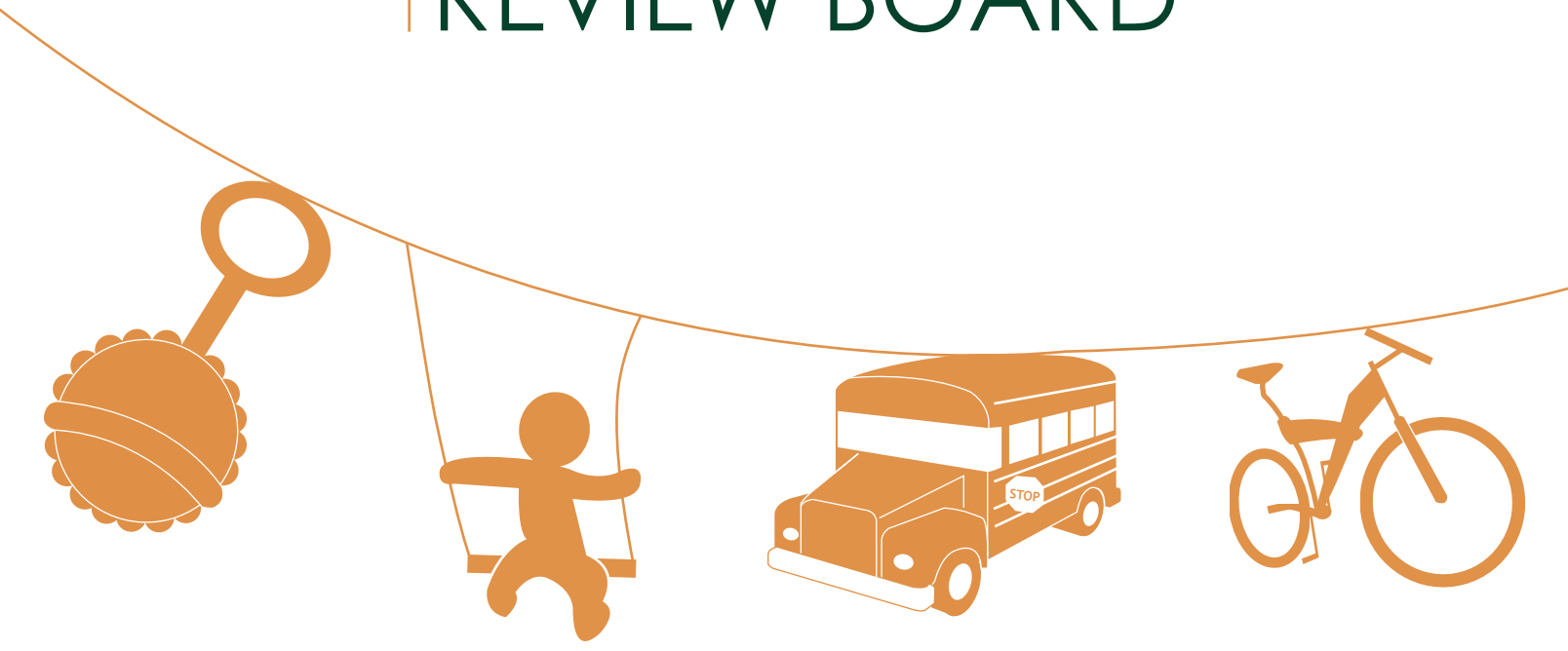
NEW JERSEY

CHILD FATALITY & NEAR FATALITY REVIEW BOARD



2010 ANNUAL REPORT

ISSUED SEPTEMBER 2011

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Introduction

In the United States an estimated 1,770 children died as a result of being abused or neglected in 2009. The youngest children are more vulnerable to death as the result of child abuse and neglect, 80% of deaths occurred among children younger than age four.[1]

The Mission, Purpose, Mandate, and Scope of the CFNFRB

The New Jersey Child Fatality and Near Fatality Review Board herein referred to as the Board or CFNFRB was established after the adoption of the N.J.S.A. 9:6-8.88, the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA) on July 31, 1997. Although this Board was established within the Department of Human Services, it is statutorily independent of "any supervision or control by the department or any board or officer thereof." The CFNFRB also serves as a Citizen Review Panel, mandated under the federal Child Abuse Prevention and Treatment Act (CAPTA) and its subsequent amendments to examine the policies, practices and procedures of state and local agencies and, where appropriate, specific cases to determine the extent to which the agencies are effectively discharging their child protection responsibilities.

