later disputed this, saying C.C. was sleeping with the mother in her bed at the time of her death. DYFS records indicate the father "stated that he fell asleep and that child rolled over."

Both parents were home when the child died. Both admitted drinking alcoholic beverages the night before and into the early morning hours of the child's death. The mother also admitted using cocaine.

Police found large vodka bottles and empty beer cans in the kitchen. Cocaine paraphernalia and residue were also found in the house. Records state the father reported having no recollection of what happened prior to the child's death.

Both parents were charged with endangering the welfare of a child. The matter was still pending at the time that this report was being prepared.

## Child's History

C.C. lived with her parents and her older brother. There were two domestic violence charges against the father in 1997 and 1999, involving the father and C.C.'s mother. In both cases, temporary restraining orders were issued but were dismissed days later. (The 1997 order was dismissed nine days after it was issued. The 1999 order was dismissed two days after it was issued). It should be noted that when DYFS investigators checked twice with local police—once in 2004 and once in 2006—the checks came back with "no record on file," even though the family still lived in the same town where the domestic violence incidents occurred.

## DYFS History

The family had two previous referrals to the Division about C.C.'s older brother.

The first report came on Oct. 10, 2003, nearly four years before C.C. died. The reporter alleged that C.C.'s older brother, who was 2-1/2 years old at the time, was in danger because his parents were drunk and fighting all the time. This referral was coded for a "child welfare investigation." C.C. was not yet born at this time.

According to DYFS records, the initial investigator interviewed the parents who denied domestic violence and excessive drinking. According to case notes, the father appeared sober at the time. This worker also contacted the police department and the family's pediatrician. No record of domestic violence was noted, nor did the pediatrician express any concerns.

The parents underwent a substance abuse evaluation in 2004, apparently in connection with the October 2003 allegation, although there is no explanation in the record for the delay in the evaluation. The evaluation showed no concerns for substance abuse. The case was not opened for services.

Two years before C.C.'s death, a staff member at the son's Head Start program reported the boy had come to school with a bruise on his head. The boy reportedly said his father had hit him. The referral was coded as child protection, immediate response.

According to DYFS records, the Division checked with the pediatrician, who expressed no concerns, and spoke to a Head Start staff person, who reported that, aside from the bruise, there were no concerns for the child at that time. The DYFS investigator again checked with local police but no record of the domestic violence incidents were conveyed to the investigator. All the assessments were completed, showing low risk, no needs and no safety intervention required. The allegation was unfounded. The case was closed.

C.C.'s brother was removed from his parents' care and placed in a relative home following his sister's death.



D.D.  
Age: 13 years

## Summary of Death

D.D. was found dead in the morning of an apparent overdose of pain medication, Oxycodone, that belonged to her mother, a woman with a history of drug abuse and one drug-related arrest.

On the night D.D. died, she was in possession of numerous pills. D.D.'s mother allegedly gave her daughter sedating medications to help her sleep. After D.D. died, her mother was charged with 2nd degree child endangerment and was sentenced to three years probation.

## The Child's History

D.D. had a history of depression, substance use and school truancy. She had, on several occasions, admitted to thinking about killing herself. She had missed 66 days of school in the year before she died. She was coded as receiving special education services.

In early 2007, D.D.'s mother tried to get help for her daughter through the New Jersey Division of Child Behavioral Health Services, but no services were initially provided. D.D. was subsequently evaluated at an emergency screening center due to concerns about self-injurious behavior, at which time she was referred for various services, including counseling and case management. She did attend two therapy sessions but did not return for ongoing treatment.

Other than a note that a follow-up call was placed to the residence six weeks before D.D.'s death, with no response, and a subsequent letter sent to the home, there is no evidence in the record that the family had been connected to appropriate treatment services.

## DYFS Involvement

The only report to the state Division of Youth and Family Services about this family came six days prior to D.D.'s death. On that date, school officials reported that D.D. had missed 66 days of school since the beginning of the year. The mother had been charged for the child's truancy and had failed to report to court. A bench warrant had been issued for the mother's arrest.

Five days prior to her death, a DYFS investigator went to the home in the morning and spoke with D.D.'s mother and also visited D.D.'s school and spoke to D.D. Both D.D. and her mother said the teenager had refused to attend treatment programs. The DYFS worker conducted a full investigation, checking with school officials, local police and other sources. DYFS substantiated educational neglect and recommended services.

