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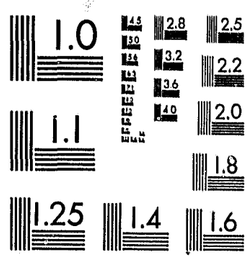

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Report
and
Recommendations
of the

STATE OF NEW JERSEY
COMMISSION OF INVESTIGATION

on the

INVESTIGATION
of
SUDDEN DEATH CASES

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U.S. Department of Justice
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November, 1979

TO: *The Governor and the Members of the Senate and General Assembly of the State of New Jersey*

The New Jersey State Commission of Investigation is pleased to submit this Report and Recommendations on the Investigation of Sudden Death Cases pursuant to P.L. 1968, Chapter 266 (N.J.S.A. 52:9M-10), the Act establishing the Commission of Investigation.

Respectfully submitted,

Arthur S. Lane, *Chairman*

John J. Francis, Jr., *Commissioner*

Lewis B. Kaden, *Commissioner*

Henry S. Patterson, II, *Commissioner*

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ACQUISITIONS

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Report of the New Jersey State Commission of Investigation On the Investigation of Sudden Death Cases

Introduction

The New Jersey State Commission of Investigation (S.C.I.) issues this report in an effort to demonstrate, and to reform, an inadequate area of the state's criminal justice system -- the lax handling of sudden death investigations. The following case studies of certain sudden deaths which occurred some time ago in Camden County are intended to serve as examples illustrating a larger law enforcement problem. The use of such case studies by the S.C.I. is not intended to reopen these cases or to suggest that any criminal activities took place that were not previously established. The Commission has utilized these case studies as a learning instrument to provide a foundation for the recommendations which are set forth in this report.

In addition, although the cases cited are concentrated in a single county, the S.C.I. regards them as revealing illustrations of more general investigative deficiencies upon which to base general recommendations. In fact, interviews with prosecutorial personnel in other counties have disclosed that deficient sudden death investigations can be identified in all counties. Therefore, this report should be read from a statewide perspective and its recommendations should be implemented on a statewide basis in order to assure a more uniformly

credible and adequate functioning of this phase of the criminal justice system everywhere in New Jersey.

*Summary of Recommendations**

The S.C.I. recommendations, summarized below and presented in greater detail at the conclusion of this report, are catalogued according to the official capacities each would affect. They reflect the Commission's view that the proposed administrative and investigative changes are dependent upon each other for the success of the whole. For this reason, the recommendations stress the importance of a more professional medical examiner function if the entire chain of law enforcement performance in sudden death cases is to be totally effective. This priority is based on the fact that a breakdown in handling sudden death cases too often begins with a failure to enlist adequate medical examiner expertise in the initial direction of an investigation and in the control, preservation and analysis of essential evidence. Such a critical deficiency must be corrected in order to guarantee the orderly start of a proper sudden death inquiry. Therefore, the Commission's recommendations highlight the need for an expanded and upgraded medical examiner role on a regional basis in order to assure a more professional course for such investigations.

*See P.149 for Detailed Recommendations

An adequate sudden death investigation, however, must necessarily involve both the County Prosecutor and Municipal Police. Thus, the recommendations also recognize the need to improve the effectiveness of each of these law enforcement entities -- particularly to achieve a more coordinated working relationship between county and local authorities and the appropriate Regional Medical Examiner acting under the authority of a more effective Office of State Medical Examiner.

The major recommendations, in brief:

The Medical Examiner System --

1. The State Medical Examiner must be empowered to establish and direct a regionalized statewide system of medical examiner offices as administrative adjuncts of the developing New Jersey Institute of Forensic Science at Newark.
2. At least three Regional Medical Examiner offices must be established at the outset. One such regional office must be operated in conjunction with the office of State Medical Examiner at Newark.
3. Each regional office must be operated by certified forensic pathologists and trained full-time supporting staffs.
4. Adequate medical examiner facilities must be available in each region to perform customary laboratory analysis and other autopsy work.

5. Existing county medical examiners must be phased out after a specified period of time when the Regional Medical Examiner offices would assume all of their statutory duties.
6. An effective network of communications must be established by the State Medical Examiner linking his office at the Institute of Forensic Science with all Regional Medical Examiner offices for the purpose of issuing autopsy and other operating directives, informational guidelines and professional reports on new expertise in forensic pathology.
7. Similar liaison must be maintained by the State Medical Examiner with County Prosecutors to improve law enforcement services to Regional Medical Examiners and for consultation on the qualifications of Municipal Police Departments in this respect.

County Prosecutors --

1. Each Prosecutor's office, or a sectional grouping of small-county Prosecutor's offices, must assume control of most sudden death investigations and for this purpose must establish a special unit of investigators trained in handling sudden deaths.
2. Such units must be required to assume full responsibility for the security of a sudden death scene, including preservation of evidence pending the assumption of medical examiner control over the scene. Such units could also be assigned to conduct

certain other types of specialized inquiries.

3. Prosecutors must establish with Municipal Police Departments flexible coordinating procedures, including the pre-qualification by the Prosecutor (after consulting with the State Medical Examiner and the Attorney General's Police Training Commission) of certain municipal departments to conduct initial sudden death inquiries.

Municipal Police Departments --

1. Broad but clearly defined areas of Municipal Police responsibility in sudden death cases must be promulgated, to include immediate notification of County Prosecutors and Regional Medical Examiners, as well as initial securing and preservation of a death scene pending the arrival of trained Prosecutor's units and medical examiner personnel.
2. Certain Municipal Police Departments with proven investigative capacities are to be accredited by County Prosecutors as capable of directing a sudden death inquiry pending developments requiring a Prosecutor's office to assume control.

Police Training --

1. All prospective police officers must be required to complete police training courses before assuming official duties.

2. Qualification standards must be established and imposed by statute for assignment to homicide, narcotics and other specialized squads.
3. In-service training must be required for all local police, particularly for superior officers prior to and after promotion to supervisory rank.

SUDDEN DEATH CASES

THE SUDDEN DEATH OF SPECIAL AGENT JAMES J. WHITE (1968)

Special Agent James J. White, 43, of the U.S. Treasury Department's Alcohol, Tobacco Tax and Firearms Division,* was found dead in 1968 in his ATF car in the parking lot behind a diner on Route 130, Pennsauken. Five weeks later the cause of his death was certified as a self-inflicted gunshot wound of the head. At the time his body was found he had been investigating a gun-running conspiracy allegedly financed by the underworld. Suspicion that White was murdered, fueled by media accounts of alleged organized crime involvement, led to the re-opening of the case twice -- by the State Police in 1972 and by the Camden County Prosecutor's office before a Grand Jury in 1974. Despite these repeated reviews of the White case, the mishandling of material evidence in the initial investigation continued to stir rumors of foul play.

The White investigation began when George Clinos, who was, according to the State Police, a manager and part owner of what was then the Prince Inn Diner, telephoned the Pennsauken Police Department at 11:02 A.M. Friday, September 27, 1968. Local police recorded Clinos as saying that an employee, A. Cortez, had observed a man at the steering wheel of a car in the diner's

*Generally known by law enforcement agencies as the ATF.

parking lot since the night before and also that "a man in a car on the parking lot behind the diner looks like he had shot himself." Not included in this initial sudden death record was the fact that Mrs. Mildred Faust, a waitress at the diner, had seen White's wounded head as she peered through a passenger side window of the ATF car when she came to work ahead of Cortez, at 10:45 A.M. Cortez reported at the time that an unoccupied 1962 or 1963 blue station wagon was parked one parking space away from White's car, but its actual owner, Mrs. Faust, was not identified in any investigative reports -- even though at least one story about her earlier arrival and observations at the death scene was published the following day in the Courier-Post of Camden. Although a photograph of the station wagon was taken by one of the first Pennsauken officers who responded to Clinos's call, the license plate was unreadable in the photograph. The ownership of the station wagon was neither thoroughly investigated nor officially established for a prolonged period of time. Mrs. Faust, who was the first to view White in his car with a bloody wound on the right side of his head, was questioned in only a general way by investigators at the scene and her name never appeared in any available 1968 police report about the case. (The significance of Mrs. Faust's recollections would become more apparent when she later appeared before

the Camden County Grand Jury, on February 28, 1974. On that date, when she testified about observing certain close-up details while looking through the window of White's car, she injected into the inquest record a contradiction of official versions of the death, namely that White's personal .38-caliber revolver had been found tightly gripped by him. The gun, Mrs. Faust told the Grand Jury, was <u>not clasped</u> in White's hands.)

After the diner manager's call to the police, Pennsauken Patrolmen John McBrearty and Joseph Eble arrived at the diner parking lot in quick succession. They were followed -- the precise times are unknown -- by Pennsauken Police Chief Joseph Brook, Lieutenant Nicholas Petitte and Detective Thomas Voight; by Prosecutor's Detective Edward Yeager, and by Camden County Medical Examiner Louis Riegert and his investigator, Thomas Daley. As the day progressed, numerous other law enforcement officers, including representatives of the Federal Bureau of Investigation, Internal Revenue Service, the ATF and State Police, converged on the scene in response to notification by police. Since the arrival time of most of these investigators was not noted in police reports, few of these officials could recall years later exactly when they appeared.

An exception was ATF Agent John Norris, whose appearance within minutes of the initial alarm was recorded by Pennsauken police. Norris's arrival was coincidental but also immediately helpful since he quickly identified White as a fellow agent. His superior in Camden earlier that morning, after receiving a worried query from White's wife that he had not been home in Willingboro since the previous day, had immediately assigned Norris to search for White along Rt. 130. At the time of Mrs. White's call, White was last known by his superiors to have been in a restaurant at the Airport Circle, which Route 130 intersects, during the afternoon of September 26. Norris, of course, did not know as he made his patrol of the highway that White would be found dead. According to his reports, Norris did little more than identify White to local police and notify his superiors of the death.

White was pronounced dead at the scene at 11:20 A.M. by Dr. Jerome Warren from the Pennsauken Medical Center. Dr. Warren noted an apparent gunshot wound of the right temple. He estimated that death had occurred 10 to 12 hours prior to the discovery of the body.

The inadequacies of the various inquiries now began to multiply. From the outset there was no centralized supervision of the overall investigation, no control over the handling and preserving of physical evidence and no coordination of the multiple governmental probes. In

addition, there apparently was no recognition by anyone, even ATF officials, that the circumstances of Agent White's sensitive ATF assignment particularly required a professionally thorough investigation of his death.

Pennsauken Patrolman Eble's report contained his and McBrearty's observations of the interior of White's 1965 Plymouth sedan. He said all of the car's doors were locked except the driver's door and all windows were shut except for window and vent of the driver's door. At the steering wheel was White, upright but with head slumped over. Eble entered the car through the back door behind White. The car keys were inserted in the ignition at the "off" position. A gun was in the agent's right hand, Eble's report said, and its holster was on the seat beside him. Eble also noted, without indicating how or when such information was obtained, that the revolver contained four live shells, one spent shell and one empty chamber.

White's gun, the investigation's most vital physical evidence, became from this point on the object of inept handling. No one knows to this day precisely where it was originally found, who initially examined its contents, who took formal possession of it at the scene, who transported it from the death car, or to what place it was taken. (Pennsauken's former Chief Brook conceded in testimony at the S.C.I. in 1979 that the gun was inadequately checked and preserved as evidence.)

Mishandling of the gun and other physical evidence in White's car first occurred directly after other Pennsauken police joined Eble and McBrearty at the scene. A series of photographs by Detective Voight of the interior of the car revealed that a pack of cigarettes, a sports jacket and other items had been moved about during the picture taking. This error was compounded when Voight, while trying to get a close-up photograph of the gun, inadvertently dislodged it. (At the time he said that, before he entered the car, the gun had fallen from White's right hand. In a statement years later to the S.C.I., Voight described the original position of the gun as in White's lap rather than his hand, adding that he tried to restore the gun to wherever it had been before being disloged. Thus, Voight's first admission that he had dislodged the gun was in his responses to questions at the S.C.I. on December 21, 1978. None of the available photographs of the interior of the car showed the location of either the gun or its holster).

Eventually the gun and its holster were removed from White's car but, as noted, without any official recording of who took them or when and where they were taken. They were gone from the car when the first contingent of State Police arrived early in the afternoon, according to Trooper Detective James Howard.

State Police Detective Sergeant J.J. Schaffer and Detective J.M. Tomko were assigned to photograph the death scene and collect physical evidence. Howard was told by someone that photographs already had been taken of both the gun and holster but such photographs never materialized. Tomko noted in a subsequent report that he snapped 14 photographs, gathered two samples of blood from the interior of the car and removed certain articles from the car for fingerprint processing. Tomko, who later would help Schaffer fingerprint White at the Camden County Morgue, obtained five latent fingerprints from the exterior and interior of the agent's car. Despite Tomko's progress, no reports could ever be located indicating the results of any comparisons, if any, of the fingerprints.

As assorted law enforcement personnel conducted their initial, and largely independent, investigations at the Prince Inn, White's body was transported to the Camden County Morgue, where an autopsy by Dr. Riegert was performed at 4 P.M.

In his post-mortem report later that day, Dr. Riegert attributed the death to "a perforating gunshot wound" of the skull and brain and noted the manner of death as a suicide. In this report, Dr. Riegert included certain comments which added to the contradictions already surfacing among the federal, state, county and local investigators. According to his

commentary, the gun was not in White's right hand or in his lap. Wrote Dr. Riegert: "A pistol was found on the seat of the car by decedent's right side." The source of this statement is not attributed in the post-mortem report, but Dr. Riegert later said that was what he was told about the weapon over the telephone either by his investigator, Daley, or by some other official at the scene. He also noted that the wound in White's head was "2 & 3/4 inches above the right ear."

During an interview at the S.C.I. years later, Dr. Riegert reviewed his autopsy report and noted that the entrance wound was higher in the temple area than would be expected in a suicide by gunshot and that the trajectory of the bullet was right to left, forward to back and downward. The area from which the bullet was extracted -- "4 inches in back of the ear" -- was not described adequately. Dr. Riegert conceded he made no attempt to approximate a time of death but merely listed the time at which Agent White was pronounced dead.

Additional details about ATF Agent Norris's ill-fated search for White on the morning of September 27 were provided in a report on White's activities during the previous day by State Police Investigator Walter Wasyluk. Wasyluk, who obtained his information from

ATF Area Supervisor Ralph Bush in Camden, among others, said that around mid-day of Thursday, September 26, White, had left Bush's office to meet Nicholas Gaglio, another ATF agent as well as a close friend, at Montanaro's Restaurant off the Airport Circle in Pennsauken. Bush then heard nothing more about White until he received a telephone call from Mrs. White the following morning at about 8 A.M. Mrs. White reported that her husband had not come home the night before and asked Bush where he might be. Bush followed up Mrs. White's call by assigning Norris to check parking lots along Route 130 in an effort to locate the missing agent. Shortly after 11 that morning Norris reported back that White had been found dead in his car at the Prince Inn parking lot.

Meanwhile, Investigator Wasyluk also checked with Gaglio about his rendezvous with White at Montanaro's. Gaglio said he and White spent five hours talking and drinking at the bar. At 6:30 P.M. they left the restaurant and went to their separate cars, Gaglio driving away first. Gaglio reported that White declined his invitation to stop at a place closer to their homes. During their long conversation at the bar, Gaglio said he perceived no signs of depression on White's part. However, Gaglio told Wasyluk that White, although indicating continued interest in his current ATF assignment, had talked about requesting a transfer to Vermont. White apparently went from Montanaro's

directly to the Prince Inn Diner only a few miles away, since a waitress at the diner recalled serving him coffee at 7 P.M. That was the last time White was seen alive by anyone who could identify him.

Other diner employees questioned by police recalled only that they had seen a man who appeared to be sleeping in his car in the parking lot at 9 P.M. Thursday and at 2 A.M. Friday. The diner's parking lot lights had been turned on between 6 and 7 P.M. No shots had been heard during the night by anyone, according to available investigative accounts. With respect to the evening's visibility in and around the parking lot, Wasyluk had ascertained that sunset on September 26 occurred at 6:45 P.M. and that complete darkness set in at 7. Even though the parking lot was amply lighted, his report concluded, a passerby would have had to come close to White's car to discover that anything was amiss.

State Police and ATF agents who interviewed Mrs. White reported her contention that her husband did not commit suicide. She said he had left work on September 26 in "fine spirits." She confirmed his request for a transfer to Vermont but said he was devoted to his duties with the ATF, and also that he was a good family man. A favorable performance and personality picture of White also came from his ATF colleagues and superiors. Although he was known by

some of his associates to have been frustrated by certain departmental decisions regarding ATF investigations, he was described as a diligent worker of unquestioned integrity.

Although White's investigative assignment at the time of his death was a highly confidential matter, the ATF indicated his wife knew some details of his final investigation and was worried about his safety. A wrap-up report by the ATF on the White death noted that when Mrs. White was first informed of her husband's death, her immediate reaction was, "I knew it. It's my fault."

In the meantime, various evidential items in the case were undergoing tests and analyses but with either varying conclusions or no references and reports as to results. State Police Detective Tomko never mentioned in his reports whether White's gun was ever analyzed for blood or fingerprints, nor were any such tests of the gun noted in reports of the State Police Laboratory in West Trenton. The ATF in its final memorandum on the case suggested an explanation for this. In the memorandum, Chief Special Investigator Paul Hankins said the failure to find fingerprints, palm or hand prints, or any print smudges or blood splatters on the gun "is explained to the satisfaction of the State Police by the fact that the gun had been removed from the very tight grip of White's right hand at the time the body was found." Hankins's summary continued:

"It had appeared to the officers a simple suicide case and no special precautions were taken to preserve any evidence that may have been present thereon. Between then and the time it was examined it had been handled by several persons and any traces of blood or prints would have been worn off. Why no prints were left by the several persons who handled the gun was dismissed without further discussion."

Hankins also noted that the laboratory examination of skin and tissue removed from White's scalp in the vicinity of the gunshot wound had revealed no traces of gunpowder residue that would normally result if the gun was discharged within 19 inches of his head. He said this was explained by the State Police "as being due to insufficient area being taken in the sample" of small cuttings from the perimeter of the wound.

Medical Examiner Reigert, subsequently commenting on this subject to the S.C.I., admitted that his original autopsy report was negligent in not mentioning either the presence or absence of gunpowder and burning in the area of the wound. Since he had determined that this was a contact wound, he said he was "surprised" when he learned of the State Police laboratory's negative report. Noting that the skin tissue sent to the laboratory would not have been washed or otherwise disturbed, the negative gunpowder test was confusing, he said. This sequence of events was puzzling because, as confirmed by the State Police in 1972, the shells in White's gun contained black powder. This now

obsolete substance generally resulted in severe soiling of wounds but no such result was noted in the White investigation.

A Neutron Activation Analysis (NAA) test of White's gun, undertaken in 1968 when it was a relatively new investigative technique, came under criticism in 1972 when State Police reopened the case. The 1968 NAA test showed White had fired the weapon, based on the understanding in law enforcement circles at that time of the way the test should be interpreted. Subsequently revised guidelines for interpreting gunpowder residue tests would have indicated a contrary finding. By 1972 NAA test standards, for example, it was determined that the levels of barium and antimony present were insufficient to demonstrate White had fired the weapon. The State Police in 1972, therefore, labeled the original gunpowder residue test results as inconclusive.

The failure to preserve evidential matter on the gun and the inadequacy of skin samples for gunpowder tests were believed by the investigators to have been so overshadowed by indications of suicide as to proscribe any death cause other than the ultimate official verdict of suicide. Hankins observed that, "despite these two final inconsistencies," other circumstances -- the natural

position of White's body at the steering wheel, the absence of facial contortions indicating surprise or fear, the difficulty for a murderer to conceal himself in the well-lighted parking lot and other areas of a busy diner, the fact that all the car doors were reported to be locked except the driver's door, the neat arrangement of personal items in the car and no signs of struggle -- "have led the State Police to the conclusion the death was a suicide."

Other tests, of White's vital organs and stomach contents and of blood samples for alcoholic content, were made at the State Police Laboratory. The examination of stomach contents led to an estimate that digestion ceased at between 6:20 and 7:50 the night before White's body was found. The alcohol level in White's brain was found to b\ .165 per cent (at the time, .15 per cent was the level at which intoxication was presumed for operators of motor vehicles.) A writing tablet in White's car was tested for evidence of indentations on blank sheets that might have been made if White had attempted to write a suicide note and discarded it, but no such indentations were found.

Nonetheless, confusion about the location of White's gun and the disappearance of evidential matter on it clouded all aspects of the inquiry. There were no documented immediate efforts to resolve such basic investigative deficiencies.

There also was no reference in any reports on whether White's gun was traced for registration data. Identification of White as the owner of the gun apparently was assumed on the basis of the oral statements of other ATF agents. State Police Detective Howard, noting such conversations, said he believed the gun had been issued to White by the ATF. The S.C.I. subsequently initiated its own gun registration tracing and verified in early 1979 that White had purchased the weapon from a retired New York City policeman.

After almost four weeks of more or less simultaneous investigations by various law enforcement agencies, certain key officials decided to hold a conference. This meeting took place on October 22, 1968, at the Pennsauken Police Department. State Police Lieutenant Wildes, as the senior officer of what Hankins described as "the primary investigating agency," presided. Present were numerous representatives of the State Police, Pennsauken police, Camden Prosecutor's office, ATF, U.S. Department of Justice and the inspection service of the IRS. Lieutenant Wildes reviewed findings that led to a conclusion of suicide and a prolonged discussion took place of various elements in the inquiry. Although the consensus at adjournment was that White had shot himself to death -- and apparently no disagreement with this decision was voiced during the meeting -- dissenting opinions reportedly were shared privately as the gathering broke up. For one, White's immediate

superior, Ralph Bush, was adamant at the time that the agent had not committed suicide. Less than a week before the meeting he had concluded in a report, dated October 17, that "of all persons knowing the deceased, none could offer any motive (as to) why he should have taken his own life."

Afterward representatives of the principal agencies who had attended the conference compiled summaries of it and of phases of the investigation. These summaries were regarded as formally winding up the overall sudden death probe that began in the morning of September 27, 1968. Detective Howard wrote a "supplementary investigation report" on behalf of the State Police, dated October 22, 1968, in which he characterized the status of the case as "closed." Hankins's memorandum of review, dated October 31, 1968, concluded with the statement that White, "unable to resolve all these inner conflicts and stresses brought on by his prolonged work on critical cases which limited his time at home with which to cope with his personal problems he, in a moment of extreme despondency, took his own life." The report of Camden Prosecutor's Detective Yeager, dated November 4, 1968, coincided with the other reports on the suicide decision.

Hankins's memorandum mentioned several "inconsistencies" in the investigation -- the absence of evidence from the gun due to mishandling it and the inadequate sampling of skin and tissue around the wound for gunpowder residue tests. However, a comparison of all the reports compiled

after the October 22 conference revealed other areas of disagreement, contradiction or oversight.

The origin of the bullet found in White's head was described with confusing contradictions by different investigators. Although the State Police Laboratory report by Sergeant August O. Hoppe said the bullet was too mutilated to be of value for firearms identification, an opinion was attributed to Hoppe by both Hankins and Yeager that the bullet did come from White's gun. Nonetheless, both Hankins and Yeager stated in their reports that the crumpled slug could not be compared with that gun, contrary to a separate statement by Detective Howard that "the victim's gun and fired cartridge showed they both were fired from the same weapon."

Although only Yeager's report referred to County Medical Examiner Riegert's autopsy findings, including the decision to label the death a suicide, he did not point out that the Medical Examiner had commented in his post-mortem report that the gun "was found on the seat of the car by the decedent's right side." Hankins wrote that the gun had been in the "very tight grip" of White's hands and Yeager, at greater length, observed that the weapon "was found tightly grasped by the right hand of the victim and in such a manner to indicate that he had held the gun prior to his death and had fired the fatal shot." Yeager later testified at the S.C.I. that his information was derived from others and that he never saw the gun in the position described in his report.

Photographs taken of the interior of White's car after he was found dead indicated certain personal items had been moved about during the photographic effort. However, Yeager reported only that "the properties of the victim were neatly positioned within the vehicle, the victim's jacket was neatly folded and lying upon the front seat, as was the custom of the victim." The source of the last statement was not indicated by Yeager. Hankins reported similarly. Both Hankins and Yeager said there were no signs of a struggle in the car at the time of White's death. Howard said a State Police review of the evidence "did not reveal anything that would point to foul play." Hankins devoted more than two typewritten pages to the background, personality, home life and working demeanor of White, leading to his conclusion that White shot himself "in a moment of extreme despondency." Yeager and Howard mentioned this matter only briefly.