The principal objective of the Child Fatality and Near Fatality Review Board is to provide an impartial review of individual case circumstances and to develop recommendations for broad-based systemic, policy, and legislative revisions for the purpose of preventing future tragedies. According to CCAPTA, the purpose of the Board includes but is not limited to the following:

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

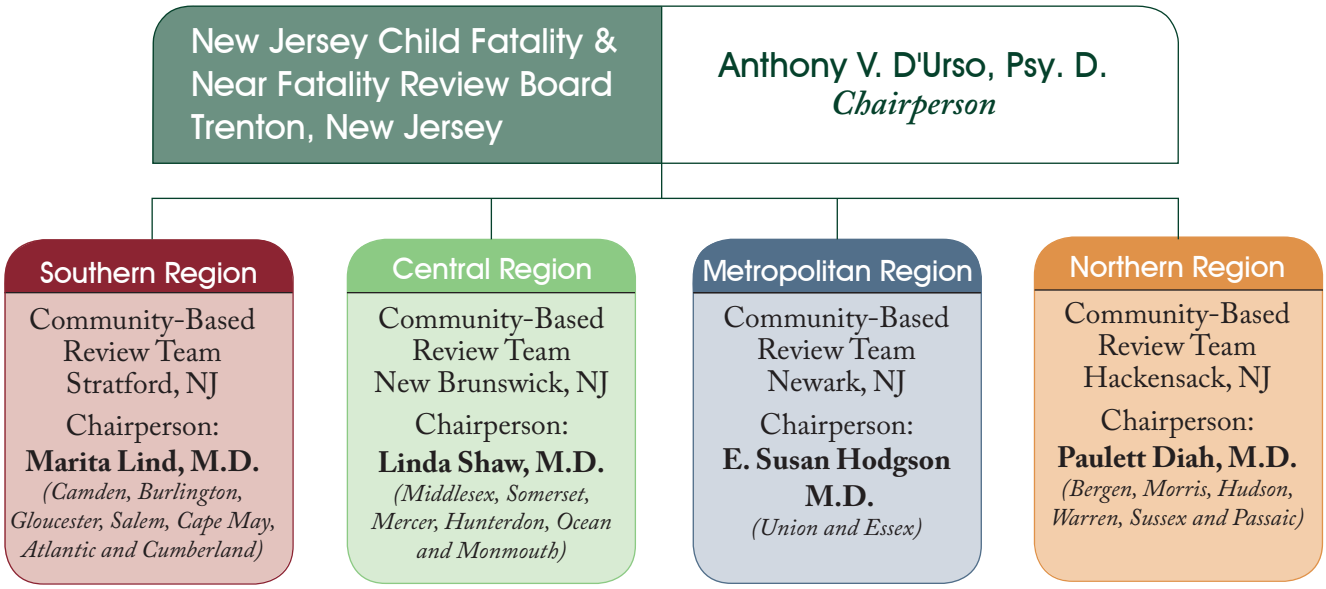
[1] U.S. Department of Health & Human Services Administration for Children and Families, 2009 Child Maltreatment Report.
http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf#page=54.

Reviewing the circumstances surrounding cases of child fatalities and near fatalities is a critically important task for state and local professionals working in an array of fields, including child welfare, law enforcement, health, judicial, medical examiner, mental health, education and substance abuse. Recognizing that deaths and near fatalities of children and youth are sentinel events, a comprehensive review by the community allows for a better understanding and identification of potential risk factors to surviving siblings and other children. In essence, the Board functions as a catalyst for needed change.

These reviews also allow a multidisciplinary team of professionals to comprehensively examine child deaths and near fatalities. Doing so allows for a determination as to why children die so that action and follow up recommendations can be implemented to prevent future deaths, develop needed service resources and improve the safety and well being of children overall.

The CFNFRB does not review all fatalities and near fatalities, but always reviews those which come to their attention involving abuse, neglect, violence, or appear preventable. The Board's data is based on this selection.

A central and guiding principle of the CFNFRB is that reviews permit the community to learn from each child fatality and near fatality and promotes ownership of prevention initiative and strategies. Subsequently, the CFNFRB established regional community-based teams with the support and cooperation of the four New Jersey Regional Child Abuse Diagnostic and Treatment Centers. The teams' membership is multidisciplinary and has expertise in the area of pediatrics, child welfare, substance abuse, law enforcement, psychology, and public health.



The state board reviews cases which were open at the time of death or near fatality with the Division of Youth and Family Services (DYFS), New Jersey's child protection and child welfare agency. The Northern, Metropolitan, Central, and Southern Teams, review all other cases meeting review criteria described below and have no active DYFS involvement at the time of the fatal or near fatal incident.

Case Selection Criteria

According to N.J.S.A. 9:6-8.90, the duties of the CFNFRB include review of fatalities due to unusual circumstances, using the following criteria:

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

The CCAPTA guidelines also mandate that the CFNFRB identify children whose families were under the Division of Youth and Family Services (DYFS) supervision at the time of the fatal or near fatal incident or within 12 months immediately preceding the fatal or near fatal incident.