While the worker was in the home during the home visit, D.D.'s mother called the state's child behavioral health services to seek counseling. At the time of that call, there was no indication that D.D. was an imminent danger to herself. The clinical coordinator said a local counseling service would call to schedule an assessment six days later, a timeframe that fell within agency policy. D.D. had died the day before.

E.E.  
Age: 3 months

## Summary of Death

Shortly before 1:30 a.m., E.E.'s father found his 3-month-old baby cold and unresponsive in a car seat where the baby had been sleeping next to his parents' bed. The family had just moved into a new apartment two days earlier and had not yet set up the child's crib.

The parents called 911 at 1:24 a.m. The police transported the baby to a local hospital where he was pronounced dead at 2:05 a.m. According to the Medical Examiner's report, the cause of death was traumatic brain injury suggestive of shaken baby syndrome. The manner of death was homicide.

The mother told police she fed the baby at 11 p.m., just hours before he died. She said E.E. ate less than usual and was fussy. She told police she put the infant to sleep in the car seat after feeding him. Two days after the baby's death, the mother admitted she had rocked the baby "very hard" after feeding him.

E.E.'s mother was charged with homicide. The case was still pending at the time that this report was being prepared.

## The Child's History

The baby was one of twin boys born prematurely at 36 weeks gestation. His mother was 24 years old when E.E. and his twin brother were born. She had two other children who, at the time, were 18 months and 4 years old. The parents and children had just moved into a new apartment at the time E.E.'s death.

E.E.'s twin brother was born with a genetic bone disease that causes bones to break very easily. He was not expected to live for more than one year. Two days before E.E.'s death, a specialist saw both E.E. and his twin brother. This doctor determined that E.E. was a healthy child and did not have the same genetic bone disease as his brother.

## DYFS Involvement

There was one referral to DYFS on this family prior to the child's death. Two months prior to E.E.'s death, a hospital staff made an anonymous referral, claiming the father threw a cell phone at the mother while she was in the hospital after giving birth to the twins. There is no indication why this referent waited at least three weeks after the mother's discharge from the hospital before calling the hotline with this report.

This referent expressed concerns over possible domestic violence in the household, noting two other children—an 18-month-old and 4-year-old—were also living in the home. The reporter also alleged the parents handled E.E.'s twin like a normal baby, even though he had a bone disease that made him very fragile and required unusually careful handling. The report was coded for an immediate child protection response.

A caseworker and DYFS nurse went to the family's home the same day. The worker spoke with both parents and observed the three youngest children. She returned to the home later that day to speak to the oldest child, who had been at preschool when she had visited the home earlier.

Both parents were interviewed separately and denied any domestic violence. The case notes say the parents were loving toward the children, the apartment was clean and the children appeared well cared for.

The DYFS nurse assessed the baby with the bone disorder and found the parents to be appropriate and knowledgeable about how to care for the infant. The records state the mother was obtaining proper medical care for the infant.

DYFS staff also obtained medical collaterals and no concerns were expressed over the parents' care and treatment of the children. Despite the mother's concerns regarding the possibility of the baby becoming addicted to Oxycontin, she administered the drug as ordered by the physician. The children's doctor did note, however, that the 18-month-old had missed two regular checkups that had been rescheduled and that he was behind on his immunizations.

DYFS offered services to the family but the family declined. A response report conclusion form states that the allegation of neglect is unfounded. The case was closed on Jan. 17, 2007.

F.F.  
Age: 3 months

## Summary of Death

On the day of her death, F.F.'s father was leaving her mother's home and asked to hold the 3-month-old baby one more time before he left. He then took hold of the child's ankles and swung the baby repeatedly into an iron railing, striking her head and then dropped her to the ground.

F.F. was rushed to a hospital immediately after the brutal incident. Resuscitative measures were unsuccessful. The autopsy showed the infant had died a rapid death after catastrophic blunt force head trauma.

F.F.'s father was charged with homicide. The case was still pending at the time that this report was being prepared. Reports indicate that he was an outpatient mental health client, diagnosed with schizophrenia and depression. He was purportedly taking two medications for depression. He had attempted suicide approximately three years prior to F.F.'s death. The man's father indicated that his son had a past history of drug and alcohol abuse.