Disparities and omissions in the investigatory reports were never clarified before the case was closed in October, 1968. As indicated by certain similar statements in the final reports, a snowball pattern was evident in which various agencies without crediting a source merely adopted information from other police reports as their own, thus making an initial finding, even though not verified, an assumed fact. This was particularly true of the assumed location of the gun when White's body was found. The initial remarks of those first at the scene that it was tightly gripped

in his right hand, despite a contrary statement by Medical Examiner Riegert, became the rigidly accepted version of all investigating forces. This snowball theory might have been confirmed or disproved had an effort been made in 1968 to systematically survey each of the officers who first arrived at the scene, including particularly Pennsauken Detective Voight. Former Chief Brook testified at the S.C.I. that he never questioned his officers about what occurred upon their arrival.

The Pennsauken police reports in the White case could not be located at that department years later when the S.C.I. sought to inspect them, although appropriate police procedure would dictate that they be preserved. Copies of some reports subsequently were found at the Prosecutor's office.

A disturbing element that developed during the course of the S.C.I.'s inquiry was an assumption by the investigators that White had held his gun in both hands and fired it into the right side of his head. As previously noted, the location of the wound two and three-quarter inches above the right ear, and the downward and backward trajectory of the bullet, would have made it unwieldy if not impossible to fire a gun held by both hands. Further, the appearance of blood splatters on the back of the agent's hands and wrists was inconsistent with the two-hand gunshot theory since the location of the stains suggested they occurred when White had both palms facing away from him.

The Commission noted during its examination of the White investigations the absence of any coordination among the several governmental teams of probers who were at work on the case in 1968. Statements made by certain investigators to the S.C.I. indicated they were confused over which agency, if any, was assuming a dominant role -- a necessary element for an efficient investigation that should have been even more apparent in view of White's status as a law enforcement agent whose death occurred while he was assigned to a sensitive investigation. Although Hankins referred to the State Police as the "primary investigating agency," Lieutenant Wildes, who subsequently retired from the State Police, testified at the S.C.I. that the police in Pennsauken, where the body was found, were in charge and were assisted by the County Prosecutor's office. However, Pennsauken Detective Voight stated under oath at the S.C.I. that no formal reports were issued by his department during the course of the investigation because "the Feds" had taken control of it.

While there was a considerable exchange of information among the investigating agencies, County Detective Yeager, State Police Detective Howard and others testified at the S.C.I. that ATF officials had not been fully cooperative. Lieutenant Wildes said State Police did receive ATF data, but he indicated this data may not have been relayed to other agencies in the probe. Yeager in his testimony before the

S.C.I. noted that there was no central coordinator in the investigation and stated that the investigation "should have gone a lot further. It should have just been a better investigation. It was not a good one." Similarly, at the time he testified before the S.C.I., Howard stated that he was not satisfied with the way the investigation was conducted, that "it was too haphazard with too many departments not working together."

There was, however, at least one commendable example of interagency cooperation in the White case. The completion of White's death certificate by Medical Examiner Riegert was delayed despite his autopsy determination of suicide, at the request of ATF Enforcement Chief H.V. Mattera until the conclusion of certain toxicological and gun tests. A death certificate was then marked "pending further investigation" after Dr. Riegert was informed that Agent White had been engaged in an important and complicated ATF investigation. The death certificate was not finally changed until November 6, 1968, when the manner of death was listed on the document as a suicide.

The White case re-investigations in 1972 and 1974, although they also concluded that his death was a suicide, nevertheless served to further emphasize the inadequacies of the 1968 probes.

In 1972, the Major Crimes Unit of the New Jersey State Police re-examined the White death after publication

by Philadelphia Magazine of an article criticizing the investigation and indicating that White was murdered. This State Police review confirmed several discrepancies that had not been resolved when the initial inquiries closed. For example, the 1972 probe determined that the death scene had been disturbed but not intentionally. In addition, further details on the mishandling of White's gun were added to the investigative record -- without, however, ever documenting who had removed the gun from the car. Also, the 1972 inquiry determined as "faulty" the use of a 1968 Neutron Activation Analysis test as a basis for concluding that White had fired the death gun.

According to reports filed in February and March of 1972 by State Police Detective Sergeant Schaffer, each of the Pennsauken police officers who had appeared at the death scene on September 27, 1968, was interviewed. These interviews focused on the primary investigative mistakes - the altering of the death scene and the mishandling of White's gun. Each of these officers agreed to be subjected to follow-up polygraph tests.

The polygraph tests were conducted, according to one of the State Police reports, "to determine if any of the above had prior knowledge of any plan to kill White and if any of the above police officers had disturbed the scene on purpose." These two factors had been "inferred," the report said, by the magazine article that had precipitated the 1972 re-opening of the case.

Detective Sergeant Schaffer, after concluding his interviews with local police, reported on February 18, 1972, that "Pennsauken police or some other person may have altered the original scene by moving the weapon and jacket found in the vehicle; but it is felt that this was done by person or persons unintentionally, and not maliciously or intentionally to distort the scene and facts at hand."

After the State Police completed their interviews and polygraphs and reviewed ATF and other federal case files, the second investigation of White's death ended. The concluding report, dated April 24, 1972, said that at no time during the State Police Major Crimes Unit review and analysis of the 1968 investigation "could the unit uncover any thing to indicate other than the fact that Agent James J. White committed suicide" and that "the case should be termed closed."

A re-opening of the White case by the Camden County Prosecutor's office in 1974 resulted because of questions raised by John J. Rafferty, then Pennsauken's police director.

A county Grand Jury in February, 1974, heard three witnesses -- Rafferty, Mildred Faust, an employee of the Prince Inn Diner in 1968, and a Zenon J. Rotuski, who had mentioned the White case while in the temporary custody of two Pennsauken policemen in 1972.

Rafferty, a former IRS inspector who had told the State Police in 1972 that he felt White had been murdered, reiterated before the Grand Jury his doubts about the 1968 investigation and particularly about the concept of White being found with his gun gripped in his right hand. Mrs. Faust testified that, until just prior to her 1974 Grand Jury appearance, she had never been formally questioned at length by any investigator since she first saw White dead in his car on the morning of September 27, 1968. She also told the Grand Jury that White's gun was not clasped in his right hand. Rather, she testified, White's left hand was "laying in his lap on the gun...on top of the gun" and White's right hand was "lying face up...on his leg." Rotuski, who had reportedly told Pennsauken police in 1972 that a certain Anthony "Mad Dog" DiPasquale had bragged to him that he killed White, denied making such a statement in his Grand Jury testimony.

The 1974 investigation was concluded by Assistant Prosecutor Seaton in a memorandum dated August 6, 1974. This memorandum stated that "because of the lack of any contradictory evidence concerning this matter it is felt that the initial determination that Agent White committed suicide is correct."

In general, the re-investigation of the White case in 1972 and 1974 did little more than confirm the 1968 investigative deficiencies that helped to stir rumors of foul play that were bound to arise after the sudden death of

a federal agent. The initial White investigations, which as noted had no central direction, no uniform standards for preserving evidence, no coordination of tactics and strategies of the various investigative groups, thus remained a fertile source of speculation about unsubstantiated connections of the underworld to the agent's sudden death.

THE SUDDEN DEATH OF DOMINIC M. TERENZI, JR. (1969)

The investigation of the sudden death of Dominic M. Terenzi, Jr., began with a telephone call to Camden Police Department at 3:59 P.M. Friday, January 17, 1969. The caller reported that there appeared to be a dead youth lying in the back seat of a car parked in front of his house on North 28th Street. When police responded to his call, the witness advised them he had first observed the car about 45 minutes earlier but had not at that time paid particular attention to it. Other North 28th Street residents told police they had seen the same vehicle previously, as early as 1 P.M. City detectives and a County Medical Examiner's investigator who went to the scene ordered the body removed to Cooper Hospital, Camden, where death was pronounced by Dr. Robert Orsi at 6 P.M. The owner of the parked car was identified as Dominic M. Terenzi, Sr., a Pennsauken patrolman who has since retired. He went to the hospital and identified the body at 6:23 P.M. as that of his son, Dominic M. Terenzi, Jr., 20.

City Detective Gilbert Upshaw, who was assigned to the case, made several observations of the body. At the scene he noted bruises on the right and left rib cage as well as numerous long scratches on the stomach. Later at the hospital he observed a fresh puncture on the right arm near the vein on the underside of the elbow and two other punctures on the bridge

of the nose.

As the Terenzi death investigation got underway, a telephone call was received by a detective in the Camden Police Juvenile Bureau that, by coincidence, quickly gave the inquiry a focal point. That call was from Henry M. Phillips, who said his daughter, Rose Patricia, 14, who had been reported as missing the previous day, had returned home extremely upset. He told police he was concerned about her condition and felt she should be questioned to determine what had happened while she was missing to frighten her. Questioning of Rose Patricia enabled police to learn for the first time the whereabouts and some of the activities of young Terenzi the night before he was found dead in the car.

Rose Patricia told two detectives assigned to question her that after she left home on Thursday, January 16, she went to the apartment of Robert and Elsie Briggs -- Elsie was her sister -- located on the second floor of 220 South 34th Street, Camden. While at the Briggs apartment, at about 7 o'clock that night, a young man arrived who was identified to her by her brother-in-law as Dominic and whose last name she learned subsequently was Terenzi. She said she overheard Dominic ask Briggs for some "stuff," which she knew to be heroin. Soon after that, she said, Briggs and Dominic left the apartment together.

When they returned about an hour later, they went into the kitchen.

Rose Patricia, who stayed overnight at the apartment, continued with her recollections to the detectives:

Not long after Briggs and Dominic entered the kitchen, Rose Patricia heard a thud-type noise, after which Briggs called out to his wife, who was in the bathroom, that Dominic had passed out. Rose Patricia then assisted in efforts to revive Dominic. When this failed, her sister, Elsie, asked Briggs to take him to the hospital. Briggs refused, saying he was afraid questions would be asked. Rose Patricia and Elsie then helped Briggs carry the apparently unconscious youth downstairs to his car, which was parked outside. Robert drove away in the car. When he returned later he left Dominic in the car. At about 11 or 12 o'clock that night, Dominic, apparently still unconscious, was carried back into Briggs's apartment. During the night he continually moaned and made other "awful" sounds. Frightened by these noises, Rose Patricia persuaded Elsie to leave the apartment some time early Friday morning, January 17. She and Elsie, with the two young Briggs children, went to the home of friends in Delair. Although this house was more than three miles away, the two sisters and two children began to make the trip on foot but were given a lift to the place while enroute by an acquaintance of Rose Patricia's. Early that Friday afternoon, Elsie

received a telephone call at Delair from her husband. Briggs, according to Rose Patricia, told Elsie that Dominic died and said the two of them should keep quiet about the entire matter. A short time later, Briggs also arrived at the house in Delair.

Rose Patricia, in testimony before the S.C.I., recalled that at least two other men -- the brothers Nicky and Robert Petitte -- were with Briggs when he came to Delair. She also recalled that there were a number of people at the Briggs apartment late Thursday night when Dominic was seemingly unconscious in the living room. She said these visitors included George Sleister, Tom Roe, Nicky Petitte, Vernon Moody and a Sonny. When Detectives questioned Mr. and Mrs. Briggs, they never asked them who had come to their apartment during the night nor did either Briggs or his wife mention any visitors other than Dominic.

Robert and Elsie Briggs were not questioned formally by either Camden city or county authorities until the morning after Dominic's body was found. However, what transpired when police located the couple and transported them to city police headquarters for interrogation at 1:30 A.M. Saturday further illustrated the lack of investigative expertise in the sudden death inquiry.

The couple was taken to the police station by City Detective Sergeant George McKenzie and at least one other officer. Whoever was assigned to accompany McKenzie is not known because no report on McKenzie's activities was

ever filed in the case. Both Robert and Elsie Briggs were well known to McKenzie since he had "used" Briggs as a source of information in connection with certain cases of breaking and entry that had been under investigation. McKenzie, while at the Briggs apartment, requested and received Briggs's "set of works," the vernacular of drug users for the hypodermic needle and syringe used for injections. While these items were never turned in as investigative evidence, for reasons unknown, another hypodermic needle reportedly found on North 28th Street about a block from the spot where Terenzi was abandoned by Briggs was included in a casual manner as part of the Terenzi case. This needle had been brought to the attention of a detective by a citizen who found the soiled item several days after the Terenzi death. The detective who submitted this needle later testified under oath that he did so not because he thought it would be relevant to the case but because he did not want to "just leave it on my desk." This needle was never analyzed for traces of narcotics or poisons, a lapse for which no explanation can be found in the investigative reports.

After McKenzie arrived at the police station with his charges, City Detective Upshaw and County Prosecutor's Detective Harry DeVore spent more than two hours -- until 3:15 A.M. Saturday -- taking statements from Robert and Elsie Briggs. Their separate versions of what allegedly happened at their apartment Thursday night and

Friday morning contained a number of inconsistencies which were never resolved by the police.

According to Briggs's statement, he admitted "taking" heroin with Dominic and then attempting to revive him by injecting salt into his body. Briggs contended he did not take Dominic to a hospital because the youth pleaded with him not to do so. According to Briggs's story, Dominic urged him instead to "shoot him with salt" and also to use ice packs if that didn't work. When the revival effort failed, Briggs said, he moved Dominic to the Terenzi car and drove around the city -- with the car windows wide open in below-freezing weather. He conceded also that during this cruise he purchased a bag of ice and packed the ice under Dominic's arms and around his genitals in a further attempt to revive him. Briggs said that after he brought Dominic back to his apartment, with the assistance of a boarder at the apartment, he went to sleep. When he awoke a few hours later, he assumed that the youth had died sometime during the night. He then put Dominic back in the car and abandoned him on North 28th Street. Upon completion of his statement, Briggs was arrested on a charge of failing to report an unusual or suspicious death.

Elsie Briggs in her statement of January 18, 1969, to the authorities said her husband had played a more dominant role in his and Dominic's quest for drugs early Thursday evening than Briggs had admitted in his

statement, although she was to reduce her husband's influence over Dominic in subsequent testimony some years later. After Dominic's collapse in the Briggs kitchen, her version of the effort to revive him also differed from Briggs's. For example, she claimed Dominic said nothing after the heroin injection. She also said Briggs told her "he was going to take him to a hospital." She gave details of Briggs's telephone call to her at the house in Delair that were not in Briggs's statement about what happened after he left Dominic on North 28th Street -- namely, that Dominic "wasn't breathing and blood or something was coming out of his mouth," that Briggs "took him some place" but didn't say where, only, "never mind, I just took him."

Another version of what took place at various times late Thursday night and early Friday morning came on January 18 from William T. Roe, Jr., Briggs's boarder.

Roe was questioned at 3 P.M. that Saturday by Camden Detectives Upshaw and Earl Smith. Roe admitted helping Briggs bring Dominic from his car to the upstairs apartment at about 12:30 A.M. Friday, but he maintained that Dominic was breathing at that time. Roe, who said he had been out with his girl friend Thursday from 4:30 P.M. until he returned after midnight, related that he went to bed after helping to bring Dominic into the apartment and that he got up at 6:20 Friday morning and went to work. Roe said he

did not know Terenzi. Later that day, he said, Briggs told him that Dominic was dead from an overdose.

Prior to police interrogation of the boarder, an autopsy was performed on Dominic by the then-Assistant Camden County Medical Examiner William Read at 11:15 A.M. Saturday, January 18, 1969. The autopsy was witnessed by City Detectives Upshaw and Estel Brown and Prosecutor's Detective DeVore. The medical examiner's performance in this case, as with other sudden death investigations described in this S.C.I. report, was inadequate.

Dr. Read compiled the autopsy report within 24 hours of the discovery of Terenzi's body and while the investigation of the death was still underway. He diagnosed the cause of death as "severe acute pulmonary congestion and edema, due to a probable overdose of a drug, type undetermined." Dr. Read did not examine the puncture marks on the bridge of Terenzi's nose or on his arm for traces of narcotics or poisons, an examination Detective Upshaw later told the S.C.I. he had requested. Although Dr. Read suspected a drug overdose, certain body fluids that are particularly useful for drug tracing -- such as urine and gall bladder bile -- were never submitted for a toxicological test. Later that Saturday, Dr. Read filled out a death certificate stating the cause of death as acute broncho-pneumonia, but withheld issuance of it pending the return of a State Police toxicological report. Nonetheless, after

receiving this report (dated April 11, 1969), which stated that examination of Terenzi's blood and body organs was negative for drugs but positive for strychnine and phosphorous, Dr. Read "issued" his January 18 death certificate on April 23 without change. Years later he told the S.C.I. that, while he had not "discounted" the findings of the State Police Laboratory, he had decided nevertheless to adhere to his original diagnosis.

Dr. Read was questioned at the S.C.I. about his reaction to the State Police toxicological report, since its findings appeared to contradict his death certificate. He conceded that he had made no effort to clarify how much and what type of phosphorous was present in Terenzi's blood or what impact on the death the confirmed presence of strychnine might have had. As noted, Dr. Read's autopsy report indicated the possibility of an accidental, rather than natural, death due to a drug overdose. Nonetheless, this report contained a "face sheet" signed by Dr. Read which characterized the death as a natural death -- a coincidence which apparently contributed to the absence of continuing action in the case for more than a year. For example, Detective Upshaw, the primary investigator in the case, told the S.C.I. his effort to convince the Prosecutor's office that a serious crime may have been committed was hindered by the cover sheet classification of the death as natural. Dr. Read told the S.C.I. that the contradictory facing page of his autopsy report was a secretarial mistake to which he had nevertheless affixed his signature.

On the Monday after Dr. Read's autopsy, three vials of blood and certain of Terenzi's body organs were delivered to the State Police Laboratory in West Trenton for the examination that resulted in the April 11 toxicological report. The official form submitted by Detective Upshaw with the test materials specifically requested that they be examined for possible traces of rat poison. Although Upshaw later told the S.C.I. that he questioned suspicious circumstances surrounding the Terenzi death at the very outset of the investigation, nothing in the police file on the inquiry indicates what prompted Upshaw's suspicion. The file shows that sparse investigative effort was made to affirm or allay Upshaw's questions.

The failure to thoroughly follow up on other investigative leads also was apparent, including the activities of Camden police in connection with statements by a prisoner at the Philadelphia Detention Center that young Terenzi's life had been threatened by certain of his street associates. This prisoner was identified in a telephone call on January 24, 1969, to the Camden Police Department's detective bureau as Terry Lee Maute of Pennsauken. He allegedly had stated at the Philadelphia Detention Center that he had heard a group of men, including Robert Briggs, discussing how "they were going to kill Dominic with an overdose of narcotics because he had ratted on George Sleister for narcotics."

Detective Upshaw on January 27 talked with Maute. He also examined a statement of recollections regarding Terenzi that Maute had written. He was denied a copy of it by the Detention Center. On April 4, 1969, Maute gave a sworn statement to Camden Detectives Joseph McComb and Earl Smith, which largely substantiated the information Upshaw had obtained during his interview with the prisoner more than two months earlier.

According to this sworn statement by Maute, he heard threats on Terenzi's life at a meeting in Rand Street, Camden, on November 12, 1968. He said Terenzi was at this meeting, as were Robert Briggs, George and Joe Sleister, and "a guy named Tony." Maute alleged that at this meeting Dominic Terenzi was accused of responsibility for the arrest of Joe Sleister and that Briggs had said that "Dominic would have to be taken care of before they all ended up in jail." Maute's statement also said:

"George, Joe and Briggsy all agreed that it would be easy because Dominic never hardly checked his bag of heroin before he would take it. While Dominic was there, Joe said, 'how are you doing, rat?' Joe asked him if he was going to retract his statement and Dominic said he didn't make any. George told Dominic, did he know what we do to rats. All four of them, Joe, George, Briggsy and Tony, said they were going to get him if Joe went to jail. Dominic left the house. George

told Joe not to worry, that he would take care of Dominic so he would not be able to testify in court. All four of them agreed to this."

Joe Sleister did wind up in jail, Maute confirmed. He was then asked if he later heard any of the four men who were at the meeting "say how they were going to take care of Dominic." Maute replied:

"Yes. Briggsy said that they could put a lot of dope into one bag or put something else into his bag and Dominic wouldn't know the difference until after he took it."

In addition, Maute said he was with Briggs and George Sleister later when they were discussing the fact that Joe Sleister was in jail and that "they would have to do something about Dominic now." He was asked if he ever heard how they would "fix up" a bag of heroin, and Maute replied: "Yes, with lye or some other type poison."

The police file on the Terenzi death -- after Upshaw met with Maute on January 27 and after Maute gave police his sworn statement on April 4 -- with the exception of a brief interview of George Sleister on April 3 -- is silent on whether anything was done to verify or otherwise take action on Maute's recollections of the statements threatening Terenzi.

Also on January 24, 1969 -- the same day the Camden police received word of Maute's statements in the Philadelphia prison -- the Camden detective

bureau was notified by Terenzi's father, then still a Pennsauken policeman, that a Robert Petitte of Delair had information about his son's death. City Detectives Joseph Alesandrini and James F. Anderson wrote two reports on this notification, one acknowledging the telephone call itself and the other saying a statement had been taken from Petitte, of 8127 Eden Lane, Delair, regarding young Terenzi's death. The second report had no comment on what Petitte told the detectives other than that collateral information had been obtained involving Robert Briggs in several thefts.

However, the actual statement taken from Petitte erroneously identified him as Robert George "Batiste" and listed an incorrect street address for him. The statement also was not signed by Robert Petitte, nor was he asked to sign it. The two detectives later acknowledged to the S.C.I. that it was standard practice to procure such a signature.

Petitte's two-page statement said Petitte had a conversation with Elsie Briggs during which she told him that "they" forced a needle on Terenzi, beat him up and then shot a needle in his nose. Petitte also said Elsie told him that George Sleister was present at the time of this incident.

Thus, within seven days after Dominic M. Terenzi, Jr., was found dead, the Camden police had received reports that he had previously been threatened (Maute) and that shortly before his death he had been beaten and a needle

had been forced on him (Robert Petitte). According to Upshaw's later testimony to the S.C.I., although he was the detective in charge of the case, he was unaware of the Petitte statement and therefore never followed it up. The detectives who interviewed Petitte indicated they were more concerned about the theft allegations against Briggs since such information was more pertinent to their investigative activities at the time. No further attempt was made to question Robert Petitte.

On April 11, 1969, as previously recorded, a third event had occurred that indicated Terenzi's death resulted from other than a natural cause. This incident was the toxicology report to Dr. Read from the State Police Laboratory which determined that phosphorous, possibly in poisonous form, and strychnine, definitely poisonous, were present in Terenzi's blood. However, Detective Upshaw, despite his leading role in the inquiry, subsequently testified before the S.C.I. that he never became aware of this report -- even though he had specifically requested in January that Terenzi's blood be tested for rat poisoning.

Nonetheless, Upshaw said, he made several efforts to persuade his superiors to charge Robert Briggs with murder, primarily because of suspicions aroused by the events preceding the discovery of Terenzi's body and allegations contained in statements subsequently obtained by police that Terenzi may have been intentionally overdosed with a drug or poisoned. Upshaw told the S.C.I.

that each time he argued for a murder warrant, he was informed by his superiors that such a charge would be impossible to support in view of Assistant Medical Examiner Read's death certificate determination that death was due to a natural cause -- acute bronchopneumonia. When Upshaw, as he later testified, then persisted in urging that Brigg's admitted failure to seek aid for Terenzi should subject him to a more serious charge than merely a failure to report a death, this advice also was resisted.

On February 12, 1969 -- more than three weeks after the Terenzi investigation began -- Detectives Upshaw and Smith took a statement from Terenzi's widow, Margaret. She told the police she last saw Dominic at 7 A.M., Thursday, January 16, when he left for work as a maintenance helper in Mount Laurel Township. She said Dominic had been a steady worker since their marriage in December, 1968. She also related an incident in which Dominic, during July or August, 1968, had used heroin while in the company of either George or Joseph Sleister. She said that occasion, so far as she knew, was the only time Dominic used drugs before or since their wedding. Other witnesses told the S.C.I. that Dominic had been a frequent drug user during late 1967 and early 1968 but apparently discontinued the practice by the summer of 1968. Terenzi's supervisor at his job, when questioned by the S.C.I., described him as a hard worker. Company records revealed that Camden police had

made inquiries about Terenzi's employment in 1969.