The CFNFRB also requires the review of "near fatalities" (a serious or critical condition, as certified by a physician, in which a child suffers a permanent neurological or physical impairment, a life-threatening injury, or condition that creates a probability of death with in the foreseeable future); pursuant to N.J.S.A. 9:6-8.84.

In addition to those reviews captured by the CCAPTA guidelines, the Board also elects to review:

- All drowning fatalities
- Motor vehicle accidents in which the driver:
  1) Was under the age of 18 and toxicology results were positive
  2) Was under the supervision of DYFS
- All Sudden Unexpected Infant Deaths (SUID); which include children whose cause of death is Sudden Infant Death Syndrome (SIDS)

2009 CFNFRB Findings at a Glance

Safe sleep concerns were identified in 72% of 25 natural fatalities in 2009 where the cause of death was determined SIDS or SUID.

42 families were under the supervision of the Division of Youth and Family Services at the time of the fatality or near fatal incident.

56% of the 16 drowning fatalities in 2009 were due to inadequate supervision.

Gun violence perpetrated by a non-caregiver attributed to 47% Black (Non-Hispanic) male victims and 37% Hispanic male victims. The majority of youth homicide victims had risk factors such as criminal activity, gang involvement, substance abuse, mental illness, run away behavior, and school problems.

69% of suicide deaths were White (Non-Hispanic) youth, 100% of the suicide deaths were male.

In 5 of 6 near fatal head injuries the father was the substantiated perpetrator.

Review Process

The CFNFRB is notified of child deaths from several sources, including the State Central Registry (SCR), the Office of the State Medical Examiner, and upon request, the Department of Health and Senior Services. Near fatal incidents are identified for review through the DYFS Director's Case Practice Unit. Once a case is identified for review, liaison staff is responsible for obtaining all relevant records, including but not limited to, autopsy, death scene investigation, medical and social service records. The CFNFRB has the authority to subpoena and secure the required materials as necessary.

All relevant documentation is forwarded to CFNFRB members approximately two weeks before a scheduled meeting for review and preparation for discussion at the meeting.

Some of the possible actions following each case review may include but is not limited to policy and practice changes in particular fields, strengthening interagency collaboration, staff training, public outreach and education or changes to state law. Lessons learned from these tragedies lead to stronger prevention efforts that help protect children, keeping them safe and healthy.

In 2010, the CFNFRB reviewed a total of 153 fatality and nine near fatality cases which occurred in 2009. Table 1-1 below shows the demographics of cases reviewed by the CFNFRB.

Table 1-1

Cases Reviewed by Race/Ethnicity, Gender and Age Group[2]

Race/Ethnicity	Cases Reviewed	2009 NJ Population under age 18
White (non-Hispanic)	54	1,088,513
Black (non-Hispanic)	61	298,868
Hispanic (all races)	41	442,088
Other[3]	6	216,379
Gender		
Male	102	1,049,520
Female	60	996,328
Age Group		
<1-4 years old	122	555,282
5-13 years old	11	1,017,592
14-17 years old	29	472,974
TOTAL	162	2,045,848

[2] 2009 NJ Population data was obtained from The US 2009 Census Bureau.
[3] Other Race/Ethnicity includes American Indian and Alaskan Native, Asian, Native Hawaiian, Pacific Islander, and multi-racial children.