## The Child's History

Four days prior to the child's death, F.F. was brought to an out-of-state community hospital emergency room after supposedly being involved in a car accident. The child had been wounded in the shoulder. The laceration was treated with sutures and she was discharged home with her mother. Although the wound was presumably caused by a safety belt buckle, the nature of the injury was much more in line with that of a stab wound, according to the Child Advocate's review of medical records. Emergency room staff failed to recognize the suspicious nature of F.F.'s wound and did not call child protective services.

## DYFS Involvement

There were two referrals on this family prior to F.F.'s death. Neither reports of alleged abuse were directed at F.F.'s mother or father and both occurred prior to the child's birth.

G.G.  
Age: 2 years, 10 months

## Summary of the Death

At 4 a.m. G.G.'s great grandmother, Ms. G., found the almost 3-year-old sitting on the floor in the hallway outside the bathroom playing with a soap dish and pills, which were later determined to be medication prescribed for family members. Ms. G. asked the toddler whether she had taken any of the pills. G.G. replied that she had not.

Ms. G., who had legal custody of G.G. and her older sister, took the child back to the bedroom where they slept together. G.G. went back to sleep. Around 11 a.m., Ms. G. noticed that G.G. was snoring loudly, later describing her snoring like that of "an old lady." A little before noon, Ms. G. tried to wake G.G., but she was unresponsive.

The woman call 911. When EMS arrived, the child had no pulse and was unresponsive. Attempts to resuscitate the little girl were unsuccessful. G.G. was pronounced dead at 12:28 p.m. G.G.'s great grandmother later admitted that she had left pills, which were opiates, in a bedside night table where she also sometimes kept snacks for the children. No criminal charges have been filed, but the state Division of Youth and Family Services substantiated neglect against the great grandmother.

## The Child's History

G.G. was born healthy and normal. Her mother, who had a DYFS history as a child, had her first child at age 17. By the time she was 20, she had three children under the age of three. She was unemployed and admitted feeling overwhelmed with the responsibility of caring for three children.

G.G.'s mother lived intermittently with her great grandmother, but DYFS records indicate she had a substance abuse problem. Police records note that she spent some time in jail on assault charges. Sometime in early 2007, she left all three children with her great grandmother.

## DYFS Involvement

There were three referrals involving this family prior to G.G.'s death.

In 2005, a caller reported that G.G.'s mother was neglecting her children, the home had no heat or hot water, the children had not received medical care and there was drug trafficking in the home. The reporter also alleged that G.G.'s mother abused alcohol and drugs and fought with her brother in front of the children. The response was coded child protection services with a 24-hour response time.

Three days later, a DYFS investigator visited the home. The investigator talked to the great grandmother and learned that G.G.'s mother was incarcerated at this time.

The great grandmother did not have the children's medical records, nor could she confirm whether the children had received medical care and immunizations. The investigator left a card and instructed the great grandmother to have the mother call if she came home. The worker instructed her to obtain legal custody of the children and secure their medical records. He also advised her to call the 211 warm line if she needed further help.

A response referral report conclusion form states the allegation was unfounded because the natural mother was unavailable due to incarceration and since release she had gone "MIA." (Note: She was still in jail at this time, according to court records). It states the children were with the great grandmother who had applied for custody.

The mother was referred to a local community agency for family support services. The case was recommended for closing about one month after DYFS visited the family for a second time.

In 2006, a caseworker again visited the home, saw the children sleeping in bed and talked to the great grandmother, who reported the mother had been released from jail and had agreed to allow the great grandmother to obtain custody of the children.

The caseworker's notes from this visit state:

"This investigator assured the MGGM that it would be a lot better for her to obtain custody of the children rather than the Division obtain custody. On top of that, once the Division has custody it would be a challenge for the family to get custody back from the Division."

The second referral was made one month later when a hospital social worker called the child abuse hotline to report that G.G.'s mother had given birth to a baby boy who was ready to be discharged. According to the referrant, no documentation existed that the mother had received prenatal care.

This call was coded as a child welfare assessment with a 24-hour response time. The case was opened for services and the mother was referred to parenting skills classes. DYFS also provided a referral for the family to receive the help of a parent aid for five hours per week. The mother never participated in the recommended services.

A month later, G.G.'s great grandmother received legal custody of her and her sister. The case was open for services at this time. There is no further contact documented until nearly 11 months later.