Detectives Smith and McComb on April 3, 1969, obtained a statement from George Sleister. He denied seeing or being in the company of young Terenzi during the day and night preceding the finding of Terenzi's body on January 17. He said he had not heard anything about the Terenzi death other than from reading stories about the case in the newspapers. He claimed he had known Terenzi for several years and that, so far as he knew, Terenzi had been taking only one shot of heroin a week but could not "take his own" and needed assistance in injecting the drug. He also denied knowledge of schemes to kill Terenzi, as well as being at any meeting at which Terenzi was discussed, although it was later established that Terenzi had indeed informed on George Sleister's brother, Joseph.

A formal statement involving Joseph Sleister had been made by Terenzi to the Cherry Hill police on March 8, 1968. It has since been established also that George Sleister had been arrested as a result of a narcotics sale he made to a New Jersey state trooper through Terenzi. In fact, although Terenzi's role with State Police has never been clarified, he did in fact help to set up several transactions in which an undercover state policeman bought narcotics from George and Joseph Sleister and at least one other person. The trooper testified

before the S.C.I. that Terenzi did not know he was assisting an undercover officer. Nonetheless, one State Police report indicated Terenzi had told some of his associates that the buyer was a State Police officer. Both the undercover officer and his superior denied that Terenzi was being used as an informant.

After April, 1969, no further indication of any activity in the Terenzi case is to be found in the investigative files for almost a year and a half. Then began a series of sporadic resumptions of the investigation - in 1970, in 1972, in 1974 and in 1976 -- the last review eventually resulting in the examination by the S.C.I. of all of the investigative efforts in the Terenzi death.

A brief re-opening of the investigation began in 1970 after Dominic M. Terenzi, Sr., complained to the State Attorney General's office that he believed the inquiry into his son's death had been inadequate. He based his complaint on information he said he had received about allegations in statements obtained by Camden Police that his son had been subjected to a beating and a forced injection by a hypodermic needle. Terenzi also told State Police Detective Charles Korostynski, who was assigned to investigate this and other complaints made by Terenzi, that Terenzi, Jr., had been working as an informant for the State

Police and had given a statement to Pennsuaken Police Detective Andrew Tippin implicating others.

In the course of his investigation, Detective Korostynski learned that Detective Tippin had arrested Terenzi, but both Tippin and State Police Sergeant Joseph DiCaro denied to the S.C.I. that any deals were made. However, Tippin and DiCaro did recall in their S.C.I. testimony that young Terenzi had confessed to several burglaries. Had Detective Korostynski obtained a copy of Terenzi's statement, he would have learned that Terenzi had implicated Joseph Sleister as a receiver of stolen goods in a statement dated March 8, 1968. Had he questioned DiCaro closely about his dealings with Terenzi, he would have learned that both Joseph Sleister and George Sleister were charged with narcotics offenses as the result of drug "buys" arranged by Terenzi, Jr., on behalf of State Trooper Ronald Perozzi during February 1968. These facts, confirmed years later during the S.C.I. probe, add credence to the statement originally made by Maute on January 24, 1969, about threats made on the life of young Terenzi involving the Sleisters and Briggs. Had all this information been uncovered in 1970, the Camden County Prosecutor's office may have given the case a more thorough review.

In September, 1970, Korostynski reported that the death appeared to be a murder and should be referred to the Camden County Prosecutors office for prosecution. Prior to this conclusion, Korostynski had discussed the case at some length with City Detective Upshaw and with Prosecutor's Detective DeVore. On September 18, 1970, DeVore requested from the State Police Laboratory a written interpretation of the April 11, 1969, report concerning the presence of toxic chemicals in Terenzi's body. DeVore's request was based on information from Korostynski that the chief toxicologist at the laboratory, Stanley Broskey, would testify at a trial that the chemicals in Terenzi's blood could have caused or contributed to Terenzi's death. A supplemental toxicological report was issued by the State Police Laboratory on November 10, 1970. This supplemental report confirmed the presence of phosphorous and strychnine in Terenzi's system. Although it offered no precise assessment of their potential for causing death, the report attempted to estimate the quantity of each substance.

Prior to the issuance of the supplemental report, Korostynski said he had interviewed the State Police laboratory chemist, Broskey, and was told by him that the phosphorous and strychnine found in Terenzi's body

were "very toxic" and that "the amount present was enough to kill him." Broskey also informed Korostynski that, contrary to an opinion among local and county authorities, he and other toxicological personnel were always available for testimony at jury trials but not at pre-trial, Grand Jury or other such preliminary hearings. Broskey acknowledged to an S.C.I. investigator that these statements had indeed been made.

Since the supplemental report failed to assess precisely the potential impact of the chemicals found in Terenzi's body, the Camden County Prosecutor's office sought an opinion from Dr. Edwin Albano, then the State Medical Examiner, as to whether any poisons referred to in the supplementary toxicology report could have caused or contributed to the Terenzi death. Dr. Albano opined that, on the basis of the police reports made available to him, the death of Terenzi could not be attributed to strychnine poisoning. He would not comment on the positive phosphorous findings since the nature of the presence of this chemical in Terenzi's system was not precisely described (he was not sure if it was poisonous phosphorous). Although admitting that the case, as presented to him, contained "physical" inconsistencies, Dr. Albano in a letter dated December 4, 1970, reiterated Dr. Read's autopsy verdict that the death was due to broncho-pneumonia, presumably as a result of acute narcotic intoxication. Although Dr. Albano had stated

he could not give an opinion on the State Police Laboratory's phosphorous finding, no one ever sought a clarification of that finding. The then-County Prosecutor A. Donald Bigley told the S.C.I. that the phosphorous aspect of this case was never really considered. Dr. Read, who received a copy of Dr. Albano's letter, never contacted the laboratory chemist to determine the exact nature of the phosphorous found to be present. Neither had Dr. Albano. The Prosecutor's office never requested any further analysis of the toxicological test results. While it might have been possible -- in 1970 -- to retest the blood and body organs of Terenzi or to review tests performed by the chemist to clarify the poison issue, such retesting and reviews never happened. Today, more than ten years later, such physical evidence no longer exists and even expert recollection of the testing procedures employed are fragmentary.

During the S.C.I.'s investigation, consultations with experts in the field, including Dr. Russell Fisher, Chief Medical Examiner of the State of Maryland, raised serious doubts about the efficiency of the original laboratory work in the Terenzi case. Dr. Fisher said that, based on the specimens submitted and the tests utilized, no one can be sure that heroin was taken by Terenzi on January 16, 1969. Only blood was submitted to the

laboratory for toxicological analysis despite the fact the bile and urine (which were available) are the best specimens for heroin detection. In addition, Dr. Fisher described the strychnine laboratory analysis as "essentially useless". He also found the reported blood phosphorous level extraordinary, but that, since the testing technique was not accurately described, the results were possibly attributable to a "false positive" reading of normal phosphates in the body. The absence or presence of pathological changes in the tissues of the deceased which would have resulted from phosphorous poisoning were not described in Dr. Read's autopsy report.

Finally, Dr. Fisher stated that the finding by Dr. Read of acute broncho-pneumonia as expressed on the final death certificate was consistent with survival for a few hours after an overdose of heroin, a "hot shot," or salt shots. Dr. Read's finding was to Dr. Fisher "a misinterpretation of the medical facts in the case in that it is given as a cause of death whereas it probably was an inconsequential side diagnosis." Dr. Fisher stated:

"In general the unsatisfactory end result of the investigation must be laid to the pathologist who failed to submit the proper specimens for drug scanning to indeed shed light on the heroin question and to the

chemist for indecipherable results which were submitted only after several weeks with a recap more than a year later. The failure of the pathologist to complete the autopsy both in the gross examination and in the further examination of microscopy of the liver and other organs leaves a lot to be desired. Finally, the lack of full detail in the time sequence by the investigator in the early hours of this case suggests that better coordination between the medical examiner in terms of information he needed and the investigators who were interviewing witnesses would have been highly desirable. One cannot always expect the investigator to know all of the information needed by the medical examiner but surely he has the right to ask for it and the investigator the duty to obtain it and this record fails to show that either of these opportunities was utilized. Our overall conclusions are that the manner of death should be left undetermined since it is unlikely that it was a true suicide and impossible to rule out a hot shot."

As noted, Dominic M. Terenzi, Sr., had informed the State Police investigator that he thought his son was being used as a police informant. Detective Korostynski testified that he asked several fellow officers about the elder Terenzi's statement but came to no firm conclusion on it. Had he consulted the arrest reports and related materials on the younger Terenzi's March, 1968, arrest in a State Police narcotics case, he would have discovered a statement given by Terenzi implicating

Joseph Sleister as a "fence" for stolen goods. A further review of the case would have indicated that, apparently on the strength of Terenzi's statement, Joseph Sleister was indicted. The case was dismissed, however. in April, 1969, several months after Terenzi's death. Although Korostynski's report had indicated a belief that Terenzi, Jr., had been murdered, the further corroboration that young Terenzi had indeed implicated one of the Sleister brothers could have made a review of the case more compelling to the county Prosecutor's office. The combination of this statment and Terenzi's presence during narcotics purchases that led to the arrest of George Sleister may well have sufficed to generate the threats reported by Maute.

After the 1970 activity, no official reference to the Terenzi death occurred until 1972. On May 30, 1972, the Camden County Grand Jury issued a "no bill" termination of its review of the charge against Robert Briggs that he failed to report a suspicious death when he abandoned Terenzi on North 28th Street on the morning of January 17, 1969.

In 1974 allegations were referred to the Camden County Prosecutor's office that three individuals possessed information about the Terenzi death. Two of these individuals were summoned before a Grand Jury and the third was interviewed in the field. One of the witnesses told the Grand

Jury she learned indirectly that Terenzi had been murdered because he had been talking to the police. The other witness, who was the actual source of the information (and who was placed at the Briggs residence on January 16, 1969, by Rose Patricia Phillips in her S.C.I. testimony) refused to repeat the story to the Grand Jury. In addition, this Grand Jury heard testimony by Rose Patricia and Robert and Elsie Briggs, after which the inquiry was concluded. The transcript of Briggs's testimony revealed that, although he could have been considered a suspect at the time, his interrogation was not prefaced by the customary constitutional warnings of the possible incriminating impact of his answers. Additionally, the transcript shows that when he hesitated in answering certain peripheral but potentially incriminating questions, he was instructed that he faced no jeopardy.

In the opinion of Philip Seaton, the assistant prosecutor at the time, nothing "new" had been developed by the Grand Jury inquiry. He later testified before the S.C.I. that he did not assess prior findings of the Terenzi investigation but only pursued avenues which had not been foreclosed by the past inquiry. For example, the possible impact of the phosphorous found in Terenzi's body was not considered by the Grand Jury, as it also was ignored in the 1970 probe. Dr. Albano's letter was considered the final word even though he had declined to consider the phosphorous issue. Apparently satisfied with the testimony presented to the Grand Jury, the prosecutor's inquiry went no further after polygraph tests were performed

on Rose Patricia and Mrs. and Mr. Briggs -- the only original figures in the case who were questioned. The assistant prosecutor either ignored or was unaware of certain inconsistencies that marked the several statements made to the Grand Jury in 1974 and to the police on January 18, 1969, particularly by Robert and Elsie Briggs. In fact, Seaton concluded in a memorandum dated August 6, 1974, that the death was a suicide -- the first time such a theory was introduced in this case.

The polygraph tests indicated that the Briggs and Rose Patricia were truthful. There were, however, certain problems with the procedures utilized by the polygraphists. Two examiners rather that a single examiner were used for the three examinations, a practice strongly discouraged by competent polygraph authorities. In addition, the number of specific issue questions exceeded that recommended by polygraph schools the examiners had attended. Further, one examiner said he felt he did not have sufficient time to prepare for his test and he is now doubtful whether the test he performed was effective.

In 1976 the Terenzi case was reopened by the Camden Police Department -- as the result of which it was subsequently brought to the attention of the S.C.I.

THE SUDDEN DEATH OF LYNN FULLER (1973)

At some time prior to 5:37 A.M. on Friday, March 30, 1973, Lynn Fuller, the wife of Stratford Borough Police Sergeant James Fuller, suffered a fatal gunshot wound in their Hi-Nella Borough apartment. The area's District 6 Police and Ambulance Dispatcher received a telephoned request for assistance and oxygen from Sergeant Fuller, a call that was logged at 5:37 A.M. Three police officers quickly responded, in separate cars, as well as the Stratford Ambulance Corps with a crew of three men.

The first of the responding officers to arrive at apartment E-3 of the low-rise Hi-Nella Apartments was Police Sergeant Kirk Fleming of Stratford, who was Fuller's best friend. Fleming found the apartment door open. His first observation was of Fuller on the floor cradling the head of his unconscious wife. It appeared to Fleming that Mrs. Fuller had bled profusely from the mouth and head and that she was already dead.

The other responding officers were Lieutenant Harold Miller of Somerdale (another borough that, like Hi-Nella, adjoins Stratford) and, only seconds later, Stratford Patrolman Anthony Gianndrea. Miller and Fleming had been talking to each other while out on patrol when Fuller's call for assistance was relayed over the police radio. Although he followed Fleming

to the Fuller apartment, Miller only watched briefly at the doorway. Gianndrea, who was on Miller's heels, went back to his police car to summon an ambulance before returning and entering the apartment. Of the first officers to arrive, Fleming assumed the most active role.

Fleming stated that when he arrived at the scene Fuller yelled to him to get oxygen. Fuller was exhorting his wife to pull through. Fleming ran to the apartment's telephone, which was off the hook and stained with blood, and called District 6 for an ambulance and asked that the hospital emergency room be notified that a gunshot victim was to be brought in. Fleming then returned to where Fuller was kneeling at the side of his wife, saw a gun lying near Mrs. Fuller's right side and, as with the telephone, picked it up without regard for the preservation of such evidence as fingerprints or blood stains.

Patrolman Gianndrea recalled that when he returned and entered the apartment, Fleming handed him the revolver which Fleming had taken from the floor and placed on a towel. After storing the gun under a seat in a police car, Gianndrea returned again to the apartment. He recalled that Mrs. Fuller was lying on the floor about five or six feet inside the doorway, Fuller was kneeling by her right side, and Fleming was standing directly behind Fuller.

When the ambulance crew arrived, they put compresses on the head of Mrs. Fuller and placed her on a stretcher. Fleming led Fuller away from the body to enable the ambulance crew to use the stretcher. As Mrs. Fuller was carried into the ambulance, Fleming escorted Fuller to his police car and drove him to the nearby John F. Kennedy Hospital.

The ambulance left for that hospital preceded by Gianndrea, at which point Lieutenant Miller also left the scene to return to Somerdale. No one remained to guard the apartment.

Mrs. Fuller was pronounced dead on arrival at Kennedy Hospital at 5:52 A.M. by Dr. Richard Rissmiller, only 15 minutes after the initial call for help had been received by the District 6 Police and Ambulance Dispatcher. Medical testimony later established that, due to a massive injury to the brain which the bullet had penetrated from the roof of the mouth, death had probably been almost instantaneous.

The pronunciation of death on arrival at the hospital did not surprise those who were first at the Fuller apartment. Fleming recalled that he thought Mrs. Fuller was dead when he saw her lying on the floor. The three ambulance attendants also thought she was dead since they detected no vital signs of life. Despite these immediate impressions, however, no effort was made to diagram for investigative purposes the position of the body on the floor before removal.

Later recollections by those who first arrived at the apartment as to what was said, and by whom, were vague and contradictory.

Fleming said that when he arrived at the scene he either assumed what happened or did not have to ask what happened based on spontaneous remarks made by Fuller. Other officers who were there, however, could not recall Fuller saying what had happened. In fact, these other officers later testified before the S.C.I. that there was no conversation at all about what had occurred. The ambulance attendants recalled that upon their arrival "somebody" said Mrs. Fuller had been shot or had shot herself, but none could identify the speaker.

The hazy, conflicting recollections of what was said and done during the period immediately after Fuller's call to the dispatcher at 5:37 A.M. contrasted with more detailed evidence of Sergeant and Mrs. Fuller's movements up to 5 A.M.

The evidence established that at about 9 P.M. Thursday, March 29, 1973, the Fuller couple went to the nearby apartment of a mutual friend, Marcia Stoeffel, for drinks. This was confirmed by Fleming, who was on patrol duty throughout the night and who brought cigarettes to her apartment while the Fullers were there. At about 1 A.M., Friday, the Fullers drove from the Stoeffel residence to the White Lantern Tavern, where Fleming again spoke to Fuller at the doorway, at 3 A.M.,

when the tavern had closed. Having ordered additional drinks just prior to closing time, the Fullers remained at the tavern for about two more hours. This was known to Fleming, since he observed that the Fuller car was still parked at the White Lantern at 4:45 A.M. but was gone at 5 A.M. The Fuller apartment was only a few minutes' drive from the White Lantern Tavern. The official investigation never established what transpired between 5 A.M. and 5:37 A.M.

It developed later during a canvass of Fuller's neighbors, by Prosecutor's detectives and local police, that two women reported they overheard Fuller remark to someone outside the apartment that he had had an argument with his wife. Their attention had been drawn to the area in front of the Fuller apartment by the presence of police cars and the ambulance. The statements of these two neighbors were never followed up by either local or county investigators.

As Mrs. Fuller was being transported to the hospital, the apartment was left empty, unlocked and unguarded until approximately 5:55 A.M. At that time Patrolman Ronald Raynore of Hi-Nella arrived at apartment E-3. He found the exterior front door closed but not locked and the inner door to the apartment wide open. He looked into the apartment briefly and noted that it looked "like a fight took place." He specifically recalled that a "lot of money" had been scattered around. As he then locked

the door and left, Hi-Nella Police Chief Glen Potts arrived. Without going inside, Potts proceeded with Raynore to the hospital, where they were told that Mrs. Fuller had died of a gunshot wound.

The Hi-Nella police, who served part-time, operated under an understanding that Stratford police would "cover" their borough when there were no scheduled Hi-Nella patrols. Chief Potts had been awakened at home by a telephone call from District 6 at 5:46 A.M. about the incident and he had requested the District dispatcher to telephone Raynore.

At the hospital, Chief Potts and Stratford Police Chief Francis Washart discussed the situation and agreed that the Camden County Prosecutor's Office should be called. The Hi-Nella police officers then returned to their headquarters. At 6:25 A.M. Potts dispatched Raynore to guard the apartment. At 6:40 A.M. Potts contacted the office of Camden County Prosecutor Thomas J. Shusted to report the death of Mrs. Fuller. Prosecutor's Detective Luis Rodriguez called Potts back to instruct him to make sure that the hands of the dead women were covered to preserve them for a Neutron Activation Analysis (NAA) test. That test, which was performed later in the day by Prosecutor's Investigator Thomas Steubing, yielded inconclusive results. No protective effort had been made on Fuller's hands. The NAA test, by analysis of trace elements found in gun powder primer, might have indicated whether either Fuller or his

wife had recently fired a gun.

Upon his return to the apartment, Raynore found the outside door to the apartment vestibule ajar and the door to the apartment that he had locked earlier again wide open. The bills of various dollar denominations that he had seen scattered on the living room floor shortly after 5:55 A.M., were now -- a half hour later -- stacked in a neat pile on the dining table in the main room of the apartment. In addition, what appeared to be a gun rack (later identified by Fuller as a knick-knack shelf) that had been on the floor next to a chair was now on the chair. Wondering who had partly straightened up the place, Raymore also observed a pool of blood on the floor and blood on the baseboard and the wall. In addition, there was an open pocketbook on the floor near a couch. The patrolman examined the contents of the pocketbook, recorded the amounts of a check and money it contained, and put it back on the floor. He noted a towel in the living room and, on the floor, a comb, a newspaper and a container of fish food that had spilled near an aquarium. He observed blood stains on the telephone hand piece. In the bathroom the tub appeared as if someone had just used it since the inside was wet. He found the bedroom in darkness although the lights were on in the rest of the apartment. The bed was made and the bedroom itself was tidy, in contrast with the rest of the premises. Raynore thus busied himself at the scene until he was relieved by Patrolman Dominick Palese of Hi-Nella.

Palese waited at the place until the arrival of county detectives at about 7:30 A.M.

Earlier at the hospital, after his wife was pronounced dead, Fuller was described in later testimony by Chief Washart as being "very distraught" and by Patrolman Gianndrea as "hysterical." Fuller was given at least one injection of a sedative and Fleming was advised by a nurse that the sedative would make Fuller sleep. He also was permitted to wash up. Although it was evident to one of the officers who had initially responded to the apartment -- Fleming -- that Fuller had been drinking, his blood-alcohol level was not tested.

Arrangements were then made by Fleming, and approved by Stratford Chief Washart, to allow Fleming to take Fuller to the Stoeffel apartment. While a comfortable place was deemed necessary to permit Fuller to sleep, a more appropriate accommodation for rest and observation was immediately available at the hospital. At this time, about 6:00 A.M., Chief Washart telephoned Robert Fuller of Haddonfield in Camden County, a New Jersey State Trooper who was the brother of James Fuller, and told him what had taken place.

After receiving notice of the sudden death from Chief Potts in Hi-Nella, the county prosecutor's office dispatched Detective Rodriguez and Investigator Steubing to the Fuller apartment to photograph the scene and to

sketch the apartment and its contents. His initial viewing of the interior of the apartment, according to Steubing's subsequent testimony, gave him the impression that there might have been "an argument or a tussle" in the living room.

When Investigator Steubing returned later that same afternoon, he was "disturbed" to find that some items had been moved from their original place in the apartment by other police officers who had been there previously. Steubing was again annoyed to learn later that day that Fuller had refused to permit a Neutron Activation Analysis test on his hands, as requested by the Prosecutor's office. At that point, Fuller's brother, who was with Sergeant Fuller at the Stratford Police Station, informed the Prosecutor's investigator that on the advice of an attorney Sergeant Fuller would not take the test. Although Fuller had no legal right to refuse the test, his position was not challenged by the Prosecutor's staff or anyone else and he was allowed to leave the police station to see the lawyer. In fact, Sergeant Fuller was never detained nor were his movements ever restricted even though he was the only witness to his wife's death. In addition, no effort was ever made by any of the investigative authorities to preserve his clothing as potential evidence nor did the local police ever ask him at anytime for his version of what had occurred.

One early opportunity for obtaining Fuller's version of what happened was either missed or unrecorded. That opportunity arose after Fleming, with his Chief's permission, drove Fuller from Kennedy Hospital to the Stoeffel apartment after Mrs. Fuller was pronounced dead. Details of Fuller's stay there were fragmented.

Mrs. Stoeffel later said she was "shocked" when she noticed Fuller's shirt was splattered with blood, not in blotches but in specks that also appeared on his chest and an arm. Trooper Fuller and the Fuller brothers' parents also came to the Stoeffel apartment to see Fuller, at about 7:30 A.M., and persuaded him to take a shower and to rest. However, Fleming was worried about Fuller's condition, knowing he had been drinking early that morning, that he had been sedated at the hospital, and because he now feared that Fuller had taken pills at Mrs. Stoeffel's. Fleming said this fear was prompted by the noise of pills rattling in a bottle of barbiturate pills while Fuller was in the Stoeffel bathroom. Fuller denied taking the pills when Fleming questioned him. Fleming subsequently drove Fuller back to Kennedy Hospital, from which the sergeant again was released, at 9:20 A.M.

During the Fuller family's visit to the Stoeffel residence, Trooper Fuller, according to Fleming, left to drive to the Fuller apartment. There he spoke to one or two officers briefly and returned to Mrs. Stoeffel's home.

After Sergeant Fuller's second release from Kennedy Hospital, he was taken to Stratford Police Headquarters by Fleming and his brother. Another chance to obtain Fuller's story apparently was missed by Fleming when he drove Fuller from the hospital to the Stratford police station. In fact, Sergeant Fuller was never officially asked during the entire day of March 30, 1973, about what had transpired at the Fuller apartment just prior to 5:37 A.M. Both Trooper Fuller and Sergeant Fleming assumed personal rather than professional roles with regard to Fuller, as they subsequently testified before the S.C.I. For example, after Fleming brought Fuller from the hospital to the Stratford police station, Trooper Fuller requested Chief Washart to contact a lawyer for his brother. The Chief did so, using a headquarters telephone. Since no formal questioning of Sergeant Fuller was contemplated, Washart permitted Fleming and Trooper Fuller to accompany the sergeant to the lawyer's office.

Sergeant Fuller met with lawyer Thomas Higgins of Blackwood. The attorney advised him not to submit to a Neutron Activation Analysis test because of the lawyer's unfamiliarity with the test. Fuller also was advised not to give a statement that day, Friday but to wait until the following Monday. Fuller then was

driven to the office of Dr. Marvin Herring in Stratford. There, according to Fuller, the doctor noticed, in addition to Fuller's distraught condition, a fresh nick at the hairline of his forehead. From the doctor's office Fuller was driven back to Stratford Police Headquarters and then to his parents' home in Lindenwold. When he arrived at his parents' house, he told them to "get rid of" his bloodied clothing. They apparently complied. In any event those clothes were never examined by the investigators.