In early 2007, the case was assigned because of a report on another family that was living in the same household. As a result, a DYFS investigator discovered that G.G. and her older sister had no beds. According to case records, background checks were conducted on all the people living in the house. The house appeared in acceptable condition. The worker provided a referral for a parent aide and opened the case for services. The worker also ordered beds for the children.

The caseworker visited the family again 2 days later. The worker confirmed the beds were delivered to the family and the great grandmother was caring for all three children. The plan was for the great grandmother to obtain legal custody of the boy and the worker recorded that she would see this procedure through. The record states the home was neat and clean, with plenty of food.

The caseworker visited the family two other times over the two following months and noted no concerns.

Two months after the last home visit, the caseworker contacted the local health department and confirmed that the children had received immunizations. She also visited the family and noted the house was clean, utilities working, with sufficient food in the refrigerator. The children were dressed appropriately and there were no visible marks or bruises. No concerns were noted.

Six weeks later, DYFS received an allegation that G.G.'s baby brother had not received any medical care or immunizations since his birth about six months earlier. The reporter also stated that the mother was abusing drugs and alcohol and evading a warrant for her arrest. This referral was coded for a child protection investigation within 24 hours.

An investigator made an unannounced visit to the great grandmother's home and learned that G.G.'s baby brother was living in Virginia with a maternal great aunt.

During this visit, the DYFS investigator noted that the apartment was clean with no visible safety threats. The children, however, were sleeping in the great grandmother's bed because the children's beds were stacked in "disarray," according to case notes.

Neglect was substantiated against G.G.'s mother for leaving the baby boy in the grandmother's care without health insurance. The risk level was recorded as high. A strengths/needs assessment documented that the family had no needs. The case was opened for supervision at this time.

Three weeks later, there was a conference between the caseworker and supervisor. The supervisor instructed the worker to put a parent aide into G.G.'s home and to help the maternal great grandmother navigate social services, including child care, Medicaid and obtaining financial assistance for G.G. and her sister.

One month later, the Medical Examiner called the hotline to report G.G.'s death.

Neglect was substantiated against the great grandmother. The case was reported to the prosecutor's office. DYFS conducted an emergency removal on G.G.'s 4-year-old sister who was placed in foster care.

H.H.  
Age: 3 years

This 3-year-old boy was found submerged in a swimming pool in the backyard of the home of a family friend. The child was removed from the pool by the homeowner, who unsuccessfully performed CPR on the child before police arrived. The child was pronounced dead at a local hospital.

The boy's father was visiting the friend's home when the incident occurred. The two adults were initially inside the home, while the boy and other children played outside, but the adults later joined the children in the front yard. The children were apparently playing in the front of the house, away from the backyard pool, which was enclosed by a fence and only accessible by going through the house.

At some point, the children went to the backyard without parental supervision. The 3-year-old was given a toy boat and was left playing near the pool unsupervised. The other children left him alone in the backyard when they went to locate friends to play a game. The boy was subsequently found in the pool. The Medical Examiner concluded the death was an accidental drowning.

There was one previous allegation of neglect against the boy's mother, which occurred on June 27, 2002, over a year before this child was born on Sept. 23, 2003. The mother allegedly left a child, who was 2 years old at the time, in a car unattended for less than five minutes while she ran into a local store.

DYFS workers met with both parents and created a case plan, which the parents accepted. The allegation was substantiated and the case was closed five months later.

## Profiles of Children Who Died With No DYFS Involvement

I.I.  
Age: 22 months

This 22-month-old girl was allegedly beaten to death by her father's girlfriend in her apartment. The Medical Examiner ruled the child's cause of death to be blunt force trauma. The autopsy showed the child had a lacerated liver and other internal injuries.

The father is a caseworker with the Division of Youth and Family Services. He was not with his girlfriend when the murder occurred. He had left his daughter in his girlfriend's care. The father brought the child to the hospital after the girlfriend called him. The child was unresponsive upon arrival at the hospital.

The girlfriend was charged with homicide. The case was still pending at the time that this report was being prepared. According to the investigator, the girlfriend also has another child, who was in the care of the maternal great grandmother. DYFS assessed the safety of this child.