Meanwhile, sometime after Hi-Nella Chief Potts had officially notified the Prosecutor's Office at 6:40 A.M. of the sudden death of Mrs. Fuller, Investigator Steubing was dispatched to the Fuller apartment. He was instructed to photograph the scene and to check up on the requested Neutron Activation Analysis test of Fuller's hands. Steubing left after taking photographs but returned that afternoon to diagram the physical evidence he had observed scattered about the living room. However, he was "disturbed" upon his return to find that the apartment had been cleaned up, preventing him from fully diagraming the original disarray he had observed on his earlier visit. He also noted that the position of Mrs. Fuller's body near the doorway had not been outlined.

After responding with Steubing to the Fuller apartment, County Detective Rodriguez contacted his superior, Detective Sergeant Jerome Banks, who then went to the scene. Banks later recalled he was "angered" when he learned not only that the physical evidence in the area of the sudden death had been moved but also that the apartment had been left unlocked and unguarded for some time. While the disorder in the apartment's living room suggested merely sloppy housekeeping to him, Banks nonetheless said he was "disturbed" enough by the effort to set the place straight to complain to his superior, Prosecutor's Lieutenant William Reeves. He emphasized in this complaint his irritation over what he felt was a lack of cooperation by Stratford police. Banks, the senior Prosecutor's detective in the case, subsequently testified that he never believed that Mrs. Fuller was a suicide. He said his assertions to his superiors in the Prosecutor's detective section -- that Mrs. Fuller did not fit the profile of a person likely to commit suicide -- went unheeded.

The Camden Prosecutor's office, having begun an investigation on the day of the incident, failed to follow through on certain key aspects of the case, including statements by the two neighbors who said they had overheard Fuller remark outside the apartment

that he had an argument with his wife. In addition, in a statement given to the Prosecutor's detectives on April 10, 1973, Sergeant Fleming had made the unsolicited assertion that there was no argument -- but he was never called upon to explain the discrepancy. Years later in testimony before the S.C.I., Fleming admitted that Fuller told him the day after the incident that there had been an argument. Fuller, on the other hand, consistently denied that there had been an argument although he admitted for the first time at the S.C.I. that he had engaged in a discussion with his wife about some purchases after their return from the White Lantern bar. He said that his wife was upset and that he may have raised his voice during this discussion. These contradictions concerning an argument were not assessed during the investigation nor were they presented a year later to the County Grand Jury.

The investigation also failed to evaluate the potential revelations at the scene of the sudden death. Although the Prosecutor's photographs showed that numerous items were out of order in Fuller's apartment, and several officers had thought privately that there may have been some sort of a struggle, this point was never clarified in the case reports. There was no direction from the higher ranking Prosecutor's detectives to obtain answers to critical questions.

During the brief period in which the Prosecutor's Office initially investigated the case, a friend of Sergeant Fuller reported that several months prior to her death Mrs. Fuller had fired her husband's gun in an attempt to kill herself. This woman later stated to the S.C.I. that she thought Mrs. Fuller had attempted to kill herself or to scare Fuller. Such statements contrasted sharply with later testimony and interviews of others who knew Mrs. Fuller's personal characteristics, including Sergeant Fuller -- none of whom could imagine that she would kill herself.

The Prosecutor's file on the case became inactive within about two weeks, based on a conclusion, bolstered by the autopsy report, that the death was a suicide.

A post-mortem examination of Mrs. Fuller's body was conducted at 10:30 A.M. Friday by Dr. Richard Schiffman, an Assistant Camden County Medical Examiner. His report listed the cause of death as a self-inflicted gunshot. Since this appeared to him to be so obvious a suicide, he made his conclusion without conducting a full autopsy of the head. The entrance wound caused by the .38 caliber bullet at the roof of the mouth was not closely inspected, Dr. Schiffman said, and he concluded that the weapon was actually inside the mouth when the shot was fired. Evidence, if any, of powder burns,

tatooing or charring, which might have indicated the distance of the gun from the victim, was not mentioned. Details of physical surroundings of the death scene were not made known to Dr. Schiffman. There was no inspection of the death scene by him. No analysis was made of a recent scratch on the victim's chest or of a recent gash on the pad of the victim's thumb. Although the presence of the scratch and the gash was noted in the post-mortem report, the doctor, when subsequently questioned about these wounds, could not recall them. No photographs of such cuts were taken -- a step regarded as essential by many pathologists and which could have helped to refresh the recollections of the doctor as to the possible significance of the wounds. No effort was made by medical analysis to date the onset of these wounds.

In July, 1973, the investigation of Mrs. Fuller's death was reactivated by the Special Investigation Unit of the County Prosecutor's Office. This second investigation continued for about four months, until the file was reassigned or closed. At about this time the unit was disbanded.

When subsequent Grand Jury proceedings took place, the investigator from the Special Investigation Unit was not called to testify. The original Prosecutor's detective in charge, Banks, had been removed from the

inquiry soon after its inception and was never consulted thereafter concerning it. Steubing also did not testify.

In June, 1974, during the county Grand Jury review of the death, the Prosecutor's office failed to submit relevant evidence. For example, the inquest heard testimony from certain police officers who had never been formally interviewed by the Prosecutor's staff -- but several of the Prosecutor's detectives who were at the scene and had the most direct initial involvement in the investigation were not called to testify. One of those who was a part of the Prosecutor's initial inquiry, Luis Rodriguez, was questioned before the Grand Jury only peripherally concerning the sudden death. He (Rodriguez) was questioned only as to certain events which occurred during the course of the investigation but not about the results of the investigation or concerning any of his conclusions.

Sergeant Fuller's version of what took place between the time he left the White Lantern Tavern and his telephone plea for assistance at 5:37 A.M. Friday, March 30, 1973, was never explored by the Grand Jury. The fact that he was called before the Grand Jury by Assistant Prosecutor George Stillwell, coupled with the absence of constitutional warnings prior to his testimony, indicated he was not considered a suspect.

As to what happened during those 37 minutes, Fuller years later testified before the S.C.I. that when he and Mrs. Fuller arrived home he went to the bedroom to get ready for bed by emptying his pockets. Before entering the bedroom, Fuller stated that he put his personal, off-duty revolver on a table in the living room (where the fatal shot was fired) but left the holster on his belt. Mrs. Fuller, he testified, said he didn't love her and that she had his gun. Fuller said he responded "'knock yourself out' or something to that effect" and that seconds later he heard a shot. When he went back into the living room, Mrs. Fuller was on the floor. He immediately called the Police and Ambulance Dispatcher. Fuller also said that he and Mrs. Fuller were in the apartment 20 to 30 minutes before that incident. But, at the time she was mortally injured, Mrs. Fuller was wearing a topcoat over her street clothes. Bloody keys and a purse were on the floor, the door was ajar, and the apartment was in disarray when the police arrived.

Such details as these were never explored or questioned at the Grand Jury proceedings.

Fuller also told the S.C.I. that he always kept his off-duty gun fully loaded. When the gun was examined after the shooting, however, it was found to contain an empty chamber in addition to the one from which the fatal bullet was discharged. He

could not explain -- nor was he ever asked by any investigators -- how this could have occurred. In addition, a bloodstained, live bullet was found at the scene underneath the baseboard heater. The baseboard, as previously noted, was smeared with blood. This area where the bullet was found was some distance from where the body of Mrs. Fuller was found. These additional facts were never presented to the 1974 Grand Jury inquiry into the sudden death.

In fact, Fuller's direct testimony before the Grand Jury consisted of only 2 1/2 pages of transcript.

In summary, up to this point, at no time after Mrs. Fuller's death -- during the initial investigation, its renewal in July, 1973, or the Grand Jury proceedings in mid-1974 -- was there any recorded evidence that either the local or county law enforcement agency ever took full control of the death scene or directed an orderly, professional course of inquiry.

Stratford Police Sergeant Fleming conceded his own conduct at the scene was not standard police practice for a sudden death investigation, since he had moved the gun and had not marked the position of the body. Nonetheless, he testified before the S.C.I. that he would act the same way again, except for transporting Fuller from Kennedy Hospital to Mrs. Stoeffel's apartment. As he explained later, Fleming "did not have one thought of destroying evidence ... on a crime scene because I didn't think anything was wrong . . . " This was so,

he said, because he "personally thought she shot herself." He further stated that "I really don't think that piece of evidence that everybody thinks I destroyed on purpose was valuable to that investigation."

Fleming, upon assuming command of the initial inquiry, had made no effort to preserve immediately the physical evidence at the death scene. He later explained that he moved the weapon lying near the head of dying Mrs. Fuller to prevent Fuller from possibly using the gun on himself, even though two other police officers were immediately available to escort Fuller from the scene. After the body was moved to the hospital, all of the police then left the apartment unsecured and unattended, despite the fact that the Hi-Nella police had not yet appeared.

Once at the hospital, Fuller, after his wife was declared dead, was cleaned up by a nurse and sedated. No instructions were given to hospital personnel not to alter Fuller's physical condition, such as preventing him from washing his hands in preparation for a Neutron Activation Analysis test. Nor was he questioned, prior to receiving sedation, about what had happened at his apartment. In fact, none of the local police at the scene, including the Chiefs of Police of Hi-Nella and Stratford, ever officially questioned Fuller as to what had taken place. Yet, it had become quickly apparent that Fuller was at the very least the only material

witness to whatever had happened. There had been an almost immediate conclusion, based on someone's statement, swiftly backed up by an incomplete autopsy, that Mrs. Fuller shot herself. Thus, the consensus became fixed that the death was a suicide and that no substantive inquiry was essential. What follow-up investigation was made was a perfunctory one; potential leads evaporated due to failure to pursue them.

Other examples of an inadequate investigation developed later that day of Friday, March 30, 1973, further compounding errors which had already been made. Someone picked up the loose bills from the floor and made a neat pile on the dining room table. A Hi-Nella police officer handled the evidence prior to receiving any clearance from the prosecutor's office. The evidence was not catalogued and tagged at the scene for identification and other investigative purposes.

Regarding the requested use of the Neutron Activation Analysis, it should be noted that since Mrs. Fuller's death in 1973 this test came to be considered inconclusive. Nonetheless, the conduct of the investigators should be measured by what they did to assure the validity of a procedure which was regarded at the time to be viable. The investigative steps were highly inadequate in this regard. For example, no effort was made to preserve the condition of Fuller's hands after 5:37 A.M. for

submission to such a test -- a test which could well have been undertaken in his own best interest. By contrast, there was an effort to cover Mrs. Fuller's hands so such a test could be performed on her.

As for other investigatory improprieties, there remained unsolved the mystery of a comb that was found on the floor of the Fuller living room. While it was later catalogued as evidence, for some unexplained reason it was not sent by any local or county investigators to the State Police Laboratory for analysis. This comb was re-discovered by an S.C.I. investigator about 3 1/2 years after Mrs. Fuller's death in storage at the Hi-Nella Police Department. The S.C.I. requested a State Police test to determine if it contained any matter that might have provided clues to what had taken place in the Fuller apartment prior to 5:37 A.M. on the day of Mrs. Fuller's death. When tested, after such a long lapse of time, the presence of human blood was verified but the specific blood type could not be ascertained. Almost all key evidential material was either disturbed by the police or by anyone else who might have entered the unsecured apartment. Whether this potential but mishandled evidence would have been incriminating or exculpatory, it had lost its efficacy for any tests, analytical deductions or conclusions and other requirements of an investigation.

During the course of the subsequent S.C.I. investigation, the then-Chief Medical Examiner of New Jersey, Dr. Edwin Albano, testified in 1977 that the original autopsy performed in the Fuller death was incomplete. Therefore, the State Division of Criminal Justice, at the request of the S.C.I., obtained from Superior Court an order for the exhumation of Mrs. Fuller's body, hoping that a re-autopsy might possibly clarify the manner of her death. In the opinion of the Chief Medical Examiner, there had been an insufficient examination of the deceased on which to base an opinion that the gunshot had been self-inflicted, an opinion that nevertheless was officially accepted less than six hours after the death. The original autopsy was confined to the head. Even considering the limited scope of the first autopsy in the area of the gunshot wound, the wound itself was not probed for evidence, if any, of charring, tatooing or powder smudging which could have indicated the distance at which the gun was held from the victim. There also had been no effort during the initial autopsy to ascertain whether the victim's mouth had sustained any damage from the recoiling of the gun.

At the time of the second autopsy, performed February 15, 1977, almost four years after Mrs. Fuller was buried, it was impossible to determine the existence of such trauma.

Although the re-autopsy revealed a fracture of the lower jaw, which had not been previously detected, it was again concluded that the gunshot wound was self inflicted. This conclusion by Dr. Albano's office was based on the finding that there was no damage to the tongue. This finding, according to Dr. Albano, rendered the death a suicide according to reasonable medical probability. Although Dr. Albano, who had presided over the second autopsy, later testified that there was a slim chance that the wound was not suicidal, he contended that none of the many related circumstances, conditions and findings amassed by the S.C.I. investigation would alter a verdict based only on the second autopsy.

At the completion of Dr. Albano's testimony, the S.C.I. sought further expert counsel, an established forensic pathologist who told the S.C.I. that a verdict of suicide was untenable. This expert was Dr. Frederick T. Zugibe, the Chief Medical Examiner of Rockland County, New York. After studying the investigative reports on the Fuller death at the S.C.I.'s request, he observed that there was "no history of depression, suicidal tendencies or other significant psychiatric behavior and no written or verbal evidence of intent." Dr. Zugibe also stated that not only was the first autopsy incomplete but Dr. Albano's conclusion of suicide based on the second autopsy was without firm foundation since neither homicide nor accidental death was ruled out. The absence of trauma

to the tongue, he added, would not in itself be conclusive. Dr. Zugibe stated that the cause of death should have been listed as a "gunshot wound to head, pending further investigation." Considering the numerous grounds for suspicion in this case -- the disarray in the living room, the blood splatter on Fuller's shirt, the wound on the victim's index finger, the denial of an argument with contradictory statements by witnesses -- the possibility of death by a cause other than suicide remained a question that has yet to be resolved.

THE SUDDEN DEATH OF WILLIAM BEELER (1975)

The body of William Beeler, 24, was found at about 1:50 A.M. Sunday, January 19, 1975, beside the rear concrete block base of an unoccupied bungalow-type dwelling at 319 North 10th Avenue, Lindenwold -- about 100 feet from Beeler's home at 309 North 10th Avenue. He had suffered a fatal gunshot wound of the head. According to his wife, Jane, he had left by the front door of their house to search for a prowler whose presence was believed to have caused the family dog to bark. Although the weather was cold -- the temperature was only a few degrees above freezing -- and the night was misty, Beeler had left the house wearing only a sleeveless undershirt, pajama bottoms and slippers. At home at the time, in addition to Mrs. Beeler, were the Beelers' two children, ages 6 and 1, Mrs. Beeler's parents, Harold and Wilhemina Lavala, and their daughter, Patricia, 14. The Beeler and Lavala families shared the 309 10th Avenue home.

Mrs. Beeler later recalled that she had resumed dozing when Beeler left the house but awakened after about 20 minutes. Worried because he had not returned, she arose and hurried to the front door. When she called out to him and received no response, her concern increased. She awoke her parents and her mother telephoned the Lindenwold Police Department -- at 1:03 A.M., according to the police record.

A Special Officer, Joseph Taunitis, arrived at the Beeler home at about 1:25 A.M. He spoke briefly to Mrs. Beeler, scanned the adjoining grounds, and then drove around the block in an unsuccessful attempt to locate Beeler. Upon returning, he put out a radio call for assistance. Sergeant Lowell Burlap and Patrolman John Davenport of Lindenwold police responded within 10 minutes of receiving Taunitis's call at 1:40 A.M. They proceeded to search on foot for Beeler through the yards and grassy lots around the Beeler home. In a short time, Burlap found Beeler on the ground at the rear of the empty bungalow and summoned Davenport. Beeler was lying on his left side. A .38-caliber Colt revolver was on the ground behind his legs. The policemen checked Beeler's pulse but detected no sign of life. A radio call was issued that there had been an apparent shooting and an ambulance was summoned.

Detective Michael McCarthy next responded to the scene. Although a three-year member of the Lindenwold Police Department, McCarthy was inexperienced as a detective, having been promoted to that rank only 19 days earlier, on January 1. Upon his arrival, about five minutes after the body was found, he inspected the area. He noted certain details, as had Burlap and Davenport -- of the position of the body on the ground, of the location of the weapon, and of an ashtray con-

taining an extinguished cigarette on a large wooden box near the body. He also observed a large pool of blood near Beeler's head and shoulders and that the blood was beginning to congeal. Although blood had splattered the base of the house where the body lay (as indicated in photographs), this prompted no investigative effort. (McCarthy later would draw a diagram of how he recalled the position of the body with Beeler's hands in front of it and the revolver behind it. This diagram was the only accurate attempt by any investigators to specify where the body was relative to the weapon. The position of Beeler's body on the ground was not traced before its removal).

Before the ambulance arrived, at 2:09 A.M., another newly appointed Lindenwold police detective, Barry McCutcheon, interviewed members of the Beeler family. They told him that indications of a prowler around the house had caused Beeler to leave the house. The family confirmed that the revolver found by the body belonged to the deceased.

An unsuccessful effort was made, before the ambulance crew removed the body, to photograph the scene with a department camera that McCarthy had brought with him. None of the Lindenwold policemen knew how to operate the camera so a special police officer from nearby Laurel Springs, Jay Wilkins, who had responded to the sudden

death radio calls, was asked to photograph the body and its surroundings. Although Wilkins was a professional photographer, he testified later that his camera work was rendered useless by an improper setting of the camera's strobe mechanism.

Beeler was pronounced dead on arrival at John F. Kennedy Hospital in Stratford at about 2:30 A.M. by Dr. Julius Mingroni of the hospital staff. There Wilkins made a more successful series of photographs depicting the bullet wound in Beeler's right ear and indicating blackish discolorations on his right thumb and index finger. Also at the hospital, at the telephoned request of Assistant Camden County Medical Examiner Harvey Bellin, who was to conduct the autopsy, Beeler's head was X-rayed to help determine later the course and location of the bullet. The body was then moved to the Camden County Medical Examiner's Morgue for an autopsy.

By this time all of the police officers engaged in the case -- at the scene and at the hospital -- were convinced that Beeler had shot himself to death. This early surmise, primarily generated by the fact that Beeler's personal gun was found by his body, quickly became a rigid theory of suicide that remained unchanged throughout subsequent local and county investigations.

Dr. Bellin's autopsy was limited to Beeler's head and brain. He concluded that death was caused by a bullet wound of the right ear. The horizontal trajectory of the bullet caused extensive destruction of brain tissue. The doctor's post-mortem report also noted a recent half-inch oval-shaped abrasion on the forehead just below the hairline, which he assumed was the result of a fall. During the autopsy, Detective McCarthy took six photographs, which turned out to be of poor quality. Why a more experienced official photographer who attended the autopsy was not assigned this task was never clarified.

Dr. Bellin later testified before the S.C.I. about his autopsy and report on Beeler. After examining the head, he did not scrutinize the remainder of the body for other injuries, including bruises which could have raised questions about an immediate verdict of suicide. The discolorations of Beeler's right thumb and index finger, which Special Officer Wilkins had taken pains to photograph at the hospital, were not mentioned in the post-mortem report. Dr. Bellin acknowledged that discolored fingers should have been thoroughly inspected, microscopically if necessary, in order to shed more light on the position of Beeler's hand when the revolver was fired. (Personnel at the funeral home from which Beeler was buried testified later that the discoloration of the fingers could not be removed by washing and heavy make-up was necessary to cover it). Dr. Bellin also told the S.C.I.

that he should have examined more closely the abrasion on Beeler's forehead, conceding it was well above the area that would more likely be damaged by a fall.

Dr. Bellin candidly admitted in his S.C.I. testimony that he might have been subconsciously conditioned for a suicide decision. Prior to the autopsy, he recalled, the Medical Examiner's investigator, Thomas Daley, had telephoned Kennedy Hospital to arrange for the autopsy and had reported back that the Beeler death was an apparent gunshot suicide. The police officers who attended the autopsy, Dr. Bellin said, had concluded in advance that the gunshot was self-inflicted. As a result, Dr. Bellin conceded, his professional reaction might have been influenced "subliminally" to the extent that his examination was less thorough than it should have been due to the prevailing consensus that suicide would be the ultimate verdict. Dr. Halbert Fillinger, an assistant Philadelphia medical examiner, who reviewed several sudden death cases at the request of the S.C.I., described this post-mortem report as "grossly inadequate." For example, there was no indication of the presence or absence of gunpowder tatooing, which might have indicated how close the weapon had been to Beeler's head. There was no examination of the rest of the body; nor did Dr. Bellin submit a skin sample sufficient for a State Police laboratory gunpowder test.

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No representative of Prosecutor Thomas J. Shusted's staff arrived at the death scene until almost an hour after Beeler's body was found. The first Prosecutor's detail to reach the scene was a mobile crime laboratory van. This unit arrived at 2:45 A.M., by which time Beeler had already been removed to Kennedy Hospital. Members of this detail photographed the area and gathered blood samples. Some time later at the hospital, laboratory Detective Michael Scarduzio performed a Neutron Activation Analysis (NAA) test on Beeler's hands, but made no notes of his observation or the time of his test. A subsequent analysis of this test, conducted by a private laboratory employed by the Prosecutor's office, produced a negative report. However, because of the lack of any notations by Scarduzio during the swabbing procedure on which the analysis was based, it was not known whether Beeler's hands had been dampened by mist or rain while the body was lying on the ground. Such a dampening, along with the passage of several hours, could have erased gunpowder primer residue from the hands. In any event, the existence of a negative Neutron Activation Analysis was never addressed in the Prosecutor's staff reports. This oversight raised further question about the possible dismissal of any element in the case inconsistent with the premature conclusion of suicide by the initial investigators.

As noted, photographs were taken of the blood-stained wall beside which the body was found. Neither Lindenwold Detective McCarthy nor Prosecutor's Detective Scarduzio examined these stained areas for clues as to whether Beeler was standing, sitting or lying on the ground at the time of the fatal gunshot. According to Scarduzio, he had never considered blood stains as an evidential element in any previous case. Detective McCarthy, testifying about these blood stains at the S.C.I., said merely that "it wasn't considered because it wasn't noted."

Scarduzio also told the S.C.I. that he remained at or near the death scene from 2:45 to 4:15 A.M., after which time the place was left unguarded -- despite the need, as dawn approached, for further examination of the area by daylight. If Scarduzio is correct, the NAA test was not performed until some time after 4:15 A.M. At no time during the hours immediately following the shooting did Scarduzio or any other Prosecutor's personnel gather and catalogue physical evidence, other than blood samples. This overall responsibility was left to the Lindenwold police, primarily Detective McCarthy, who had never before undertaken such tasks. McCarthy reported he took custody of the weapon and ashtray at the scene. Subsequently, the gun and the ashtray containing a cigarette butt were taken to the hospital. No one noted who transported these items from place to place or what specific precautions, if any, were taken to preserve their evidential value. Only the ashtray

was photographed at the hospital.

The .38-caliber gun was a "police special" registered in the name of Beeler's late father, a former Lindenwold police officer. A report compiled by Prosecutor's Detective Joseph Alesandrini on the day of Beeler's death noted that the weapon contained four live rounds, one spent shell under the firing pin and an empty chamber. His report did not say who opened and examined the gun chambers. Another report written the next day, Monday, January 20, 1975, by the same detective -- who had not appeared at the scene until after the body and weapon had been removed -- contained such erroneous statements as "the revolver was laying about a foot from the body just below the right arm" and "there were no other marks or wounds on the victim" (aside from the bullet wound).

The former comment was contrary to the diagram prepared from memory by Lindenwold Detective McCarthy -- who said Beeler's hands were in front of the body and the gun was behind it. The latter comment was inconsistent with the autopsy report of the abrasion observed by Dr. Bellin on Beeler's upper forehead and with the police photographs of severe discoloration on two of Beeler's right hand fingers.

No test was ever performed on the gun for fingerprints after Detective McCarthy took possession of it at the scene. McCarthy said he was not asked to make such an examination. According to the Prosecutor's

crime laboratory detective, Scarduzio, he never saw the gun and was never asked to examine it for potential evidence. The ashtray and cigarette butt also were not examined for fingerprints despite a theory reached by the initial investigators that Beeler, after going out into the cold night skimpily clothed, had smoked the cigarette and extinguished the butt in the ashtray before putting the gun to his right ear and firing it.