J.J.  
Age: 10 years

J.J. was stabbed repeatedly by his mother, following a verbal dispute. She stabbed him multiple times with two kitchen knives. The mother then apparently “lowered” the boy’s body out of the window of their second floor apartment. Police found the body in the mother’s minivan. The mother tried to kill herself after murdering the child. The child’s father was living in Florida at the time. There was no known history of drug or alcohol use/abuse or mental illness. The mother worked as a school bus driver.

The night of the killing, the mother and son had gone to a neighbor’s apartment to use the Internet to look up information about Lego sets. They were there from 8:30 p.m. to about 9:30-10 p.m. Just a little while later that same night, the mother knocked on the neighbor’s door and told him she had killed the third grader. Police arrived on the scene at 10:24 p.m.

The mother later pled guilty to killing her son. Her lawyer said she was clinically depressed at the time of the killing, although she had not been diagnosed with a mental illness prior to killing her son. Neighbors said she was worried about money and frustrated at raising a child alone. They described J.J., her only child, as a quiet boy who was a Cub Scout, according to newspaper reports.

The mother pled guilty to homicide and was sentenced to 30 years in prison.

K.K.  
Age: 4 years

The 4-year-old boy died from multiple blunt force trauma. The Medical Examiner ruled his death a homicide. Police arrested the boy’s father who was 23 at the time of the killing. K.K. had been on a 3-week visit with his father when he was killed. The boy sustained three separate blows to the torso, with each hit enough to lacerate the boy’s liver, according to newspaper reports.

Local police were called to the father’s home and found the child unresponsive. He was later pronounced dead. The father was charged with manslaughter in the second degree.

As a juvenile, the boy’s father was arrested six times. When he turned 18, he was arrested on three separate occasions within one year: for possession of a handgun, disorderly persons, marijuana possession and resisting arrest. He was also arrested for aggravated assault with a weapon. He was sent to jail for that charge. He was released just a couple of weeks before he allegedly killed his son.

DYFS was conducting an assessment of K.K.’s surviving sibling and “will be offering services to the family,” according to Department of Children and Families records. There were no other children in the father’s home.



L.L.  
Age: 5 months

L.L. was brought to the hospital by her mother since she had been vomiting and not eating well for six days. The exam revealed the child had a pelvic fracture, two fractures to the right clavicle, a fractured femur, multiple rib fractures and bruises and bite marks all over her body. She also had two subdural hematomas and retinal hemorrhaging. She was placed on life support and died two days later.

Her mother's paramour had been caring for the child and admitted to biting L.L. on the buttocks while they were playing and shaking the child when he found her not breathing. Both the mother and boyfriend were indicted on charges of homicide. The case was still pending at the time that this report was being prepared.

M.M.  
Age: 11 months

This child was being cared for in a registered family daycare home that had been operated in the caregiver's home for 12 years. A 9-year-old child, also under the supervision of the caregiver, approached M.M. and kicked him in the head multiple times. The cause of this attack is unknown. The assault and resulting injuries ultimately caused the baby's death.

The 9-year-old was charged with the juvenile equivalent of manslaughter, pled guilty and was given 18 months probation. The caregiver was charged with child endangerment. She pled guilty and was sentenced to five years probation. She also forfeited her right to run a daycare home in the future.

N.N.  
Age: 6 years

This boy's mother slashed his throat, while his father and 9-year-old sister were upstairs in their home. According to the father, the boy warned his sister to run to safety before dying. Newspaper reports say the family had persistent money problems and that the father had filed for bankruptcy twice in the past eight years. Neighbors said the man recently lost his job, according to newspaper accounts. He is also disabled and unable to work full time, according to local authorities.

DYFS took the 9-year-old girl and put her in foster care. The father has been fighting to have her returned. The child remains in a resource home at the time this report was being prepared. The mother was charged with homicide, possession of a weapon for unlawful purposes and child endangerment. The case was pending at the time this report was being prepared.

O.O.  
Age: newborn

O.O.'s mother was treated for abdominal pains at a hospital, where it was determined that she had given birth. The mother told the hospital that she had put the baby in a garbage can somewhere in Bayonne. A police search of the home revealed the baby's body in a plastic container. The mother was 19 years old at the time of the fatality. She was charged with endangering the welfare of a child.

The mother's parents were reportedly not aware of the pregnancy. A 20-month-old sibling was placed in foster care pending investigation of the mother, who pled guilty in December 2007 to aggravated manslaughter. She was sentenced to 15 years in state prison.

P.P.  
Age: 3 months

This baby girl was beaten to death, stuffed in a trash bag and hidden behind a dryer in the basement of her mother's home. The mother's boyfriend was charged with first degree murder.

According to the Medical Examiner's report, two blankets soaked in blood were stuffed in the trash bag with the baby, who was wearing a blood-soaked pink onesie. Autopsy results showed the baby died of multiple traumatic injuries to the head and face. There were also bite marks on the baby's face.

The mother told police she left the infant in her boyfriend's care at about 4:45 a.m. Tuesday when she left for work at a food processing plant. According to police, when the woman returned at 7:30 p.m., she found no sign of her boyfriend or her child. According to reports, she found blood in the first floor bedroom. She began searching for the child and then called the police, who found the baby about 11 p.m. after an extensive search of the house, according to newspaper accounts.

The alleged perpetrator was an undocumented citizen who had been incarcerated in 2005 for multiple offenses. He was not the child's father.

The man reportedly lived with the child's 19-year-old mother in a small house. When he was arrested for the murder, the man reportedly told police he had been drinking but offered no other explanation for the crime.

When he was 17 years old, his family had involvement with the Division of Youth and Family Services. A judge ordered DYFS to place him in foster care because there were no relatives in America willing to care for him. The youth had two placements in resource homes in Southern New Jersey in 2005 and 2006. He ran away from a foster home in 2006. He was indicted for homicide. The case was pending at the time that this report was being prepared.

Q.Q.  
Age: 46 days

According to DYFS records, the parents put Q.Q. to bed at midnight the evening before his death. When they awoke in the morning, the baby was not breathing. The parents called 911 and the baby was taken to a local hospital. He was pronounced dead at 5:40 a.m. A sibling, just under one year old at the time, was placed with her great aunt.

Possibly due to being born premature, the baby reportedly cried a lot. The father kept late hours. On the night before Q.Q.'s death, the father tried to comfort the crying child at 2 a.m. He put the baby back in the bassinet. At about 5 a.m., the mother found the baby unresponsive. The child's grandmother called 911.

It was preliminarily believed the baby died from SIDS. Abuse and neglect were not initially suspected. However, upon further investigation the Medical Examiner found trauma to baby's head and ribs. The Medical Examiner determined the baby had died from traumatic brain injury.

Q.Q. had a 1-year-old sister who was later placed in a relative's care. No charges have been filed.

R.R.  
Age: 10 years

R.R. was strangled by his step-father, who also killed R.R.'s mother and then hung himself. The step-father's mother said her son suffered from bi-polar disorder and had been on medication since he was a young child, according to police reports. This woman said she spoke to her son on New Years Day and that he was behaving like he was off his medication, and had plans to file for bankruptcy, according to police reports. The murders occurred five days later.

The bodies were found by R.R.'s uncle, who came to the house to find out why the family had not shown up for breakfast. The step-father had left a note on a chair near the front door, advising his in-laws not to enter the house and to call 911, according to prosecutor's report. There were still toys under the Christmas tree.

According to the prosecutor's report, the man was in debt and had lost his job. He had a criminal history including several minor offenses. A note left at the scene said he "couldn't take it anymore."

S.S.  
Age: 6 years

T.T.  
Age: 5 years

The parents of S.S. and T.T. were separated and the mother had custody of the children. The girls were visiting their father. When the mother went to pick up the children, she got no response. She called the police, who found the children fully clothed and dead in the bathtub. The Medical Examiner determined the cause of death to be strangulation and drowning. Their father was discovered in the attic, where he had committed suicide by hanging.

The mother had been granted a temporary restraining order against her husband nearly three months before the reported deaths. A final restraining order was issued, reportedly in response to an incident of domestic violence. Although he was to have no contact with the mother, he did have regular legal visitation rights with both daughters and was ordered to undergo psychiatric evaluation and attend a batterer counseling program.

U.U.  
Age: 2-1/2 years

On the day she died, the police responded to a 911 call and found U.U. submerged and unresponsive in the bathtub. The mother reportedly had left her two young children unattended in the bathtub for several minutes. When she returned, she found U.U. submerged and unresponsive. The child was transported to a local hospital, where she was pronounced dead. After the autopsy and police investigation, the case was ruled to be an accidental drowning.