The day after Beeler's death, available physical evidence such as the gun, the ashtray and cigarette butt, blood samples and Beeler's clothes were taken to the State Police Laboratory in West Trenton for analysis.

The State Police gun test simply confirmed that the bullet which killed Beeler came from his revolver. The analysis of the cigarette butt, however, compounded the investigative confusion. The State Police determined that the cigarette had been smoked by a blood-type O "secretor."* Since Beeler's blood type was O, this finding bolstered the theory of the local and county investigators that he had smoked that cigarette while contemplating suicide. No one involved in the inquiry had sufficient interpretive knowledge or inquisitiveness to realize the cigarette test result was inconclusive without a further determination that Beeler also was a "secretor."

*A "secretor" is one whose body fluids other than blood (here, saliva) can be analyzed to determine, (by examination of saliva residue on the cigarette butt), the blood type of the actual smoker. Not all people are secretors, however.

It was never determined whether Beeler was a "secretor" since no saliva sample had been sent with the cigarette butt to the State Police Laboratory for a complete test.

Other significant factors in the Beeler death -- the frequently reported presence of prowlers in the area of his home, the possibility of family discord or financial difficulties, and observations or reactions of neighbors to the gunshot death -- were inadequately investigated by both local and county officials, all of whom appeared to be convinced beyond any doubt that the case was an obvious suicide. Assistant Medical Examiner Bellin had marked on Beeler's death certificate that the manner of death was by a self-inflicted gunshot wound and the State Police analysis had shown that the fatal bullet came from Beeler's own .38-caliber revolver. Interviews with neighbors and co-workers were followed by investigative reports that emphasized negative rather than positive or neutral versions of what anyone knew of Beeler as a person.

From the outset, however, Mrs. Beeler and other members of the family opposed the official belief that Beeler had killed himself and their protests caused arguments with the authorities, resulting in deteriorating communications and estrangements. Since Mrs. Beeler and her mother, Mrs. Lavala, had been insisting that no family problems existed, the Prosecutor's staff decided

to check Mrs. Beeler's statements by means of a polygraph examination on January 27, 1975. Almost two months later, on March 19, 1975, Mrs. Beeler's brother-in-law, Francis Knowles, also was given a polygraph test to determine the truthfulness of his assertion that he was not aware of any domestic problems involving the Beelers. The test of Mrs. Beeler was taken by Prosecutor's Detective Gus R. Balzano, a certified polygraphist. The Knowles test was conducted by Prosecutor's Detective T. James Conroy, who had been schooled in the procedure but had not been certified.

Balzano asked Mrs. Beeler whether she and Beeler had discussed the possibility of divorce and if, on the night of his death, they had argued. Balzano construed her responses to two key questions in these areas to be false. When questioned later by the S.C.I., he conceded that her physiological reaction of deception to one of these questions was ascertained only once in three separate but identical sequences and that the other key question brought two reactions, one of deception and one not. Despite Balzano's polygraphic training and experience, he would not alter his opinion in the face of admitted test response variations that should have dictated at least an inconclusive result. When Conroy tested Knowles on whether Beeler enjoyed a good relationship with his family, his positive answer was ruled as false. Again later, when Conroy was asked by the S.C.I.

to re-interpret his test charts, he conceded that Knowles may have been telling the truth since he could not point to any definitive physiological reactions. Both of the Beeler-Knowles test conclusions -- that they lied about Beeler's family relationship -- were considered by the prosecutor's staff as further evidence of probable suicide. (Later polygraph tests conducted by the S.C.I., centering on the same family relationship topics, produced no conclusive findings).

As for the Beelers' financial situation, it was known that Beeler earned $5.42 an hour at his regular job at the Bordentown National Guard Armory, buttressed by $750 a year for participating one weekend each month in National Guard drills and by his wages, which averaged $139 per week, at the United Parcel Service (UPS), where Beeler held another job as a driver. No clear picture of Beeler's financial circumstances was ever obtained, although Prosecutor's Detective Alesandrini made inquiries, including a visit to the UPS office. It was not noted in the prosecutor's staff reports whether Beeler had either debts or savings of any substance or what his general housing, clothing and food costs were. His family would later tell the S.C.I. that he was in the process of shopping for a home in the Bordentown area.

In one of the county detective's reports, the comment by a co-worker at UPS that Beeler had requested more work so he could make more money and "get away from it all" was emphasized, although that same report also

contained a statement by a close family friend, Charles Ellis, a former Lindenwold police officer, that he knew of no problems at the Beeler-Lavala home. The S.C.I. learned as recently as 1978 from a neighbor, Andrew Yiller, that Mr. and Mrs. Beeler had walked arm-in-arm to and from the Yiller home the day before the death. An investigation independent of the police inquiry established that Beeler was attending religious classes in order to convert to Catholicism and have his marriage blessed by the Catholic Church.

One of four co-workers Alesandrini interviewd at UPS said Beeler "was having problems with his wife and in-laws" and wanted to move out. The other three UPS co-workers said they were not aware of any domestic difficulties. None of Beeler's superiors could report any problems with his job performance at any place of employment.

During the separate investigative efforts by local police and county detectives, there was no effective, continuous coordination of their individual investigative findings. The only common thread that extended throughout their inquiries was the tendency to accept statements that supported the initial suicide theory and to ignore contrary views. This was particularly true of the field work that ensued, including the questioning of co-workers and family members about Beeler's home life and his personal outlook. Some of this questioning by Alesandrini was conducted en masse, including one group of seven of Beeler's various co-workers. When the S.C.I. questioned

these individuals separately, several of their responses differed from the responses Alesandrini said they made to his questions.

There was a misunderstanding about whether winding up the investigation was a local or a county responsibility.

On February 7, 1975, Alesandrini recommended in a memorandum to his superiors at the Prosecutor's office that the case be "filed" as a suicide. Lindenwold Detective McCarthy, shortly after he was told by Alesandrini that a final disposition in the Beeler case had been made and "therefore the case is closed," also closed the Lindenwold file. McCarthy later testified before the S.C.I. that it was his understanding Lindenwold police were to remain active on the case until the Prosecutor's office closed it out. However, Alesandrini, in his later testimony at the S.C.I., contended that the role of the Prosecutor's staff was to assist rather than direct the local police inquiry. As McCarthy's action had illustrated, the county detective said he "imagined" that the Lindenwold Police Department would disagree with his characterization of the county role as a subordinate one. Although Alesandrini placed final responsibility for the investigation on Lindenwold police, he conceded in his testimony that a problem existed if neither agency recognized actual responsibility and believed, instead, that each was supposedly assisting the other. After reviewing the Lindenwold police file, Alesandrini told the S.C.I. the file suggested to him that "McCarthy is making me the

person in charge of the case."

Whatever the case-closing situation was on or about February 7, 1975, the Beeler death continued to receive investigative attention. Reports of prowlers in the vicinity of the Beeler home before, after and on the night of Beeler's death were a subject of further inquiries.

In March, 1975, Mrs. Lavala, mother of Mrs. Beeler, notified both Lindenwold police and the Prosecutor's office that she had recognized an individual she had seen prowling about the Beeler-Lavala home.

After receiving Mrs. Lavala's statement that she had recognized an alleged prowler, Lindenwold Detective McCarthy located that person and obtained a brief formal statement from him. His reason for being in the area of the Beeler-Lavala home -- that he was going to a fire -- was accepted without question by the authorities. It subsequently turned out that the individual's story was untrue. This segment of the investigation was marked by a number of inadequacies, including failure to substantiate the alleged prowler's alibi and an insufficient check to determine whether he had a criminal record. At least one other person, one of Beeler's co-workers, told Alesandrini that Beeler said he had chased a prowler from his yard on the Wednesday prior to his death.

Dissatisfied with progress of the official investigation, Mrs. Beeler and the Lavalas negotiated with a private detective, John Troutman, a former Camden city detective, to conduct an independent investigation. Troutman eventually compiled a 150-page dossier of interviews and reports detailing his investigation. This file was subsequently read and dismissed by the Prosecutor's staff. However, it may have advanced a legal suit filed by the Beeler family against the office of Camden County Medical Examiner William Read. This suit challenged Dr. Bellin's verdict of a "self-inflicted gunshot wound" on the Beeler death certificate.

The Troutman investigation developed certain angles of potential significance in the Beeler case that local or county authorities had either not uncovered or had considered but dismissed as having little or no relevance.

For example, Troutman interviewed three neighbors who recalled hearing two shots in the area of the Beeler-Lavala home early in the morning of January 19. Only one of these three individuals, Irene Haines, was ever interviewed -- but there apparently was no follow-up report assessing her statement. In addition, during Troutman's canvass of the neighborhood, he learned that other residents in the vicinity of the Beeler-Lavala home had complained of hearing or being annoyed by prowlers. Several stated they had chased a prowler and one said she had taken a shot at him.

At Mrs. Beeler's request, Troutman on October 31, 1975, submitted a copy of his Beeler file to the Medical Examiner's office as part of her attempt to change the wording on her husband's death certificate. Prosecutor's Detective Sergeant Robert DePersia was assigned -- as he later testified at the S.C.I. -- to compare Troutman's findings with those of the official investigation. He noted "some discrepancies." No one later questioned by the S.C.I. was ever able to clarify whether the Prosecutor's staff or the Lindenwold police made any effort to double-check new or expanded evidential material in the private investigator's report. DePersia submitted to Assistant Prosecutor Philip Seaton a four-page review of Troutman's file, the emphasis in which was that the file added nothing of value to the investigative efforts that had preceeded and followed the Assistant Medical Examiner's suicide verdict. DePersia said certain aspects of the investigation by the Prosecutor's staff were "deliberately being clouded" by Troutman. Although he told the S.C.I. that "I could picture Troutman trying to do everything right for his client in every direction possible," DePersia also conceded that the Beeler death should have been classified as an unsolved death.

Detective McCarthy had heard that Troutman's extensive report indicated investigative inconsistencies but did not read it because his file on the case was closed. He read only what he characterized as Detective DePersia's

"rebuttal." McCarthy subsequently told the S.C.I. he was satisfied that the Beeler investigation had been "complete and thorough."

Since no cause other than suicide was ever considered by local or county investigators, no effort ever was made to examine other possible versions of the Beeler death. Although the Beeler case contained certain characteristics of a suicide -- the gun was owned by the victim and the wound was in the area of the temple and was probably a contact wound -- there were other indications. For example, the blackish discolorations on Beeler's fingers could have been gun powder discoloration that might have revealed whether Beeler or someone else fired his gun. But these blackish marks were never examined. In addition, other blackish material removed from Beeler's ear and presumed by Dr. Bellin to be soot was not identified as such by the State Police Laboratory.

In order to clarify certain other factors in the Beeler probe, the Commission consulted Professor Herbert MacDonell, an adjunct professor of criminalistics at Elmira College and a nationally known bloodstain analyst. Professor MacDonnell reviewed the photographs of the victim's body and also photographs of the scene taken after Beeler had been removed to the hospital. These photographs were interpreted on the basis of Detective McCarthy's diagrammed description of the location of the body and of the Beeler gun. They indicated to the professor that Beeler could not have been alone at the time the shot

was fired. He stated that the position of the weapon where it was found on the ground by police was inconsistent with the diagrammed position of the body. According to the location of the blood stains found on the wall of the bungalow, he concluded that Beeler's head was three feet from the ground when the fatal shot was fired. In addition, the photographs taken of Beeler's body at the hospital indicated to MacDonell that whole drops of blood may have fallen on it, suggesting to MacDonell that another person may have stood over Beeler's body immediately following the shooting. Had investigators of the Beeler death attempted to reconstruct the position of his body at the time the fatal shot was fired, such a procedure might have at least raised a serious question about whether this case was actually a suicide.

Since personal appeals by the Beeler family to strike the suicide reference from the Beeler death certificate had been unsuccessful, they filed a suit against Medical Examiner William Read on January 12, 1976. This suit eventually resulted in a settlement by the Camden County Medical Examiner's Office. Under a judgment dated December 17, 1977, Dr. Bellin's reference on the certificate to the manner of death -- "by a self-inflicted gunshot wound" -- was deleted. In its place was left a blank space, which remains today as a silent rebuke of the Beeler death investigation.

THE SUDDEN DEATH OF WILLIAM ROHRER, 3rd. (1975)

At 8:40 A.M. on May 28, 1975, Patrolman Henry Voigtsberger monitored a call for assistance at 730 South Park Drive, Haddon Township, the residence of then-Mayor William G. Rohrer and his family. Mrs. Rohrer had called the police dispatcher, Henry Gannon, saying that the Rohrers' recently adopted child, William (Billy), 3rd, 2 1/2, had hit his head and was unconscious. (Billy, born in El Salvador in Central America, had been adopted by the Rohrers in February, 1975). Voigtsberger, who had been patrolling nearby, recalled that he arrived "within a minute." Mrs. Rohrer ran toward him with the child in her arms as he drove up the driveway. The officer felt the boy's neck and thought he perceived a slight pulse. He also observed dried blood around the boy's nose. Rather than wait for an ambulance to arrive, the patrolman took mother and child directly to Our Lady of Lourdes Hospital in Camden. Voigtsberger testified subsequently before the S.C.I. that he asked Mrs. Rohrer what happened and was told the boy "fell out of the high chair." (His only report states that Billy "had struck his head"). During the trip to the nearby hospital, the child remained unconscious.

The hospital had been notified by the dispatcher that the child was being brought in and was apparently in danger. The patrolman escorted Mrs. Rohrer into the emergency room where Billy was examined and pronounced dead. Sgt. George Harris of Haddon Township, who had followed Voigtsberger to the hospital, tried to assist Mrs. Rohrer regain her composure. Meanwhile, at Harris's request, Voigtsberger asked the dispatcher to find the mayor and to call a detective to

the scene. Voigtsberger, who had no further participation in this sudden death case, later recalled in S.C.I. testimony that he commented to the dispatcher on his return to police headquarters that "something just didn't seem right to me."

The child was pronounced dead at 8:47 A.M. by the hospital's emergency room physician, Dr. Albert Jurecic. As Harris had requested, a township detective, Harold Armstrong, was assigned to investigate the death. Harris, who remained at the hospital only 15 or 20 minutes, until Mayor Rohrer arrived, made no report on his activities.

Detective Armstrong was assigned to the case at about 9:00 A.M. When he arrived at the hospital, he learned that his fellow officers and Mayor and Mrs. Rohrer had departed. He did not see the child's body. He returned to headquarters, where he was told that the Camden County Prosecutor's office had been notified about the sudden death. He then proceeded to the Rohrer home -- arriving only 20-30 minutes after he had gone to the hospital. At the house, the detective asked the Rohrers what happened to Billy. He said Mrs. Rohrer told him the boy had been throwing his head back in his kitchen high chair, had hit his head a couple of times and then slumped over, and also that Billy had fallen downstairs and bumped his head earlier that morning on his way to breakfast. Mrs. Rohrer said she became worried when she went over to him in the high chair, saw blood coming from his nose and felt that his pulse was weak. She added that the child fell down frequently and that she believed he was retarded. Rohrer told Armstrong he had nothing to add since he had been in the bedroom or his office

in the home at the time of some of the incidents his wife described.

Meanwhile, the Camden County Prosecutor's office had assigned homicide Detective Joseph Alesandrini to investigate the death. He and Prosecutor's Investigator Edward Bandoch first went to the hospital and spoke to Dr. Jurecic, who recalled the mother saying the child had been banging his head on the high chair. Bandoch took photographs of the body. Bruises were noted on the body at the time but were apparently not questioned by either of the detectives or, in the detectives' view, by the doctor himself. Nonetheless, Dr. Jurecic later testified before the S.C.I. that he thought that the death was "suspicious" and "puzzling" and probably the result of violence. He testified that it was "unlikely" that the child could hurt himself "in this way."

At approximately 10:00 A.M. the county investigators left the hospital for the Rohrer home, where they met Township Detective Armstrong and then questioned the Rohrers. Alesandrini and Bandoch testified later at the S.C.I. that Mrs. Rohrer told them she believed the boy had fallen down the steps and hit his head on the bannister but that she had not witnessed such an incident. No blood was found on or near the high chair in the kitchen. Mrs. Rohrer stated she had wiped up a small spray of blood on the kitchen wall, but no effort was made to check this statement. Photographs of the interior of the Rohrer home were taken by Bandoch. Armstrong remained at the Rohrer

house while Alesandrini and Bandoch continued questioning the Rohrers into the morning.

Armstrong and other investigators next attended the autopsy conducted at 11:47 A.M. by Camden County Medical Examiner William T. Read, Jr. During that procedure, Armstrong said he learned that the Prosecutor's office had indicated to Dr. Read a belief that Billy's death was accidental or self-inflicted. This belief coincided with Armstrong's final opinion at the autopsy. Although he told Dr. Read of Mrs. Rohrer's various statements (that Billy apparently fell down a stairway, banged his head against the back of the high chair -- and was retarded and "self-destructive"), Armstrong did not submit a written investigative report to the medical examiner.

Dr. Read's autopsy report listed the cause of death as "severe contusions of the brain with subarachnoid hemorrhage." Numerous bruises scattered over Billy's body were observed during the autopsy but X-rays were not taken. Dr. Read in later testimony before the S.C.I. confirmed the absence of X-rays and conceded that X-rays would normally be taken if child abuse were suspected. In addition, although the autopsy report did not indicate the manner of death, the cover sheet of the report contained the additional notations: "Self-inflicted injuries to the head and body" and "had been in Philadelphia hospital for self-injury." Dr. Read stipulated the death as self-inflicted on the death certificate, a stipulation that also went beyond the inconclusive contents of the autopsy report itself.

Prior to the autopsy, Township Detective Armstrong had suspected a possibility of child abuse after questioning Mrs. Rohrer. He telephoned Dr. Robert P. Barroway of Cherry Hill, the family's pediatrician, and Dr. Eliott J. Gursky of Philadelphia, a psychiatrist who also had been consulted by the Rohrers. They reported the child was normal but had found it difficult to adjust to his new environment so soon after being brought from El Salvador. According to Armstrong, these doctors also reported a relationship problem between mother and child and that treatment was recommended. They had observed, however, no evidence of child abuse. Although Armstrong never clarified or attempted to clarify in these telephone conversations the contradiction between the doctors' statements that Billy was normal and Mrs. Rohrer's statement that he was self-destructive and retarded, he included in his final investigative report a comment attributed to Dr. Barroway that the child needed further help for his own safety. Dr. Barroway later denied making that statement to Armstrong. The detective later testified that his conversations with the doctors had finally caused him to conclude that the child was a victim of self-destructive tendencies rather than of abuse by others.

In the afternoon of the day of Billy's death, after attending the autopsy, Detective Armstrong ended the municipal police inquiry even though (as he later testified) he believed that the Haddon Township Police Department was the dominant investigative agency in the sudden death case. He wrote

a two-page report stating his assumption that no foul play had occurred and that the case therefore was closed. Thus, the local investigation was suddenly ended by an officer who had been a detective for less than a year and a half, who had never investigated a child abuse case, and who, although making an assumption of the county investigators' initial findings, had never checked on such findings at the Prosecutor's office.

From that time on there was no further documented communication between Haddon Township police and the County Prosecutor's staff regarding the death of the Rohrers' adopted son.

Under the sole direction of the Prosecutor's office, the investigation was hampered by failures to resolve discrepancies in statements by Mrs. Rohrer, by inaccurate and incomplete reports by detectives, by confusion over the county medical examiner's inadequate performance, and by tardy and unprofessional interrogation of witnesses. As with other sudden death cases reviewed by the S.C.I., the inquiry into the Rohrer baby's death was handicapped at its outset by a premature consensus among the investigators -- in this case, that the death was accidental or self-caused. No concerted effort was made to double-check the investigative inconsistencies that marked the case even as the local police withdrew from it immediately after the inconclusive May 28 autopsy.

County Detective Alesandrini, by his own admission, proceeded with his investigation without a thorough reading of Dr. Read's autopsy report. He later told the S.C.I. that he never spoke to Dr. Read and that he gave the autopsy findings only cursory consideration. He testified he "just looked over the autopsy," that he did not "review it, go into it."

In addition, Alesandrini never met face-to-face with the doctors involved in the case. He talked with them only by telephone -- Dr. Barroway, the pediatrician, on May 28, the day Billy died, and Dr. Gursky, the psychiatrist, on May 30. No direct investigative interview with Dr. Gursky, other than by telephone, ever took place despite a request personally signed by Prosecutor Thomas J. Shusted on June 2, 1975, that Dr. Gursky be questioned.

Alesandrini filed a report with the Prosecutor's homicide unit on June 3 in connection with his telephone talk with Dr. Gursky (who was affiliated with the Child Care Center of Children's Hospital in Philadelphia). Dr. Gursky in later testimony before the S.C.I. said Alesandrini inaccurately described the conversation in his report. The June 3 report stated that Dr. Gursky said Billy had been finding it difficult to adjust to "his new way of life in the United States" and that the child's background, "being born and raised in a prison in Central America, was a contributing factor." Alesandrini's report continued:

"I then asked Dr. Gersky (sic) if he felt in his personal and professional opinion if Mrs. Rohrer was capable of beating this child. He answered that since he has been working with her and knowing her background and position, he stated definitely not. Dr. Gersky also stated to me that Mrs. Rohrer explained to him exactly what the child would do as far as throwing himself against objects and trying to hurt himself when she first took him to his office. Dr. Gersky stated that Mrs. Rohrer was very, very concerned about this and she wanted help. He stated that he felt what he was doing would sooner or later correct this condition."

Alesandrini concluded his report by "recommending at this time that this case be filed as a sudden death in which William G. Rohrer (Jr.) did in fact beat his head against the high chair causing a wound that (led) to his death."

Meanwhile, Frank Senatore, director of detectives at the Prosecutor's office, learned that Mrs. Rohrer had undergone "some kind of psychiatric treatment years before." Further, the Prosecutor's office had been informed that the Rohrers had been having family problems and that some family members believed Mrs. Rohrer might have harmed Billy. Instructions were issued to the detectives assigned to the case to interview the Rohrers again, particularly about their family life, and to contact neighbors about conditions in the Rohrer household.

This re-interview of the Rohrers took place on June 13 at the Rohrer home in the presence of Alesandrini, Bandoch and Lieutenant Anthony DiMaggio, commander of the Prosecutor's homicide unit. In a report on this interview, dated June 17, Alesandrini said DiMaggio "did the questioning, asking Mrs. Rohrer if she had struck her son the evening before, causing her husband to get angered and leave the house to return the next morning," and also if "she had ever abused the child." The June 17 report continued:

"She stated no, but admitted biting her son on the head and cheek to see if he felt pain. She stated he never cried. Mr. Rohrer stated the child was spanked by him, but not abused. Mrs. Rohrer kept insisting that she wanted the best doctor to see her son and when she finally went to Dr. Gerski, he treated her and her husband, not the child...

"We also asked about the child being left with friends for two weeks because she could not handle him. She stated that was a lie.

"She had let her son go with Mr. & Mrs. Baker of Mickletown, New Jersey for two days. She stated Mrs. Baker was a good friend of hers and a nurse and felt she would like to see if she could help the child. Mrs. Baker was also trying to adopt from the same mission as Mrs. Rohrer did."

Although Alesandrini and his colleagues had been instructed to question neighbors about the Rohrers, this assignment was never carried out. Alesandrini subsequently told the S.C.I. that he did not think it would be productive, that neighbors of the Rohrers "are quite far apart in that area....I don't think you can look into one another's yard or houses." Later investigation, however, would show the contrary.

At some point during June, 1975, Assistant Prosecutor Philip B. Seaton was assigned to take charge of the investigation. One of his first steps in this assignment was to discuss with First Assistant Prosecutor Joseph F. Audino and Detective Alesandrini the possibility of a child abuse prosecution, particularly in light of discrepancies in statements made by Mrs. Rohrer that Seaton himself had noted. Seaton also discussed various aspects of the case with Medical Examiner Read, including Billy's background and Dr. Read's findings during the autopsy.

One essential interview in the investigation by the Prosecutor's staff did not take place until almost three weeks after Billy's death. That was the interrogation of William K. Lovell, a partner and the general manager of Rohrer Chevrolet, who by coincidence was inside the Rohrer home before local police responded to Mrs. Rohrer's call at 8:40 A.M. on May. 28. Alesandrini

did not interview Lovell until June 17, but the questioning produced few additional details about the sudden death. Lovell told the detective he went to the house at 8:30 A.M. according to pre-arranged plans for both him and Rohrer to attend a General Motors meeting in Cherry Hill. He told the investigator Mrs. Rohrer answered the door bell ring with Billy in her arms but that he did not observe whether the child was hurt. After about 10 minutes, according to Alesandrini's report, Lovell saw Mrs. Rohrer leave the house with the baby and drive off in a police car. Close to 9 A.M., Rohrer appeared in the living room, saying he had not known that Lovell was there. Rohrer then answered the telephone, after which he told Lovell he was wanted at the hospital and that Lovell should go on to the meeting alone. Later, Lovell said, Rohrer came to the meeting and told him Billy had died. Lovell also told Alesandrini he had never seen the Rohrers abuse Billy. Lovell later told a similar story at the S.C.I., except that he was not sure if Mrs. Rohrer had responded to his ringing of the door bell or had discovered him at the doorway by accident. He recalled that Mrs. Rohrer did not say anything to him. When Rohrer discovered his presence, he told Lovell the "boy had fallen." Lovell testified that the house was in a state of confusion.

As noted, Assistant Prosecutor Seaton questioned Medical Examiner Read sometime after taking charge of the inquiry into Billy's death. On June 27, Dr. Read in a letter to Seaton

briefly reviewed some of his autopsy findings and his views about them. This letter concluded that the origin of the contusions on Billy's body "was thought to be self administered as can be found in Lesch-Nyham Syndrome"* but that, since the autopsy did not distinguish between self-inflicted injuries and injuries inflicted by another person, "other evidence would be necessary to establish the mechanism." The Doctor's letter appeared to suggest further investigation. Nonetheless, the "other evidence" Dr. Read said was required to establish whether the child's injuries were inflicted by some one other than the boy himself was never sought with any vigor. This was yet another investigatory deficiency, whether such evidence was available or not.

Two weeks prior to his death, Billy was placed by the Rohrers for three days with Mr. and Mrs. Bruce Baker of Mickleton, N.J. Temporary custody of Billy by the Bakers was arranged after Mrs. Baker, who also wanted to adopt a child from a foreign country, had learned by chance that the Rohrers adopted Billy from El Salvador and had contacted Mrs. Rohrer. The arrangement was approved by the child psychiatrist, Dr. Gursky, who felt Billy should be in another environment for a brief period while the Rohrers worked on their marital relationship.

*A rare kidney malfunction resulting in self-destructive activities, usually to the mouth and fingers.

On July 9 County Detective Timothy McCarthy of the Prosecutor's homicide unit questioned the Bakers about their observations both of Billy while in their care and of the Rohrers. Mrs. Baker, a nurse who had some knowledge of the Spanish language, said Mrs. Rohrer brought Billy to her on the evening of May 11 and that Rohrer took the child back home the following Wednesday night. According to McCarthy's report, Mrs. Baker said the child appeared healthy, alert and well clothed and showed no signs of abuse. McCarthy also reported Mrs. Baker as saying that Billy "showed no signs whatever of being retarded nor did he subject himself to any physical pain (such as throwing himself down or into other objects)," that he was a normal child, and that, based on her telephone conversation and two meetings with Mrs. Rohrer, she found Billy's adoptive mother to be stable and "very concerned with being a good mother." Mrs. Baker also recalled Mrs. Rohrer asking her for a recommendation on where to "seek treatment for an autistic child (one who refuses to adapt to the environment)," according to McCarthy's report.

On July 21 Alesandrini submitted a report on a background check of Mrs. Rohrer. Among other details, the investigator reported that she was 34 years old, had been married to Rohrer for a year and a half, and with Rohrer had adopted Billy as well as another younger child, Lisa, from Central America.

Not until August 26, 1975, were formal statements taken under oath from Rohrer and his wife. The questioning took place in the Prosecutor's office in the presence of Assistant Prosecutor Seaton, Detective Alesandrini and lawyers for the Rohrers. Although the statements to be taken were potentially incriminating (the Rohrers' appearance had been preceded by the issuance of Grand Jury subpoenas), no constitutional warnings were given to either of them.

In separate interviews, the Rohrers described their visit to El Salvador in February, 1975, when they arranged for the adoption of Billy and Lisa through a church mission. Rohrer recalled that Billy had just been transferred from a jail to the mission and that, while Lisa "adjusted very well," the boy was "stubborn and bullheaded." Rohrer, who had four daughters by a previous marriage, was asked to describe Billy's behavior from the standpoint of his experience with his other children. Rohrer said Billy "would get in the corner and he would stand there for hours, which is more likely the punishment they gave him in jail, if he didn't do something right. I don't know, I said to my wife, I don't know how a man or a kid can stand there for hours, but he would do that. Of course he had trouble. I mean if he just felt like eating he would, if he didn't he wouldn't. I couldn't talk to him about it

or force him to eat, if he wanted to eat he did, and if he didn't..." Mrs. Rohrer said they had hoped Billy would respond to his new environment when the family returned to the United States but that, while Lisa did adjust, Billy "didn't play with anything, he didn't look, he didn't want anything, he didn't like anything." Rohrer said his wife had difficulty controlling Billy while he was at work, that when he came home Mrs. Rohrer would complain that she "had an awful day with Billy." Rohrer said the boy would "just throw himself on the floor and carry on, he would cry" and that, during the two or three weeks before Billy's death, Mrs. Rohrer told him the child had thrown himself down a staircase in the Rohrer house "I didn't see any results of the fall," Rohrer said, "although I didn't feel over his body and see if he had any bumps on the head or anything."

In response to Seaton's questions, Rohrer gave this version of what occurred at his home just before Mrs. Rohrer and Billy were taken to the hospital:

He awakened late that morning and was eating cereal in the kitchen when Mrs. Rohrer "brought Billy in and said here, he's acting up again." Mrs. Rohrer put Billy on the table "and he didn't move," Rohrer said, and "I said to her, well, he's not moving, and she said well, he's pulling that playing possum, he won't move..." Mrs. Rohrer then took Billy upstairs to test his blood pressure, after which "she said it didn't show no blood pressure or

pulse." He suggested that they call a nearby doctor but Mrs. Rohrer "wanted to rush him to the hospital." She persisted, however, and the "next thing you know she called the police." Rohrer then found his general manager, Lovell, sitting in the living room and, "well just then the phone rang and I answered the phone and they said well, come to the hospital, your boy is dying." He recalled he had previously seen "some black and blue marks on his (Billy's) fanny a couple of times" but he regarded them as "just kids bruises, and I didn't even take it seriously." He said he didn't notice any blood on the high chair or any other area of the kitchen but that "I didn't look for it either."

Seaton next questioned Mrs. Rohrer, separate from her husband, about her recollection of the events preceeding Billy's death:

After dressing the child before going down to the kitchen, she said she next "saw him at the bottom of the steps" in a "slightly bent position." However, she thought Billy was following his usual custom -- "if he was mad at you for some reason he would go down five steps or so and stop, and then you would have to say go on further." She then went down the steps and said "okay, let's keep going, get in the high chair." After she put him in the chair, and while she was getting him some bread

and jelly, "he was banging around in his chair hitting his head on the back of the chair." She went to the high chair "to make him stop if I could" and "just as I got to him he just swooned over." She "thought he was faking," she said. She then recalled that earlier, while she was dressing Billy, "he threw himself back and hit his head" either on the bathroom sink or "on the floor or on the rug."

Back in the kitchen, after Billy swooned, Mrs. Rohrer said she "laid him down in front of my husband on the table," telling Rohrer that "he was faking and didn't want to eat." She went upstairs at that point. Returning to the kitchen in about five minutes, she said, "I went to the table and picked up the little boy, and he felt looser than he had before, in other words, when he was faking before, he was always rigid." She next took the child upstairs and checked his blood pressure "and couldn't get a reading." Mrs. Rohrer said she "ran downstairs with him on my arms," laid Billy on the kitchen table and "tried to give him artificial respiration." When her husband told her to summon the doctor who lived in their neighborhood, "I said no, and I picked up the phone and called the operator, and I said get me an ambulance." She also recalled seeing blood on Billy's nose but "it wasn't running enough" to wipe. She said that after she returned from the hospital she "noticed some blood on the wall" of the kitchen, in back of the high chair, "a little bit of a spray" which she wiped off.

Mrs. Rohrer told Seaton she had noticed bruises on Billy's body on previous days but attributed these injuries to his habit of "throwing temper fits, tantrums." She recalled that during the day before Billy's death she decided to see if the child felt any pain and "I bit him on the side of the face and made a bruise." However, she continued, "a little bit later I waited a while and bit him right directly on the top of the head where he couldn't see what I was doing, and then I talked to him and I said ouch, ouch, and nothing, so I put my hands in his mouth and I made him bite down on me, and I said ouch, and tried to communicate that I had done the same thing to the top of his head. He didn't feel anything."

The interrogation of the Rohrers was followed by interviews with certain individuals with whom Mrs. Rohrer said she had discussed Billy's behavior. These interviews, all by telephone, were conducted by Detective Alesandrini with Mrs. Rohrer's brother, David Mangello, and her best friend, Rita Urivitz of Philadelphia, on August 27, and with the Rohrers' part-time housekeeper, Cora Thomas of Woodbury, on August 28. He asked them if they had any knowledge of Mrs. Rohrer mistreating Billy and each reported they knew of no such activity on her part. Of the three, only the housekeeper had more than minimal contact with the child.

On September 17, 1975, Seaton gave to First Assistant Prosecutor Audino the case file on the Rohrer baby's death and a note requesting comments on it and recommending

that further investigation be ended. Seaton's note stated: "I see no criminal violations at this time that are supported by any factual evidence." On September 29 Audino referred the file to Prosecutor Shusted with a memo stating he agreed with Seaton's judgment "in that there is no evidence to support a criminal prosecution and therefore [I] am recommending at this time that we terminate any further investigation and close the file."

The S.C.I. subsequently included the case in its general inquiry into the handling of sudden death investigations. The doctors and local and county officials who had participated in the case were questioned by the S.C.I. under oath. These interrogations confirmed a lack of professionalism throughout the investigation in that reports on interviews by police and detectives were not accurately compiled and investigative leads either were not recognized or were not followed up. Particularly inept were interviews by investigators of the physicians -- those who immediately tended to the child upon arrival at the hospital on May 28, 1975, as well as the specialists who had been treating the Rohrers and Billy prior to his death.

Dr. Jurecic, who had pronounced the child dead at the hospital, testified before the S.C.I. that he found the death "puzzling" since no single external sign of violence appeared to have caused it. Although the skull was intact and no fractures were apparent to him, Dr. Jurecic expressed an opinion that the child had met with a violent death. However, he neither made his opinion known at the time nor did he recall

speaking to any investigator who asked any questions concerning the possibility of child abuse.

The medical examiner's investigator, Jeffrey Brown, recalled writing on his investigating slip the statement: "Baby banging head against wall. Passed out." According to Brown, he obtained the information on which those statements were based from an emergency room nurse at Our Lady of Lourdes Hospital. The nurse, Linda Dugan, testified before the S.C.I. that, although neither of those statements appears on the emergency room record, she made those remarks to Brown by telephone. She testified that Mrs. Rohrer had supplied the information.

Dr. Barroway, the pediatrician, testified at the S.C.I. that his first meeting with Billy was on February 17, 1975. The boy was treated by him that day for a skin rash and for diarrhea but otherwise appeared to be in good condition. Billy was again fully examined on March 5, 1975, at which time he appeared to Dr. Barroway to be normal. Neither bruises nor signs of emotional disturbance were noted. The doctor recalled that the mother rather than the child may have been depressed. Since Mrs. Rohrer had stated to him that the child hated her, he said, he perceived a relationship problem and accordingly referred the mother and child to Dr. Gursky, the psychiatrist. Dr. Barroway testified he felt that Mrs. Rohrer needed the counseling of a psychiatrist in "straightening out" the mother-child relationship. Dr. Barroway said Billy did not exhibit symptoms of the Lesch-Nyham Syndrome. He also said

he did not find the child to be autistic.* Dr. Barroway in his testimony denied ever stating that Billy needed further help for his own safety, as Armstrong had reported. This alleged inaccuracy was later interpreted by Assistant Prosecutor Seaton to be Dr. Barroway's verification of the danger of self-trauma, and Seaton so testified before the S.C.I.

The psychiatrist, Dr. Gursky, testified at the S.C.I. that he held the first of three sessions with the Rohrer family, including Billy and two-year-old Lisa, on May 2, 1975. He said Mrs. Rohrer wanted an evaluation of Billy to see if he was normal, adding that Mrs. Rohrer "certainly had a negative attitude towards this child" and he "was concerned about the possibility of her harming him emotionally or physically." After the first consultation, a telephone call from Mrs. Rohrer led Dr. Gursky to conclude that a foster placement for Billy was necessary. At the next meeting with the family, the idea of a foster placement was explored with Rohrer. Dr. Gursky received a call from Mrs. Rohrer three days later confirming that the Bakers would take Billy temporarily while Mr. and Mrs. Rohrer tried to resolve marital difficulties. He said it was his understanding that "if things didn't work out," Mrs. Rohrer would permit the Bakers to adopt Billy.

Dr. Gursky last saw the Rohrer family on May 16, two days after Billy's brief stay with the Bakers. On the last visit, Dr. Gursky testified, "Mrs. Rohrer seemed more together"

*Subject to self-centered mental activity, such as day dreams fantasies, delusions, especially when accompanied by withdrawal from reality.

and "easier with Billy." He said the Rohrers expressed a desire for another consultation two weeks later. The next contact the doctor had with regard to the Rohrer family was a call from Detective Armstrong on May 28 notifying him that Billy died of a subarachnoid hemorrhage that day. Armstrong told Dr. Gursky that the child was reported by the family to have hit his head on the high chair "to attract attention." The doctor reportedly told Armstrong that Mrs. Rohrer was having difficulty with her new role as a mother but that there had been no direct evidence of child abuse. A day or two later Dr. Gursky gave the same information to Alesandrini, who told the doctor there was no evidence of foul play. When Dr. Gursky was shown Alesandrini's report of their telephone conversation at the S.C.I. hearing, he observed that only those portions dealing with Billy's background and the child's difficulty in adjusting to his new life in the United States were accurate. But what Alesandrini wrote regarding Dr. Gursky's manner of treatment was "not... altogether accurate," the doctor testified. He said he never delved into Mrs. Rohrer's "background and position," as stated in Alesandrini's report, nor did he tell Alesandrini that Mrs. Rohrer was "definitely not" capable of beating the child. The doctor said he told Alesandrini only that he did not think the mother would physically abuse the child. Although the doctor confirmed to Alesandrini that Mrs. Rohrer had said the child had self-destructive tendencies, he also said he found the child to be normal and thought Mrs. Rohrer

was alluding to normal rough-and-tumble play activities. However, Alesandrini's report was so worded as to indicate that the doctor had verified the complaints made to him by Mrs. Rohrer. As noted, Dr. Gursky had diagnosed that Mrs. Rohrer rather than the child needed treatment. The doctor in his testimony also recalled that Billy exhibited no symptoms of the Lesch-Nyham Syndrome. Having viewed photographs of Billy taken the day of his death and having read the autopsy report, Dr. Gursky stated that the cause of death and the numerous bruises of varying age on the boy's body "raise an index of suspicion of child abuse." Dr. Gursky said he tried to contact the Rohrers but never again heard from them after Billy's death.

Assistant Prosecutor Seaton testified before the S.C.I. that the issue of the Lesch-Nyham Syndrome was an important investigative factor. Another important question, he indicated, was whether the child had a blood coagulation problem which could have caused the bruises on his body, although tests did not establish such a problem.

Dr. Read testified before the S.C.I., however, that his mention of the Lesch-Nyham Syndrome in the June 27 letter was merely exemplary of diseases which cause self-destructive behavior. He further testified that he did not believe Billy suffered from this disease, since it results in damage only to the face and fingers. Although Seaton did communicate with Dr. Read on this issue subsequent to the receipt of the letter, he never understood that Dr. Read's reference to the Lesch-Nyham Syndrome was merely hypothetical. Thus,

the misleading character of the letter was never clarified. The investigation may have suffered as a result.

Overall, Seaton said he did not feel that the State could prepare an adequate prosecution. Dr. Gursky's statements, as reported by Alesandrini, were given weight by Seaton but the assistant prosecutor never personally interviewed the psychiatrist.

Seaton conceded to the S.C.I. that the Prosecutor's office case files do not reveal any source other than Mrs. Rohrer for the various statements about Billy's supposed self-destructive tendencies. Had he known Dr. Gursky did not say (contrary to Alesandrini's report) that Mrs. Rohrer was "definitely" incapable of child abuse, Seaton testified he would have handled the case differently. Nonetheless, Seaton said the inconsistencies in statements by Mrs. Rohrer and attributed to her by investigators were "exculpatory." Seaton further testified that, after his discussion with Dr. Read and after reviewing the autopsy report and photographs taken of Billy at the hospital -- and after considering the entire record in a light most favorable to a prosecution -- he concluded there was no basis for any criminal action. Although he also found the autopsy results to be inconclusive, he noted the absence of any affirmative evidence of child abuse.

A stronger reaction to the issue of Dr. Gursky's reported statements came from First Assistant Prosecutor Audino. In his S.C.I. testimony, Audino said if he had

known that Dr. Gursky had not made the comments attributed to him by Alesandrini, the case probably would have warranted presentation to a Grand Jury.

During Dr. Read's S.C.I. testimony, the medical examiner indicated he had recognized Billy's death as a possible child abuse case. He said that in such a case, "I want to know everything that I can to prove it one way or another." This was the reason why Dr. Read telephoned Dr. Edwin H. Albano, then the State Medical Examiner, to discuss Billy's death -- but he did not recall receiving any particular suggestions. Dr. Read also testified that, as Seaton had requested, he wrote the June 27 letter summarizing his views. That letter to Seaton stated in its entirety:

> "In the case of William Rohrer, Jr., deceased May 28, 1975, a history of head banging and other self-injury was given me by the medical investigator. At autopsy the evidence of contusions of the body did not have any obvious pattern and the contusions of the scalp were multiple with no single major blow. After examining the organs the contusion of the brain with subarachnoid hemorrhage was considered the cause of death. Studies of his blood revealed

it Type O, R.H. negative, hemoglobin S negative. The blood did not clot in 36 hours and a smear suggested the number of platelets reduced. Microscopic sections of organs together with blood findings also suggested diffuse intravascular coagulation.

"The origin of the multiple contusions was thought to be self-administered such as can be found in Lesch-Nyham Syndrome, but autopsy did not distinguish self-inflicted injuries from injuries inflicted by another person in this case, and, therefore, other evidence would be necessary to establish the mechanism."

After writing the above letter and then discussing the Rohrer case with Seaton, Dr. Read was next asked by Seaton to contact Dr. Gursky. That contact was never made. Dr. Read explained to the S.C.I. that although he telephoned Dr. Gursky "at least 20 times...and I must admit, after about two months of effort, I gave up on reaching him, but he apparently was the doctor that had seen the child." Dr. Read testified he also did not seek Dr. Gursky's views by letter, relying instead only on data gathered by the Prosecutor's office.

Dr. Read explained in his testimony the autopsy's inconclusive findings in connection with the bruises on Billy's body. He said there was no pattern to them to indicate whether they were caused by hand or by a blunt instrument. Therefore, in the doctor's opinion, there was no way of determining from

an autopsy what produced them. The bruises were not believed by Dr. Read to have been spontaneous. Significantly, the coagulation test noted in the letter to Seaton did not demonstrate, Dr. Read said, that a relatively slight force could have caused the excessive hemorrhage that the child suffered, nor could any conclusion be reached from the blood findings.

Dr. Read was questioned at the S.C.I. about the contradiction between the death certificate, on which the manner of death was listed as self-inflicted, and his June 27 letter to Seaton, which concluded that the manner of death was uncertain. Dr. Read acknowledged that he "had no further information" for preparing the letter than he had when he filled out the death certificate, except perhaps a verbal report on the telephone call Detective Alesandrini made to Dr. Gursky. When asked to explain the contradiction more fully, Dr. Read stated: "I do try to come to a conclusion so that I can complete a death certificate, unless there is further information that is readily obtainable. Now, from the information that I had at that time, this is what I had to presume, and there's no reason for me yet to believe that isn't correct." Dr. Read admitted, however, that "I can't...say what appears on the death certificate from the autopsy findings" and that the death certificate conclusion was "based on statements made to me by the investigators and so on."

Although the concerns Dr. Read expressed in the June 27 letter were not based on any new information, such concerns were not indicated by Dr. Read in his autopsy report. In spite of the ambiguous nature of his autopsy findings and his subsequently expressed desire for further evidence, Dr. Read took no action to withhold a conclusion on the death certificate that Billy's death was self-inflicted.

Had he been aware that Dr. Gursky diagnosed the child as normal but had prescribed treatment for the mother, Dr. Read testified, "I would have paid a great deal of attention to it." Dr. Read also revealed he was not aware that Mrs. Baker, Dr. Barroway and the maid, Cora Thomas, all considered the child to be normal.

Both Dr. Read and Haddon Township Detective Armstrong, in their S.C.I. testimony, sought to clarify the notations on the cover sheet of the autopsy report which differed with the inconclusive nature of the report itself. (The cover sheet was never corrected).

Dr. Read said the cover sheet of the autopsy report was prepared by his clerical staff on the basis of his own death certificate characterization of the death as self-inflicted. He reasoned that a death certificate was generally prepared within a 24-hour period to expedite funeral arrangements by the family and undertakers. A death certificate, he added, should not be considered a final verdict on the cause of a death since it was always subject to revision based on any subsequently revealed evidence.

As for the cover sheet's note that Billy had been in a Philadelphia hospital "for self-injury," Armstrong told the S.C.I. he might have been accidently responsible for that reference even though, he insisted, he never made such a statement to Dr. Read at the autopsy. Rather, Armstrong testified, he told Dr. Read that Mrs. Rohrer had "contended the child was self-destructive and...that's why she had taken him...to the child guidance clinic in Philadelphia. I guess that's what was meant by that inference. They thought I meant the child was treated at the Philadelphia hospital for injuries."

The then-State Medical Examiner Edwin H. Albano testified before the S.C.I. after reading Dr. Read's autopsy report for the first time. He concluded that Billy's death appeared to be accidental or an infanticide and that a medical examiner could not reasonably conclude that it resulted from self-inflicted blows to the head. Dr. Albano testified, in part:

> A. Well, the autopsy is more or less complete. The autopsy revealed numerous contusions over the body, particularly marked over the left arm, the leg and side of the body; also, numerous contusions of the face, particularly left side, and the left ankle and the jaw; also, contusions of the chest and a few of the upper shoulder area.

Now, the contusions vary in color. Some are greenish, some are purplish in color, indicating they are different ages.

The greenish, the green contusions, are probably five to six days old. The purple contusions are of recent origin. They may have occurred just before death. So, there is evidence here of trauma. Bruises and contusions over the entire body.

Now, examination of the head revealed subarachnoid hemorrhage, that's hemorrhage over the surface of the brain, and, also, contusions of the brain.

Allegedly, this is supposed to have occurred as a result of the baby banging its head against the wall. I've never seen that happen, that a baby can just bang its head against a wall and you get severe contusions and subarachnoid hemorrhage. I could see where it could happen from a fall from a considerable height, not from a baby chair or anything of that sort or from a bed.

I've seen a number of these cases as a result of child abuse, blows on the head.

Now, the examination of the head reveals numerous small contusions of the scalp. Now, if there were to be enough of a injury sustained as a result of banging the head against the wall, there would be one massive contusion of that scalp, and it doesn't indicate it here. It talks about "numerous small areas of contusion are noted beneath the skin of the scalp." "Numerous small," they could come from multiple blows, see, but not from one banging up against the wall. That's impossible. Never seen it happen.

So, here it's -- again I would have put down, "pending further investigation," and I certainly would depend and rely on a thorough and complete investigation of the case, because I said it was an infanticide or accidental.

THE SUDDEN DEATH OF ANDREW YORKE (1976)

On March 23, 1976, at 4:11 P.M. a call was received by the Camden County Central Police and Ambulance dispatcher that assistance was needed at 637 White Horse Pike, a one-story, store-front apartment building in Haddon Township. The Oaklyn ambulance responded and was directed to a shabby apartment at the rear. The ambulance crew found a mortally wounded man lying on the living room floor. Cardiopulmonary resuscitation was attempted and oxygen was applied without success. Two other men were also in the apartment, one of whom said the victim fell out of a chair. Sergeant George Harris of Haddon Township Police Department arrived shortly after the ambulance squad, followed by his colleague, Patrolman Henry Voigtsberger. No foul play was immediately suspected. Harris did not notice blood stains that were on the living room wall and floor. In fact, he believed that the victim, identified as Andrew Yorke, 61, may have suffered a heart attack. Voigtsberger, although he had noticed the blood stains, acted nonetheless as if nothing suspicious had taken place. Yorke was removed to Our Lady of Lourdes Hospital in Camden city on the slim chance he might still be alive.