U.U.'s 4-year-old sibling remained in the home with his father and the father's paramour. DYFS maintained an open case on the sibling to ensure that he received treatment in coping with the death of his sister. The mother moved out of the country. No charges have been filed.

## NEAR FATALITIES

V.V.  
Age: 3 months

V.V. was admitted to Robert Wood Johnson Hospital, presenting with diarrhea, vomiting, and decreased sodium levels. He was transferred to the Intensive Care Unit two days later. It was determined that he had injuries consistent with Shaken Baby Syndrome.

According to DYFS reports, the child had been in the care of his uncle on that day while his parents worked. According to records, the uncle's 3-year-old child reportedly picked up and dropped the baby. When the uncle found him, the baby was not breathing so the uncle shook the baby in an attempt to revive him.

The child's condition soon worsened and he was brought to a nearby hospital. A CAT scan revealed blood on the child's brain. The radiologist reported V.V.'s injury occurred 24-36 hours prior to the test. The child is now undergoing specialized medical treatment and the family is under DYFS supervision.

The police investigation is pending and no charges have been filed.

If V.V. survives, he will have permanent neurological damage.

W.W.  
Age: 9 months

W.W. had received severe, non-accidental head injuries. The injuries were noted after the child returned from an outing with his father. The child's mother observed a scratch and lump on the child's head. The baby was also having difficulty breathing. The mother called 911. At the hospital, W.W. was diagnosed with a depressed skull fracture and swelling on the brain.

Surgery was performed on the baby to relieve swelling of the brain. The child was put on a ventilator. The child was found to have a skull fracture at the site of the lump. X-rays and a CAT scan of W.W. also disclosed two foreign objects in the child's body, one of which was in his stomach, both possibly metallic. His father was subsequently charged with endangering the welfare of a child. The case was still pending at the time this report was being prepared.

X.X.  
Age: 8 months

X.X.'s injuries were reportedly caused by his father when he tried to quiet the infant while talking on the phone to the child's mother. The injury was reported to authorities two days later, but the father was not criminally charged until 12 weeks later, when he confessed to the crime and was charged with aggravated assault. The case was still pending at the time this report was being prepared.

The parents took the child to the hospital and stated that the child was lethargic and not eating, and began having seizures on the way to the hospital. The child was subsequently diagnosed with subdural hemorrhaging and disruption of oxygen to the brain. The parents had no explanation of how the child may have suffered these injuries, although they said that the small children of some friends they lived with could have caused injuries to X.X.

The father admitted to causing X.X.'s injuries but claimed it was an accident. The baby will need long-term care.

This family had two previous referrals to the state Division of Youth and Family Services—both before X.X. was born. In November 2004, DYFS received a referral stating that the mother's home was filthy and there was domestic violence in the home. After investigation, the allegations were unfounded.

In December 2004, DYFS received a report that the local police department responded to an anonymous call concerning small children in a home where marijuana was being smoked. The police arrested others in the house but X.X.'s mother was reportedly not impaired and was capable of caring for her son.

Y.Y.  
Age: 11 months

Y.Y.'s baby-sitter contacted the infant's parents and said he was having involuntary spasms. He was taken to the hospital two hours later, where he was diagnosed with a subdural hematoma, multiple skull fractures and swelling to his brain. His doctor called the injuries traumatic and non-accidental. His condition was listed as critical and near fatal at the time.

According to a newspaper account, the babysitter claimed she dropped Y.Y. while he was having a seizure, but his doctor said that the injuries were inconsistent with this account. She was charged with aggravated assault. The case was still pending at the time this report was being prepared.

Z.Z.  
Age: 5-1/2 months

Z.Z. was in the temporary care of his father in New York. While there, he began vomiting and was taken to the hospital. He was diagnosed with a fractured rib, which had already started to heal, and subdural hemotoma, which was at least one week old. The doctor suspected Shaken Baby Syndrome, as there was no outside trauma. Y.Y. was admitted to the Intensive Care Unit in critical but guarded condition.

Prior to the injury, the parents had been to a wedding and left Z.Z. and his 2-year-old sister with a family friend in Long Island. The parents stayed out overnight. The next day, they went back to Long Island, where the kids were staying. The mother went out between 9 a.m. and 1 p.m. and left children with father. The father called the mother at 11 a.m. to inform her the baby had vomited. At 11 p.m., the baby vomited again. His parents brought Z.Z. to the home of a friend who is a doctor. He advised they take the baby to the hospital.

The doctor said the injury was at least 72 hours old, and may be Shaken Baby Syndrome. The injuries appeared to have happened at separate times, according to a DYFS intake summary. Z.Z.'s sister was still with the family friend. A referral was made to New York child protection services, and she was placed with her paternal grandparents. Z.Z. was discharged from the hospital eleven days after the incident and also placed in the physical care of the grandparents.

No charges have been filed.

A.B.  
Age: 6 months

A.B. was transported to the emergency room and was unresponsive. She was diagnosed with a fractured skull and blood on her brain, which the ER doctor determined to be the result of physical abuse. Due to her condition, A.B. was transferred to a specialized hospital, where it was reported that she had multiple skull fractures, bleeding and swelling of the brain and old rib fractures.

She was in the care of her father at the time of the incident. He had reportedly been drinking at the time. He claims to have seen A.B. shaking, at which point he unsuccessfully gave her CPR and chest compressions.

A.B.'s father pled guilty to assault. He had not yet been sentenced at the time this report was being prepared. A.B. was released to her mother's care. She requires continued medical treatment for her injuries.



## Source List

Records were obtained and reviewed from the following sources:

### **Medical Sources**

AmeriChoice of N.J.  
Atlantic City Medical Center  
AtlanticCare Regional Medical Center  
Anjali Biswas, M.D.  
Brick Hospital  
Center for Family Services Inc.  
Children's Hospital of Philadelphia  
Community Medical Center  
Dorothy B. Hersh Regional Diagnostic Testing Center  
Fairlawn Pediatrics  
Family Services of Burlington County  
Hackensack University Medical Center  
Jersey City Medical Center  
Jersey Shore Medical Center  
Jewish Renaissance Medical Center  
JFK Medical Center  
Kessler Institute  
Morristown Memorial Hospital  
Muhlenberg Hospital  
N.J. Cares Institute  
N.J. State Metabolic Screening Lab  
North Jersey Pediatrics  
Nyack Hospital  
Raritan Bay Medical Center  
Robert Wood Johnson University Hospital  
Shore Memorial Hospital  
South Jersey Regional Medical Center  
Steininger Psychiatric Crisis Intervention Unit  
Steininger YCM Program  
Value Options  
Warren Hospital

### **Medical Examiner's Offices**

Atlantic County Medical Examiner's Office  
Bergen County Medical Examiner's Office  
Camden County Medical Examiner's Office  
Essex County Medical Examiner's Office  
Hudson County Medical Examiner's Office  
Northern Regional Medical Examiner's Office  
Ocean County Medical Examiner's Office  
Southern Regional Medical Examiner's Office  
Warren County Medical Examiner's Office

### **Law Enforcement Agencies**

Atlantic County Prosecutor's Office  
Bayonne Police Department  
Bergen County Prosecutor's Office  
Cumberland County  
Fairlawn Police Department  
Hudson County Prosecutor's Office  
Jersey City Police Department  
Montclair Police Department  
New Jersey State Police  
Ocean Gate Police Department  
Ocean County Prosecutor's Office

### **Other Agencies**

Full case records from the Division of Youth and Family Services, NJ Department of Children and Families, for all DYFS-involved cases  
Catholic Charities  
Essex County Family Court  
NJ Administrative Office of the Courts  
N.J. Office of the Public Defender Conflicts Unit  
Phifer Middle School

## **ABOUT THE NEW JERSEY OFFICE OF THE CHILD ADVOCATE**

The Child Advocate's primary mission is to ensure the safety and well-being of children who are involved with state systems, especially the child protection, mental health and juvenile justice systems. To accomplish this goal, the Child Advocate monitors certain state agencies, using the office's statutory authority to hold these agencies accountable for the care and treatment of children under state supervision or guardianship. The Child Advocate recognizes that all children have the right to be safe, healthy and well educated. Through effective collaboration with policymakers and stakeholders, the Child Advocate works to craft innovative approaches to achieve positive change for New Jersey children.

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**Lissette Villegas**, *Receptionist*

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*To learn more about the Child Advocate go to [www.childadvocate.nj.gov](http://www.childadvocate.nj.gov).*