Meanwhile, a crowd had gathered outside the apartment and Voigtsberger attempted to disperse it. Harris was in the apartment's entrance foyer while two other residents, Yorke's roommates, stayed in the living room.

These men, Edward Dougherty and David Koch, remained there until the police officers left and then returned to the nearby Heritage Room Bar, where they had previously spent much of the day. It was never clearly established when the police actually left the scene but several witnesses recalled Yorke's roommates returning to the bar after the initial excitement in the neighborhood abated. The Haddon Township police could neither document nor testify to a continuous police presence at the scene. This, in fact, would have been inconsistent with the officers' immediate opinion that Yorke had succumbed to a heart attack.

At the Heritage Room Bar, Dougherty announced that "Andy's dead" and "I hid the hammer," according to bystanders. He and Koch lingered in the tavern for about 45 minutes. During this period in the bar, Yorke's death was discussed and several bystanders recalled hearing statements that a hammer was thrown or hidden.

Yorke was pronounced dead at the hospital at 4:23 P.M. When hospital personnel observed from Yorke's appearance that a violent death might have occurred, the Haddon Township dispatcher was notifed as well as the Camden County Prosecutor's office and the Medical Examiner's office. Detective Edward Slimm of Haddon Township reached the hospital at 5 P.M. At about the

same time, the Medical Examiner's investigator received information from the hospital that Yorke's injuries possibly were inflicted by another person. Two Camden County Prosecutor's detectives, Joseph Perry and Estel Brown, who was actually off-duty at the time, arrived at the hospital at about 5:15 P.M. County Detective Joseph McComb also was summoned to take photographs.

The wounds sustained by Yorke included a gash about two inches long at the top of the right forehead, near the hairline. As photographs were taken, Detective Slimm noticed several other red marks -- "like he was struck there," he said -- on Yorke's head. Slimm remained at the hospital more than an hour and then went to the Yorke apartment at 6:35 P.M. Patrolman James Maycott, a fellow officer, was at the back door. Maycott had been assigned to protect the scene by a superior once it was suspected at the hospital that this was a suspicious sudden death. The patrolman believed he was to relieve Harris but he was not sure whether the sergeant was there when he arrived. No record of the order dispatching Maycott to the scene appears in any police reports. Further, since Maycott never filed a report on his participation in the case, it is not known how long he remained.

Voigtsberger had noted that the two men he and Harris encountered at the apartment were apparently intoxicated at the time. While Harris was in the area, he had allowed the two residents to remain unguarded at the scene.

When Voigtsberger met Slimm at the hospital, he reported that a neighbor said he had seen Yorke standing at the door holding a hammer, and bleeding. This same man said he had called an ambulance, Voigtsberger added. When he learned the nature of the gash on Yorke's forehead, Voigtsberger attributed the injury to a malicious act. Slimm then sent Voigtsberger back to the scene to transport Yorke's roommates to police headquarters for questioning. Voigtsberger was unaware that, after the crowd had dispersed, the two men had returned to the Heritage tavern. Because of their unsteady condition, questioning was postponed until later that evening. None of the police reports sets forth with particularity where these two witnesses were found when they finally were sought for questioning.

Slimm and Prosecutor's Detectives Brown, Perry and McComb visited the apartment later that night. Only Slimm recorded his time of arrival. Blood stains again were noted on the floor and also on an armchair. Slimm believed at that point that he was in charge of the investigation since his superior, Detective Sergeant Jack Chatelain, had not yet appeared. It is not certain when Chatelain arrived since he filed no reports concerning this investigation and no one noted the movements of police in and out of the apartment. The apartment was inspected. Items deemed to be of evidential value were collected. Photographs also

were taken. A diagram of the interior of the apartment was drawn by Voigtsberger. He said this diagram, which he characterized as very rough, was sketched on his own volition so he could later recall the scene. He assumed one of the detectives assigned to the case would eventually construct a more precise diagram. Another diagram was made by a county detective but it did not indicate where any evidence was located. Neither diagram included the bedroom of the apartment, although photographs taken in that room show prominent discolorations, which could well have been blood stains. No explanatory report accompanied these photographs and no investigator can now remember the reason for them. Whether any investigators other than the photographer ever inspected the bedroom is not known.

No evidence was tagged at the scene, nor was any record made of who located each item, where it was found and in whose custody it was transported to police headquarters. An evidence list was compiled but lacked the date or the identity of the officer who compiled it. One item, a bloodied claw hammer that was found under a blanket on the living room couch, was never shown to the residents of the apartment for possible identification nor was it processed for fingerprints or blood analysis. In addition, Dougherty, who denied on the day of the death that he owned a claw hammer with a broken tine, later admitted in testimony before the S.C.I. that such a hammer belonged to him.

During the time the apartment was being inspected, no one police officer assumed a commanding or coordinating role. At least six officers were on the scene without specifically delineated duties. One detective recollected that a ball peen-type hammer also had been found in the apartment but even after learning from witnesses of its possible significance, he did not have this hammer examined. Indeed, no ball peen hammer was ever listed as evidence in the case. He apparently assumed that this would be done by another officer -- or even another agency. When questioned by the S.C.I., Prosecutor's personnel stated that Haddon Township police were in charge. But Sergeant Chatelain, the senior Haddon Township police detective, placed this responsibility on the Prosecutor's office. Detective Slimm of Haddon Township, who said he believed at one point that he was in charge, was not present at the apartment when evidence was collected at the scene. He did, however, make tags later for items that were brought to the Haddon Township Police Department.

In any event, after investigators inspected the apartment for evidence, they next prepared to question witnesses who had, at some unknown time, been transported to headquarters. Since there was no report on this facet of the case, it is unclear who located these men, where they were found, and what time they were brought

to headquarters. Although it was stated that these witnesses were separated while "sobering up," there is no police record of this. The witnesses were interviewed from 10:30 P.M. to 12:26 A.M. The transcript of their statements contained numerous inconsistencies -- but there was no systematic attempt to resolve these during the subsequent investigation. At least one witness related that Dougherty had said, "I threw the hammer." Meanwhile, an autopsy was scheduled for the next day.

At that autopsy on March 24, 1976, Dr. William Read, the Camden County Medical Examiner, determined that death was caused by severe contusions of the brain. The final judgment on the manner of death was deferred pending further investigation. Dr. Read's post-mortem report indicated there were injuries to at least four regions of the brain, including numerous bruises, but no fracture of the skull. His examination also revealed that Yorke was suffering from cancer of the larynx. Since Dr. Read felt that further investigation was necessary, it was not until June 25, 1976, that the manner of death was officially determined as suicidal. The Yorke death certificate was changed to conform. No memorandum explaining these actions by Dr. Read could be found in any files on the case. One factor that influenced Dr. Read, he later testified at the S.C.I., was a statement by an investigator that Yorke was alone at the time he was injured.

Although Dr. Read's suicide conclusion coincided with that of the Prosecutor's investigators, the Haddon Township police disagreed with it.

The Prosecutor's investigators theorized that there was no foul play after Yorke's roommates and neighbors had satisfied them that they had no involvement in the death. Four of these individuals were given polygraph examinations but were determined to have answered the questions truthfully, despite a concern that, since they were heavy drinkers, the test results might not be valid. Ostensibly, since no one suspected of inflicting the wounds ever emerged, Yorke's injuries were characterized as self-inflicted, based largely on the sworn statement of one of the roommates, Dougherty, that Yorke was severely depressed about a cancerous condition and for that reason took his life.

Dr. Read had in late March discussed the Yorke case by telephone with Dr. Edwin Albano, then New Jersey's Chief Medical Examiner. Dr. Read recalled Dr. Albano telling him that self-inflicted hammer blows could have caused the death. On the other hand, Dr. Albano later remembered the gist of his answer to be that it was possible but highly unlikely that such injuries could be self-inflicted. At the time of the telephone discussion, Dr. Albano did not have a copy of the autopsy report in hand.

When shown the report at an S.C.I. hearing, Dr.

Albano stated that the injuries sustained by Yorke could not have been self-inflicted. They were too numerous, too scattered as to location, and too severe, he said, and several of the blows were individually sufficient, in his opinion, to have caused an immediate loss of consciousness. Dr. Halbert Fillinger, assistant Philadelphia medical examiner, also stated after reviewing the autopsy report that the magnitude of these injuries was such that Yorke probably would have been incapable of inflicting the entire sequence of them.

The failure during the investigation to follow certain basic procedures probably resulted from confusion over which agency was in charge. Once Detective Slimm of Haddon Township left the scene to participate in questioning of the witnesses, his superior, Sergeant Chatelain, believing the Camden County Prosecutor's office was in charge, neglected to assume control. As a result, it is not known in what manner the evidence was gathered. Because of the insufficiency of evidence reports or catalogue tags, none of the officers involved can now recall with any precision their individual roles in handling the evidence at the scene.

During the night of March 23, as recalled by Detective Slimm, it was determined that one of Yorke's roommates, Dougherty, should submit his shirt for evidence since it was apparently stained with blood. However, Dougherty's blood type was

not determined at the time and no one can remember asking him to explain the stain. For these reasons, both Slimm and County Detective Perry agreed that the State Police Laboratory's finding that the blood on the stained shirt matched Yorke's blood type, standing alone, had no investigative value. The failure to obtain an explanation of the origin of the blood stain on Dougherty's shirt during the original questioning was also acknowledged by them as a basic omission.

The statements taken during the night of the day Yorke was found dead contained potentially important inconsistencies. For example, Dougherty asserted that he had called for an ambulance. Under further questioning by investigators, he then stated that Koch called while he stood by. However, a neighbor insisted that it was he who called the ambulance and he who relayed this fact to Koch. No effort was ever made to resolve this conflict. An S.C.I. agent subsequently confirmed, by checking available records, that the neighbor had indeed called.

There were also discrepancies about "hiding" and "throwing" the bloodstained claw hammer with a broken tine that had been found under a blanket on the couch in Yorke's living room. Another conflict concerned such statements as "we got problems" and "don't worry about the hammer; I got rid of it" that were reported to the police by several witnesses but were then denied by the alleged speaker.

In addition, one of Yorke's roommates, Koch, told Slimm that Dougherty had run out of money and had left the bar at about 3:15 or 3:30 P.M., at least a half hour before the original call to police. However, this information was never checked out. Apparently this investigative lead was lost because, after Detective Slimm jotted this down in his notes, it never became part of his official report. That same resident told police on the night of the death that there was blood on the curtains in the apartment but no blood-stained curtains were found. Had the scene been continuously controlled by the police, such confusion might not have occurred.

Prosecutor's Investigator Timothy McCarthy submitted a report containing conflicting versions of a single incident supplied by Koch when he was interviewed on separate occasions. This divergence of information was not noted and McCarthy, when questioned about it before the S.C.I., could not remember if he had been aware of the conflict during the investigation. He was sure, however, that he never compared the information he received with the sworn statement Koch had given previously.

Nonetheless, polygraph examinations were given to four witnesses, as noted, including Koch. After these examinations, it was determined that all witnesses had answered truthfully.

This became an important element in reaching the ultimate conclusion that Yorke's wounds were self-inflicted. Two certified polygraphists were used to conduct these examinations. Although each reached separate conclusions that the answers given were truthful, the tests results were never carefully compared. No one noticed that there was at least one clear conflict in the test answers of two of the witnesses. One witness was deemed truthful when he said a certain crucial incident, the hiding of the hammer, did not occur and yet another was credited as truthful for saying that act did take place. This contradiction was never recognized by the polygraphists themselves, by the investigators in the case, or by their superiors. The investigator for the Camden County Prosecutor's office was told the men had "passed" the polygraph test but he had not examined the specific questions and answers involved.

Detective Michael Scarduzio, who conducted one of these polygraph tests, admitted in testimony before the S.C.I. that the issue of the hammer was important in determining whether the death was a suicide or a homicide. He also said he felt that issue is still unresolved and that another test would be appropriate. Scarduzio conceded in his S.C.I. testimony that he accepted one test response as truthful even though certain facts, which he learned only as a result of the S.C.I. investigation, indicated otherwise.

Since he was unaware of this major conflict and only aware of a minor discrepancy in the test answers, he did not render any opinion that the man was lying since such an opinion "would make it look like he killed him and I just didn't feel he had killed him."

Detective Slimm told the S.C.I. he thought the number of blows sustained by Yorke would have been a significant fact to consider in reaching a verdict on the death. Although the detective had access to the post-mortem report, he could not ascertain from that report how many blows Yorke had received. He himself never sought a clarification from the Medical Examiner's office. He said he believed that whoever was in charge of homicides at the time, perhaps Lieutenent Anthony DiMaggio, had spoken to Dr. Read about that topic. Detective Perry, on the other hand, believed that someone who attended the autopsy should have questioned this. Slimm believed, from the wording of the post-mortem report concerning the "main laceration," that there had to be other minor lacerations. He could not offer more specific information about the medical findings. Dr. Fillinger, after reviewing both the autopsy report and photographs of the injuries sustained, testified that they were contradictory. For example, he said one part of the report described only two wounds while the photographs depicted five distinct lacerations.

Small cuts were noticed by Slimm and Perry on Yorke's left thumb and first finger. These injuries, which appeared to be fresh, were photographed by Prosecutor's Detective McComb. No close up views were taken, however. At the autopsy these cuts were neither examined nor reported and it was never determined how or when they were inflicted. Similarly, the investigation never determined from which direction the blows sustained by Yorke originated.

Another incongruity in the investigation was a statement by Dougherty suggesting the suicide theory although Koch, the other roommate, and a friend who had visited Yorke a day or two earlier, said that Yorke was in good spirits. The neighbor, who told police he was at the Naval Hospital in Philadelphia for most of the day, was taken at his word. His movements were never verified by any investigator. That he had indeed spent most of the day at the hospital was confirmed some years later.

Photographs taken in the bedroom focus on what appeared to be blood stains on the bed sheets, yet none of the sheets was sent for examination to the State Police Laboratory. No investigator could explain why such potential evidence in the bedroom was ignored.

The Yorke sudden death remained an active, open case in the Prosecutor's office until November, 1976. The last previous prosecutor's report up to that time

was dated May 6, 1976, and the final Haddon Township report was dated May 16, 1976. On November 9, 1976, County Detective Perry wrote a summarizing memorandum in which he stated his belief that the sudden death resulted from self-inflicted injuries. His conclusion was based, according to his summary, on the results of 30 interviews and the four polygraph tests. Although he was the principal investigator for the Prosecutor's office, Perry filed only two reports totalling three pages on the Yorke case, including the November 9 summary. This latter memo stated that Detective Slimm of Haddon Township concurred in Perry's version that Yorke's death was a suicide. However, Slimm strongly disputed this in testimony at the S.C.I., stating not only that he felt the case was unsolved but also that until recently he was unaware that the Camden County Prosecutor's office had officially determined Yorke's death to be a suicide. He added that he was surprised Perry quoted him as agreeing with a suicide determination.

Recently, at the request of the S.C.I., Professor Herbert MacDonell of Elmira College, a nationally recognized bloodstain analyst, examined the shirts worn by both Yorke and Dougherty with respect to the bloodstains that appeared on them. After reviewing the patterns the bloodstains formed on the shirts, Professor MacDonell concluded in a letter-memorandum that "it was certainly more likely that Mr. Yorke was beaten to death rather than (that he was) a suicide."

RECOMMENDATIONS

IN

DETAIL

DETAIL

RECOMMENDATIONS IN DETAIL

I. INTRODUCTION

The following detailed recommendations emphasize the need for a more professional medical examiner system in New Jersey. Such heightened professionalism can best be achieved by a regionalized rather than a county system. Hence, the Commission's proposals question the necessity, under a regional system, of retaining the office of county medical examiners. Since this office, despite efforts to upgrade the quality of its performance, has not met the requirements of 1967 statutory reforms, the Commission calls for phasing out county medical examiners in favor of regional medical examiners as this regional system is realized. Such regionalization, now permissible under the present State Medical Examiner Act, should be mandated.

As this report's case illustrations document, only a proper investigation can guarantee credible rather than speculative conclusions. To achieve this credibility in sudden death investigations, such inquiries must be based at their outset primarily on the findings of qualified forensic pathologists. Therefore, the Commission's proposals call for a broad-based revision of New Jersey's Medical Examiner System at both the state and county levels. In order to clarify the reasoning behind these recommendations, a review of the overall medical examiner process as it applies to New Jersey precedes the proposed step-by-step reforms.

II. THE MEDICAL EXAMINER SYSTEM

A. Background

The medical examiner system began in this state as a replacement for the ancient office of coroner. New Jersey's former county coroners were legislated into place supposedly to ascertain more precisely the causes of sudden or unexplained deaths. In New Jersey, as in many states with a coroner system, coroners were elected rather than appointed. No qualifications were required other than eligibility for election. Payment was on a fee basis. Since some coroners were not even physicians and the coroner title itself lacked specified requirements as to professional background, duties or authority, some counties set up programs utilizing county physicians in conjunction with, or instead of, coroners.

In counties that instituted a county physician program, the physician usually was also a general practitioner receiving a salary for his official duties. The office was political in that its occupant was appointed by a county board of politically chosen freeholders. The county physician system was considered by law enforcement officers to be an improvement over the coroner system, but still left much to be desired. Many small or rural counties were unable to support a salaried county physician because of a lack of both funds and sufficient work to justify the position.

The elective office of coroner was finally abolished in 1967 in favor of a statewide system requiring the appointment of county medical examiners. Dr. Edwin H. Albano, who was New Jersey's first chief Medical Examiner under the 1967 law, was quoted in 1966 concerning the former coroner system:

> *"Many county coroners and physicians are untrained and unqualified. They don't have any knowledge or experience in forensic medicine. And it is the fault of our archaic, chaotic and untrustworthy system. It boils down to the fact that you can't accept many conclusions because there is a lack of knowledge on the part of those charged with the responsibility.*
>
> *"Medical experts strongly suspect that people may have gotten away with homicide under the State's archaic patchwork system of investigating sudden, suspicious deaths. The grave responsibility for determining the exact cause of death in many instances is placed with untrained laymen and general practitioners of medicine."*

On November 20, 1967, then-Governor Richard J. Hughes signed legislation into law creating the Office of State Medical Examiner. Dr. Albano held that office until his retirement on February 1, 1979.

B. Maryland's Medical Examiner System

The Commission examined the 40-year-old Medical Examiner's System in Maryland, one of the first states to establish a statewide program. Dr. Russell S. Fisher, Maryland's Chief Medical Examiner and a nationally known forensic pathologist, has served as a consultant to several states in the drafting of medical examiner reforms. He advised the American Bar Association in the preparation of its model Post-mortem

Examination Act. New Jersey's 1967 statute substantially reflects the Maryland law.

The primary advantage of the way Maryland implements its law, according to Dr. Fisher, is the close supervision his office exercises over pathologists who conduct autopsies. He often consults directly with the pathologist who performed an autopsy within a relatively short time thereafter. It is essential, he believes, to constantly evaluate the entire autopsy process.

In Dr. Fisher's opinion, all pathologists should be certified in forensic pathology if they are to work in the medical examiner field. The average hospital pathologist, according to Dr. Fisher, is not competent to deal with many special problems arising from an autopsy in a medico-legal investigation. He warned that the conclusions of a medical examiner untrained in forensic pathology might be adversely conditioned by the initial observations and opinions of police officers engaged in a sudden death investigation -- precisely what occurred in certain sudden death cases reviewed by the Commission.

Another advantage of Maryland's system is that it includes centralized supervision, with the Chief Medical Examiner assuming a senior role in any sudden death investigation. The Chief Medical Examiner directs his deputies in the counties in the course of investigations. Dr. Fisher has promulgated a set of specific guidelines on handling death cases from their inception. In addition, he publishes a

monthly newsletter outlining new procedures to be followed or special approaches to particular problems.

C. New Jersey's Present Medical Examiner Process

In addition to interviewing Drs. Fisher and Albano, the Commission conducted a survey of New Jersey's county medical examiners' offices and questioned numerous other county and local law enforcement officials. These inquiries into existing practices and procedures confirmed a lack of adequate and uniform performance that the 1967 Medical Examiner Act was intended to achieve. That statute, although a replica of the Maryland law, has not been effectively implemented. Despite the statutory centralization of authority and supervision in the Office of State Medical Examiner, many county medical examiners operate almost autonomously, consulting the state office only when confronted with unusual difficulties. In addition, since most pathologists working in the county medical examiner system are not trained in forensic pathology, they often fail to perceive evidence requiring specific investigative attention.

Under the 1967 law, the State Medical Examiner administers the system. He is handicapped, however, by insufficient staff and laboratory resources at his Newark headquarters and by a lack of full compliance with the statute by county medical examiners.

The State Medical Examiner directs a staff of about 20 employees in Newark. The Newark facility includes an administrative office and a toxicology laboratory for testing specimens submitted by county medical examiners. The state office has a yearly budget of about $560,000. The facility overall is inadequate and the toxicology laboratory particularly is cramped. Some testing instruments required to be housed in separate rooms for sterility purposes are not so isolated because of the lack of space. Refrigeration capability is limited. There is no appropriate place in which to conduct autopsies. There is no morgue.

The State Division of Criminal Justice has prepared a master plan for replacing the State Medical Examiner office and laboratory. The plan projects completion by 1981 of a facility six times larger than presently exists, at a cost of $4.6 million. The new complex, to be known as the Institute of Forensic Science, appropriately would be located on a two-acre site at the College of Medicine and Dentistry in Newark and would house a more adequate laboratory capability and professional staff than are now available.

Dr. Albano viewed his official role as one of consultation and guidance for county medical examiners. That responsibility, however, has been implemented primarily by means of telephone discussions of sudden death findings with county medical examiners and prosecutors in the course of their investigations. Such a practice adversely affects

the statutory obligation of the State Medical Examiner and staff to assure that post-mortem autopsies are properly conducted and assessed. In addition, specimens sent to the state toxicology laboratory for scientific autopsies are often too late in arriving for fully effective tests and analyses. Dr. Albano recalled a number of incidents of serious delays in such submissions by county medical examiners. In some cases, also, the results of state toxicology tests are not returned to county medical examiners until six or eight weeks after submission of specimens.

The state office attempts to evaluate cases filed with it. However, some counties are not filing reports directly with the state office, as required by law. When reports are filed, only two qualified people, the State Examiner and his assistant, are available to evaluate them. The only reports generally filed, however, are merely copies of autopsy protocol. The state office does not receive background data developed prior to an autopsy or afterward unless it specifically requests such material. In pending cases the results of further investigations may not ever reach the state office. Thus the state office may not possess more current facts by which to assess the final conclusions of a county autopsy.

Virtually all autopsies are performed by county medical examiner's offices. Only five of the 21 county offices retain pathologists certified in forensic pathology. The remaining

offices utilize the services of licensed pathologists certified in clinical or anatomic pathology, a less appropriate specialization. Only a few of the county offices have separate facilities for the storage of bodies and performance of autopsies. Most counties arrange with hospitals for the use of their equipment and to store bodies.

Utilization of outside facilities or services by county medical examiners is often a difficult task. One county medical examiner recalled that he had to bargain with a dental surgeon for X-rays by arranging for that surgeon's attendance at a medical examiner's seminar. In another instance, an investigator for a county medical examiner, whose office has no X-ray capability, testified under oath at the S.C.I. that essential X-rays are often omitted if the hospital where the body is located intends to charge for that service. An assistant medical examiner in this particular office also testified that there is a severe lack of basic equipment. He compared existing medical examiner conditions to those of the mid-1800s.

Few county medical examiners actually go or send a medically trained representative immediately to the scene of a death. Several offices respond to the scene only if homicides or suicides are suspected. Of course, as illustrated by certain sudden death studies in this Commission report, whether or not a medical examiner responds, and when, often depends on an initial judgment by a police officer or a county investigator at the death scene. Another reported factor in the failure of a medical examiner to respond to a death scene has been

the financial inability of some counties to employ an assistant medical examiner or a staff sufficient to permit such a response while the county office remains on call seven days a week for autopsies and related office activities.

A shortage of forensic pathologists for medical examiner work has resulted in most autopsies being conducted by physicians who lack essential and specialized medico-legal skills. The decision by many forensic pathologists to accept positions with hospitals or related facilities at higher salaries than offered for county medical examiner appointments has increased the difficulty in many counties of employing such specialists.

The S.C.I. survey of county medical examiners revealed no uniform pattern of practices and procedures. No operational guidelines have been promulgated by the state office, a lack attributed to insufficient personnel already burdened with a heavy workload. The extent of this workload is suggested by statistical data showing that in 1978 the Medical Examiner System statewide investigated about 20,000 cases, of which more than 6,000 deaths resulted in autopsies.

As previously noted, many county medical examiners often do not go to the scene of a sudden death. Therefore, the initial action and reactions of some county medical examiners are conditioned by the input of local police. If local police officers perform inadequately, or intentionally conceal facts, then the conclusions of the medical examiner are likely to be tainted. The lack of close supervision by a qualified

forensic pathologist can cause a premature or otherwise improper classification of deaths. A premature classification of a death as a suicide by a medical examiner, for instance, has resulted in law enforcement personnel refraining from further investigative activity that otherwise might have been warranted.

The Medical Examiner System that resulted from the 1967 State Medical Examiner Act was an improvement over previous procedures for investigating sudden deaths. However, as the case studies in this report demonstrate, much remains to be accomplished. The recommendations that follow, therefore, are designed to eliminate the present system's numerous deficiencies.

III. MEDICAL EXAMINER RECOMMENDATIONS

A. The State Medical Examiner

1. The statutory authority of the State Medical Examiner at the now developing New Jersey Institute of Forensic Science must be redefined and expanded to permit the establishment of a Regional Medical Examiner system replacing the present county medical examiner offices. The number of regional offices to be created must reflect the volume of services each can be reasonably expected to provide according to the population and geographic area of a region. At the outset, the Commission envisions the formation of at least three regional offices -- in the northern, central and southern sectors of the state.

2. The State Medical Examiner must be delegated full statutory control over the operation of regional offices

as adjuncts of the Institute of Forensic Science (of which the northern regional medical examiner office would be a Newark-based component).

3. The State Medical Examiner must assume statewide leadership of the Regional Medical Examiner System in sudden death investigations. When specific shortcomings are detected in the quality of police service being supplied to Regional Medical Examiners, the State Medical Examiner must exercise his authority by obtaining from the Attorney General's Police Training Commission appropriate and expeditious remedial measures to eliminate such defects.

4. The State Medical Examiner must be held accountable for compliance by Regional Medical Examiners with existing statutory provisions that now apply to county medical examiners and the enlargement of such provisions to apply to the control and operation of regional offices. The statute should make explicit the State Medical Examiner's power to supersede a Regional Medical Examiner for incompetence or non-compliance with the law.

5. The State Medical Examiner must maintain effective and constant liaison and consultation with Regional Medical Examiner offices, County Prosecutors and Municipal Police Departments. Such liaison and consultation procedures must include the development and dissemination of autopsy and other operational directives, procedural guidelines and informational reports and notices of professional innovations in the medical examiner field.

B. Regional Medical Examiners

1. The operations of each county medical examiner office within a region must be phased out as each Regional Medical Examiner office is created. Each regional office thus established must be sufficiently staffed and equipped to maintain the investigative responsibilities that had been allocated to the phased-out county medical examiner offices.

2. Each regional office must be staffed with certified forensic pathologists and sufficient full-time, professionally qualified assistant medical examiners, technicians, investigators and other support personnel to ensure adequate performance.

3. Salaries paid to qualified forensic pathologists must be competitive with the salaries paid for comparable medical and technical skills in the private sector. In addition, such pathologists must be required to participate in research and other activities sponsored by the Institute of Forensic Science in furtherance of their professional skills.

4. No determination by a Regional Medical Examiner as to whether a death is natural, accidental, suicidal or homicidal is to be entered on a death certificate until all appropriate tests are conducted and the investigative facts upon which to base a professionally sound conclusion are established. In this connection, Regional Medical Examiners must adhere to uniform autopsy procedures stipulated by the State Medical Examiner.

5. Each regional office must be equipped to perform all basic laboratory and analysis work, with more sophisticated testing and analyses being conducted, as directed by the State

Medical Examiner, at his regional office at the Institute of Forensic Science.

6. Each regional office must obtain and make appropriate use of photographic equipment for documentation and record keeping as well as for educational, peer review and internal control purposes.

7. Each regional facility must be provided with adequate storage space for bodies and specimens.

8. There must be a standard format for formal exchanges of current investigative data between the Regional Medical Examiner and the Prosecutor's office and/or Municipal Police in connection with the performance of an autopsy by the Regional Medical Examiner. Detailed records must be kept of what investigative information was available to the Regional Medical Examiner at the time of an autopsy. Such records are essential to quality control and peer review procedures.

9. A regular procedure must be established by each Regional Medical Examiner's office with Prosecutors and/or Municipal Police for the expeditious provision of additional investigative data and materials relative to an autopsy as they became known or available to a Prosecutor's office or Municipal Police within the region.

10. A procedure must be established whereby first aid and ambulance squads and hospital emergency room personnel in a region must detail all treatment steps utilized in order to assist Regional Medical Examiners in determining what injuries to a body were sustained prior to or after death.

11. Each Regional Medical Examiner must meet on a regular basis with supervisory officials of the Prosecutors' offices and Municipal Police Departments in the region to review pending cases, unusual or significant events relative to their mutual efforts, and new ideas and procedures to be utilized in future investigations.

IV. COUNTY PROSECUTORS AND MUNICIPAL POLICE

A. Preface

While the following recommendations emphasize a dominant role for county Prosecutors in most sudden death investigations, they also provide for initial Municipal Police command in special circumstances. They are designed to enable Prosecutors -- after consultation with the State Medical Examiner and the Attorney General's Police Training Commission -- to authorize certain Municipal Police Departments that have a proven record of professional capability for such inquiries to take immediate charge of a case occurring within their local jurisdictions until investigative developments actually necessitate a Prosecutor's command involvement. The recommendations affecting both county and municipal law enforcement responses to sudden deaths reflect an essential requirement -- as illustrated by this report -- that one particular agency must be immediately responsible for the overall supervision of an investigation. In most cases, the Prosecutor's office would take command because it has more adequate staff and other law enforcement resources than the average Municipal Police Department with which to handle a sudden death case. Nonetheless, by means of a formalized pre-arrangement between

a Prosecutor and a Municipal Police Department known to be capable of conducting an appropriate death probe, the Prosecutor's role in certain instances would be one of assistance pending developments necessitating the county office to assume control. (Where municipalities cannot economically maintain a full-time police force of adequate size to effectively perform all customary police functions, including initial sudden death investigations, programs for consolidating or regionalizing such departments should be expedited). An essential requirement under the flexibility provided by the Commission's proposals is that there must be a continuing coordinated relationship between a Prosecutor and all Municipal Police Departments in the county that will permit a formal prior recognition by the Prosecutor of certain police departments capable of taking charge of an initial inquiry. This desired coordination and command-recognition by Prosecutors and Municipal Police Departments must be based, however, on a firm understanding that a key component in a sudden death investigation will be the professionally staffed and equipped Regional Medical Examiner office. As noted in the preface to the Commission's medical examiner recommendations, a professionally adequate autopsy and other medico-legal findings by a forensic pathologist will be pivotal in the development of a proper inquiry by the Prosecutor's staff or Municipal Police.

B. Prosecutor's Office Recommendations

1. Each Prosecutor's office within a Medical Examiner Region must assume primary responsibility for directing a sudden death investigation in the Prosecutor's jurisdiction.

The only exception to this requirement will permit a Prosecutor -- based on consultations with the State Medical Examiner and the Attorney General's Police Training Commission -- to pre-arrange for the accreditation of certain Municipal Police Departments as capable of conducting a sudden death inquiry pending an obvious necessity for a transfer of investigative control to the Prosecutor. (See Preface, P.162)

2. There must be established in each Prosecutor's office (or on a regional basis for less populous counties where Prosecutor's staffs and financial resources are limited) specialized units of trained investigators who will be primarily responsibility for investigating sudden deaths, including homicides, within each county or region.

3. Such special units must respond to each sudden death incident and should be primarily responsible for all of the investigative activity at the scene, including but not limited to securing, photographing and sketching the scene, collecting evidence, interviewing witnesses, and following up investigative leads.

4. Such special units must consist of sufficient personnel to enable a prompt response to all sudden death incidents on a 24-hour basis.

5. Such special units must assume full responsibility for the immediate security of a body at the death scene and for the prompt transfer of the body to the Regional Medical Examiner office.

6. Such special units also must be responsible for the initial preservation of a body and other physical evidence for tests and analyses customarily essential to the conduct of a professionally adequate investigation.

7. Such special units must be furnished with all appropriate law enforcement aids for the furtherance of an investigation, including but not limited to photographic and fingerprint equipment and other evidence collecting and testing devices and paraphernalia. If polygraph examinations are required, such tests must be conducted by fully certified polygraphists in strict compliance with the most advanced professional and procedural standards.

8. Each Prosecutor's office must establish a formalized procedural program for coordinating sudden death investigations with the assigned personnel of Municipal Police Departments. This coordinating procedure should include the pre-qualification of certain Municipal Police Departments as capable of taking initial charge of sudden death inquiry.

C. Municipal Police Recommendations

1. The function of most Municipal Police Departments in sudden death investigations must be limited to (a) immediately notifying the Prosecutor's office and the Regional Medical Examiner of the incident, (b) securing the scene and preserving it and all evidence without physically disturbing either the scene or the evidence, and (c) keeping all actual witnesses and possible witnesses intact.

2. Certain Municipal Police Departments may be pre-qualified immediately as capable of conducting sudden death investigations -- based, as previously noted, on the determination of a county Prosecutor after consultation with the State Medical Examiner and the Attorney General's Police Training Commission.

3. Where feasible, Municipal Police Departments presently unable to meet the accreditation requirements for conducting their own initial sudden death inquiries should adopt such pre-qualification as an important departmental goal.

4. Use of Special Police officers (where deemed essential for economic or manpower reasons) must be limited to supplementary services for which extensive training required and proposed for regular police is not necessary. (Note: Police standards studies have demonstrated that the appointment of many such special officers is based on political or other non-professional criteria rather than on a merit system of required qualifications. In addition, although surveys have indicated that one special officer is appointed for every four regular police appointments, no law exists requiring any training of such special police appointees. Yet 90 per cent of these special officers are carrying firearms. One special officer from whom the S.C.I. took sworn testimony observed that he was permitted to patrol armed and alone even though he had no instruction in police operations, including no firearms instruction).

V. POLICE TRAINING

A. Introduction

As demonstrated by the sudden death cases reviewed in this report, many problems relating to the organization and operation of Municipal Police Departments were encountered by the S.C.I. that have remained unresolved despite being pinpointed and criticized periodically in numerous prior official surveys. The most flagrant of these continuing deficiencies at the local police level included:

1. A lack of selection standards for assignments to highly specialized homicide, narcotics and other sensitive duty squads, compounded by the absence of mandated in-service training requirements.

2. Little or no rank-and-file accountability, attributable chiefly to inefficient police department organization.

3. Inadequate in-service training of superior officers, especially for those newly promoted to supervisory ranks.

4. A widespread lack of education and guidelines for writing investigative reports, resulting in inadequate and often inaccurate investigative reports.

5. A lack of clearly stated procedures for the preservation and control of evidence.

Although New Jersey is credited with maintaining one of the best police training programs in the United States, it by no means comports with the high goals and standards long projected by the Attorney General's Police Training Commission.

A primary deficiency, according to the Police Training Commission itself, is that the training that is required of all regular police officers need not be completed prior to the start of a trainee's active police service. Thus, many police officers either have no involvement in this program or began active duty before completing their special schooling. Although the reasons for this deficiency are complex -- involving inadequate finances, manpower shortages and other local problems -- the Police Training Commission strongly contends that law enforcement instruction for all present and potential police officers is not a luxury but an obligation. The State Commission of Investigation fully subscribes to this viewpoint.

In a comprehensive report entitled Standards for the New Jersey Municipal and County Policing Systems, A Plan of Action (January 7, 1977), the Police Training Commission outlined a number of significant shortcomings affecting police training in New Jersey. This report's high priority concerns included the absence of any statewide statutory requirements (a) prohibiting police officers from exercising any powers and duties of their office prior to their being trained; (b) mandating training for police personnel assigned to specialist or promotional positions; (c) mandating training for special police officers although they may perform duties indistinguishable from those of regular police officers.

B. Police Training Recommendations

1. Qualification standards must be established and imposed by statute for the assignment of police officers to homicide, narcotics and other special squads or duties.

2. All prospective police officers must complete police training courses before assuming their official duties.

3. In-service training must be required for all superior officers, particularly for those newly promoted to supervisory duties. Such training must include the use of specialized equipment and investigative techniques.

4. Mandatory minimal guidelines for structuring Municipal Police Department organizations must be imposed to assure strict performance accountability by rank-and-file officers.

5. Training and guidelines must be required for writing investigative reports and accurately summarizing key data obtained during the investigative process.

6. Mandated police training must emphasize the critical importance of controlling, preserving and cataloguing vital evidence.

APPENDIX

APPENDIX

Introduction

During the course of the S.C.I.'s reviews of sudden death investigations, close liaison was maintained with Attorney General John J. Degnan's key law enforcement officers and with various county prosecutors. The purpose of these contacts was two-fold -- to evaluate the statewide extent of the problems disclosed by the Commission and to propose recommendations for reforms of the criminal justice system, with respect to sudden death probes, that would be feasible and effective. It is the Commission's hope that fulfillment of these objectives will generate support for the proposed reforms within New Jersey's law enforcement community that will be pivotal in their eventual enactment into law.

As a result of this liaison effort, numerous exchanges of findings and views took place, primarily with officials of the Attorney General's Criminal Justice Division and the New Jersey State Police, particularly with Colonel Clinton L. Pagano, Superintendent of the State Police. In this regard, Colonel Pagano submitted on October 18, 1979, a letter summarizing his views on the Commission's findings and suggesting recommendations for corrective action reflecting his Division's experience with similar investigatory problems.

Colonel Pagano's outline of the problems and proposed resolutions of them coincides in certain respects with a number of recommendations proposed by the S.C.I. He agrees with the Commission's general conclusion that, as he observes, the designation of investigative responsibility and control in sudden death cases is a "dilemma" that "has remained largely unresolved," that is a "most regrettable situation," and that is "at the heart of the problem." Although the Commission in its recommendations emphasizes the necessity for a stronger Medical Examiner System as the key to resolving the most flagrant deficiencies, it fully agrees with Colonel Pagano's position that suspicious or violent deaths warrant the most thorough investigations possible. Therefore, the Commission attaches in full Colonel Pagano's assessments and recommendations in this appendix.

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October 18, 1979

Mr. Michael R. Siavage
Executive Director
State Commission of Investigation
28 West State Street
Trenton, NJ 08608

Dear Director Siavage:

I am writing to expand on my response to your State Commission of Investigation findings on deficiencies on homicide investigations. The concepts which I will present also are intended as extensions of the on-going discussions in which you and I are engaged.

While it is certain that no one contends that the deficiencies cited by the Commission are representative of homicide investigations in New Jersey, it is recognized that the problems cited arise. What is not known is the extent of the problem statewide, in terms of frequency, location and consequence. However, empirical knowledge permits a realistic assessment of the problem, identification of root causes and an outline for corrective action.

Before proceeding, I must briefly repeat the general conclusions I gave to the Commission previously, and present several more important considerations. These will lay the groundwork for my final recommendations.

As I informed you in June, the Commission's findings concentrate in two broad areas: (1) the need for a high degree of expertise in all homicide investigations, and, (2) a requirement that one agency should be in charge of each investigation, according to established and agreed upon procedures.

At this juncture, it should be pointed out again that the State Police has long been involved in the effort to improve investigative competence. Special training in criminal investigation has been offered to local police for years and highly competent State Police homicide investigators have

also been provided on request. However, designating investigative responsibility and control is an entirely different matter. This dilemma has remained largely unresolved; a most regrettable situation, because it is at the heart of the problem.

Without workable methods of establishing exclusive responsibility and control, improvement only will be piecemeal. Systemwide reform must be a joint venture of the Attorney General, Division of Criminal Justice, prosecutors and police, with the assistance and prestige of the State Commission of Investigation.

The Commission's findings also require further observations in order to perceive the situation in its true dimensions. First I must point out that while the White case was most unusual in some respects, I do not believe it should be included in these considerations insofar as investigative expertise is concerned. Repeated reviews have shown that the follow-up investigation was more than adequate and the results were conclusive. The question of ultimate responsibility and control is another matter, which is a major consideration in the recommendations which will be offered.

In addressing the basic problems, one of the most important factors found in all of the homicides cited must not be overlooked: The causes of death were considered obvious by the officers at the scene, for whatever the reasons, and were treated accordingly in all but the White suicide. Three were believed death by self-inflicted wounds and one was felt an apparent heart attack, until an injury was found at the hospital.

This underscores the necessity of fully investigating all violent and suspicious deaths regardless of how open and shut they may seem at first. Without meeting this requirement, an unacceptable number of cases will be found deficient when reviewed. The prerequisite for a full investigation is properly handling the scene. This is essential, because once evidence is disturbed, its value is reduced and if evidence is destroyed, it is gone forever. After the necessary crime scene procedures, the ensuing investigation, of course, must be equally thorough.

The impact of requiring this kind of an effort in all violent deaths is unknown. It is believed thorough attention is given in most homicides now. What is not known is the number which fall into the category of the three isolated by the Commission. It is known that there was an <u>average</u> of 434[1] deaths per year identified as murders, in the state over the last five years. These ranged from a yearly high of 500 to a low of 381. When the annual rate of 387[2] violent suicides is added, a crude estimate approaching 821 in depth homicide investigations per year is reached, without considering suspicious, accidental and unattended deaths. Violent suicides ranged from a high of 416 to a low of 362.

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1 N.J.S.P. Uniform Crime Reporting data.

2 State Medical Examiner data.

Instituting a system to insure that all of these cases are thoroughly investigated according to a standard which will withstand critical review, may be perceived as a costly venture requiring significant increases in personnel. However, this need will not be the case. Effective quality control, allocation of responsibility and elimination of duplication should enable the initial effort to proceed without added resources. The probability of duplication is included because of indications in the Commission's report, although such a finding was not specified. Empirical knowledge also supports the assumption that investigative redundancy is a factor.

The following listing of five specific requirements, which square with the findings of the Commission's report will serve to introduce the recommendations which will be presented:

1. The necessity that responding patrol officers make sure <u>the scene is disturbed as little as possible</u> and see that it is protected until the designated investigators arrive. This will require not only training, but added administrative direction as well.

2. <u>Early arrival of the detectives</u>, who will have ultimate responsibility and control of the entire investigation, is imperative. Therefore, these matters must be well established far in advance.

3. In addition to the other investigative requirements, the <u>recording of the scene and search for physical evidence</u> must be thoroughly and expertly done, with the assistance of highly qualified crime scene specialists. Specimens of evidential value must be given thorough forensic examination.

4. Throughout, <u>the investigation must remain under the direction and control of the agency responsible</u>. Communications and coordination are essential. This often becomes a problem when a crime is jointly investigated by personnel from several agencies. Here is the area in which duplication of effort is found.

   Successfully managing all of the elements of the investigation depends on giving <u>exclusive authority to the officer in charge</u> and holding him accountable for the conduct of the investigation.

5. It necessarily follows that complex major crimes require investigators and managers who are well trained and sufficiently experienced in the field. This holds true not only for the mechanics of investigating, but is doubly important in managing the case.

Added to this is the fact that training for all concerned including patrol officers, must be re-enforced systematically in all police agencies. This will require coordinated in-service training programs.

Improving the situation must start with a realistic analysis of prevailing conditions in each county. This assessment must include, but is not limited to, the major crime problem and the total resources of each agency.

All things considered, it is unrealistic to expect a police department of less than 25 men to have sufficient resources to conduct a major follow-up investigation. Difficult though it may be, this conclusion must be accepted. Therefore, these departments should provide initial patrol response and police action at the scene. Thereafter, they should protect the scene until the investigator in charge arrives.

Conversely, the importance of the initial police role should not be minimized. Successful followup investigation depends on how well these vital functions are carried out. The decisions made by the responding officers are frequently weighty, sometimes involving life and death and/or the apprehension of suspects. Smaller departments should also have the continuing responsibility for relaying community information to the investigating agency. Responding departments should receive full and specific recognition for successfully handling these vital aspects of the investigation.

Similarly, many departments with between 25 and 50 officers cannot be expected to handle followup investigations of homicides independently, particularly if there is a significant incidence of other serious crime requiring demanding investigative action. Therefore, most departments of this size should handle patrol response action and make a limited contribution of personnel to a joint investigation, managed by another agency. Here we come to the question of who investigates for departments with less than 25 officers and who is responsible for managing joint investigations.

At this point, the analysis must be unflinchingly realistic and each county and municipality must be examined separately. It is unlikely that every prosecutors' office will have sufficient resources to thoroughly investigate all homicides in the county, given a significant crime rate. To give a limited perspective of dimensions of the problem, the following table summarizes murders over a five-year period. Data on violent suicides, by county, was not available. Therefore, the extend of this part of the entire picture remains a matter of speculation.

MURDERS

1974 - 1978

NEW JERSEY UNIFORM CRIME REPORTS

County	1974	1975	1976	1977	1978	Yearly Avg.
Atlantic	25	24	11	20	17	21.6
Bergen	14	27	17	18	17	18.6
Burlington	11	11	12	10	10	10.8
Camden	34	45	31	32	33	35.0
Cape May	2	3	3	5	7	4.0
Cumberland	16	16	7	6	5	10.0
Essex	157	154	126	117	134	137.6
Gloucester	4	10	13	4	9	8.0
Hudson	54	60	46	64	45	53.8
Hunterdon	2	2	-	-	1	1.0
Mercer	21	19	19	28	11	19.6
Middlesex	22	19	14	17	10	16.4
Monmouth	26	15	13	12	13	15.8
Morris	8	7	6	8	6	7.0
Ocean	12	8	5	2	11	7.6
Passaic	32	44	24	24	33	31.4
Salem	4	8	7	2	1	3.8
Somerset	4	2	6	4	6	4.4
Sussex	4	1	-	1	1	1.4
Union	27	24	20	23	27	24.2
Warren	2	1	1	10	3	3.4
TOTALS	481	500	381	407	400	433.8

In estimating the extent of the problem, prosecutors must also assess the impact of this proposal on the many other crucial responsibilities of the office. When all activities are considered, it is obvious that each prosecutor must make the most enlightened use possible of all available operational resources and management techniques. Delegation of investigative responsibility for homicides in certain cities, together with advanced case control, would enable the prosecutor's office to conduct investigations in those areas

served by small police departments and manage joint operations with intermediate departments. Where appropriate, the State Police would be available to share the burden. The delegation proposed requires that exclusive responsibility for homicides in municipalities served by departments of 75 men or over should be delegated to those departments. In exceptional cases, additional personnel would be supplied by the prosecutors' offices or the State Police. According to this plan, the prosecutors' office would provide legal services and sophisticated case monitoring.

Overlaying this plan on Camden County, as studied by the Commission, would result in the following departments exclusively conducting homicide investigations: Camden, Cherry Hill and Pennsauken. All homicide investigations would be the responsibility of the Camden County Prosecutor's Office in an area extending to Lindenwold, either exclusively or jointly, according to the criteria. If it is determined that the Prosecutor does not have sufficient personnel, the State Police would have responsibility from a point radiating east and south from Berlin, under the same conditions. In assessing the demands of the problem in Camden County, it should be pointed out that only seven of thirty-three departments have 25 officers, including the three with over 75[3].

A coordinated effort by all concerned can turn the concept I have outlined into reality. An orderly system of designating investigative responsibility will result, which will optimize existing resources. All that is required is the decision to act and the mutual support of the law enforcement community. This kind of systemwide improvement will all but preclude the kind of deficiencies exposed in the Commission report. The program will essentially parallel the recommendations found in the National Commission on Criminal Justice Standards and Goals Reports.

The State Police stands ready to participate at a level well above its already major efforts in homicide and arson investigation, laboratory service, and special training. This proposal includes an innovative training project on physical evidence and its forensic application. It will be geared to prosecuting attorneys and major crime investigators. The soon to be completed regional laboratory at Sea Girt will serve as the workshop in this program. Beyond that, there also must be ongoing communication of new developments in the field. This will be done by the State Police crime scene experts during the course of investigations and through meetings with the detectives and prosecutors.

Sincerely,

Clinton L. Pagano

Clinton L. Pagano, Colonel
Superintendent

jec

[3] N.J.S.P. Uniform Crime Reporting data, 1977.

END