Cause and Manner of Death

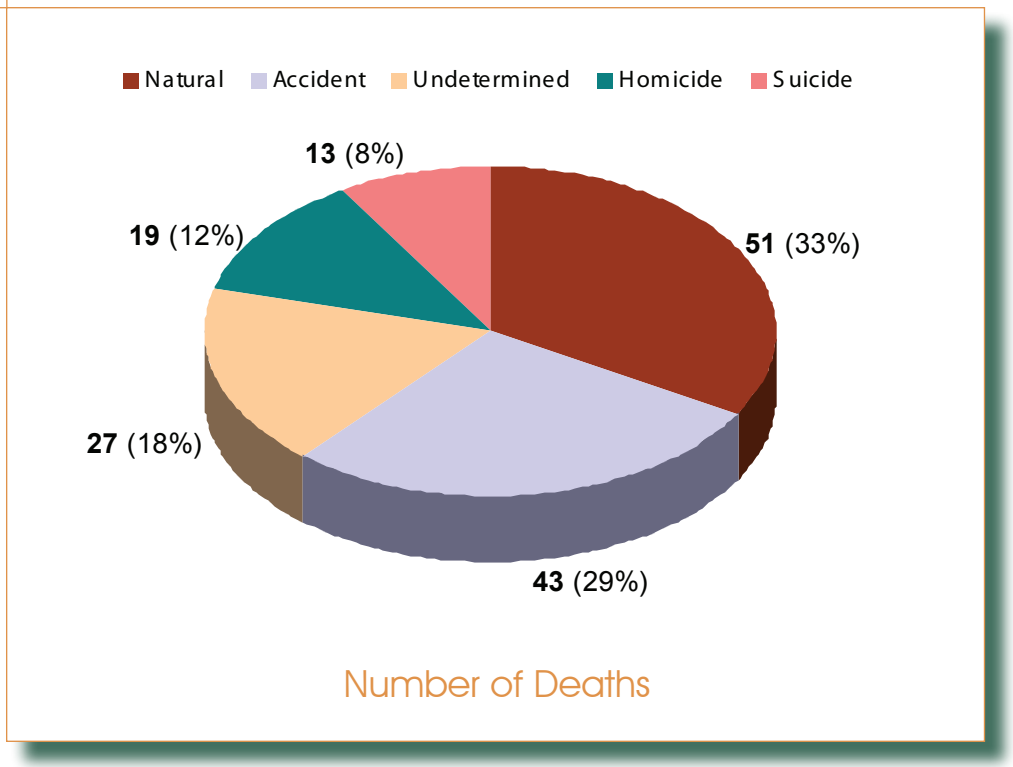
The New Jersey Office of the State Medical Examiner defines the cause of death as, "the underlying injury or disease that directly eventuates in death," and the manner of death as a "classification of death" based upon the cause of death and the circumstances surrounding the death. The five categories of manner of death are natural, homicide, suicide, accident, undetermined.

The causes of death in the 153 fatalities reviewed included, medical illness, trauma and injury, asphyxia, Sudden Unexplained Infant Death, drowning, drug and medication toxicity and overdose, firearm and weapon injury, and undetermined cause.

The manner of death in 33% (51) of the 153 fatalities reviewed was natural. In 29% (43) the manner was accident, in 18% (27) undetermined, in 12% (19) the manner was homicide, and in 8% (13) the manner was suicide.

Manner of Death

Figure 1-1



The fatalities reviewed by County table below (Table 1-2) illustrates the number of fatalities by manner of death, per county, and reviewed by either the Board or one of its regional teams. A finding of note on this table is that the number of fatalities was greatest in Essex County; however, with county child population factored in, Cape May County has the highest child fatality rate with 21.8 children dying per 100,000. In 2010, the CFNFRB did not review any 2009 fatalities from Salem County and therefore Salem had the lowest child fatality rate with 0 children dying per 100,000.

Table 1-2

Reviewed Fatalities by County[4]

COUNTY	MANNER OF DEATH							
	Natural	Homicide	Accidental	Undetermined	Suicide	% Total Fatallties	Child Population[5] (< 18 Years)	County Reviewed Fatality Rate[6]
ATLANTIC	2	2	6	1	0	7.2%	63,321	17.4
BERGEN	0	0	0	3	2	3.26%	198,585	2.5
BURLINGTON	1	0	2	1	1	3.26%	102,366	4.9
CAMDEN	6	4	2	1	0	8.5%	125,759	10.3
CAPE MAY	1	0	2	1	0	2.61%	18,368	21.8
CUMBERLAND	2	0	3	0	0	3.26%	39,208	12.8
ESSEX	11	5	2	4	0	14.4%	193,289	11.4
GLOUCESTER	1	0	1	0	0	1.3%	68,703	2.9
HUDSON	4	1	5	1	1	7.84%	122,659	9.8
HUNTERDON	0	0	1	0	1	1.3%	30,701	6.5
MERCER	6	0	4	3	1	9.15%	83,985	16.7
MIDDLESEX	3	1	3	1	3	7.2%	184,267	6.0
MONMOUTH	3	0	2	1	0	3.92%	153,862	3.9
MORRIS	0	1	0	1	0	1.3%	116,662	1.7
OCEAN	1	1	5	3	0	6.54%	132,162	7.6
PASSAIC	5	4	2	1	1	8.5%	124,538	10.4
SALEM	0	0	0	0	0	0%	15,559	0
SOMERSET	1	0	0	0	1	1.3%	80,771	2.5
SUSSEX	1	0	2	0	0	1.96%	35,792	8.4
UNION	1	0	1	5	1	5.23%	129,639	6.2
WARREN	1	0	1	0	1	1.97%	25,652	11.7
STATE TOTAL	**50**	**19**	**44**	**27**	**13**	**100%**	**2,045,848**	**7.5**

[4] Reviewed Fatalities – fatality cases occurring in 2009 reviewed by the CFNFRB
[5] Population < 18 – from Population Division, U.S. Census Bureau, June 10, 2010. http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/cnty06/cntyas.xls
[6] Reviewed Fatalities per County * 100,000 / County Child (<18) Population

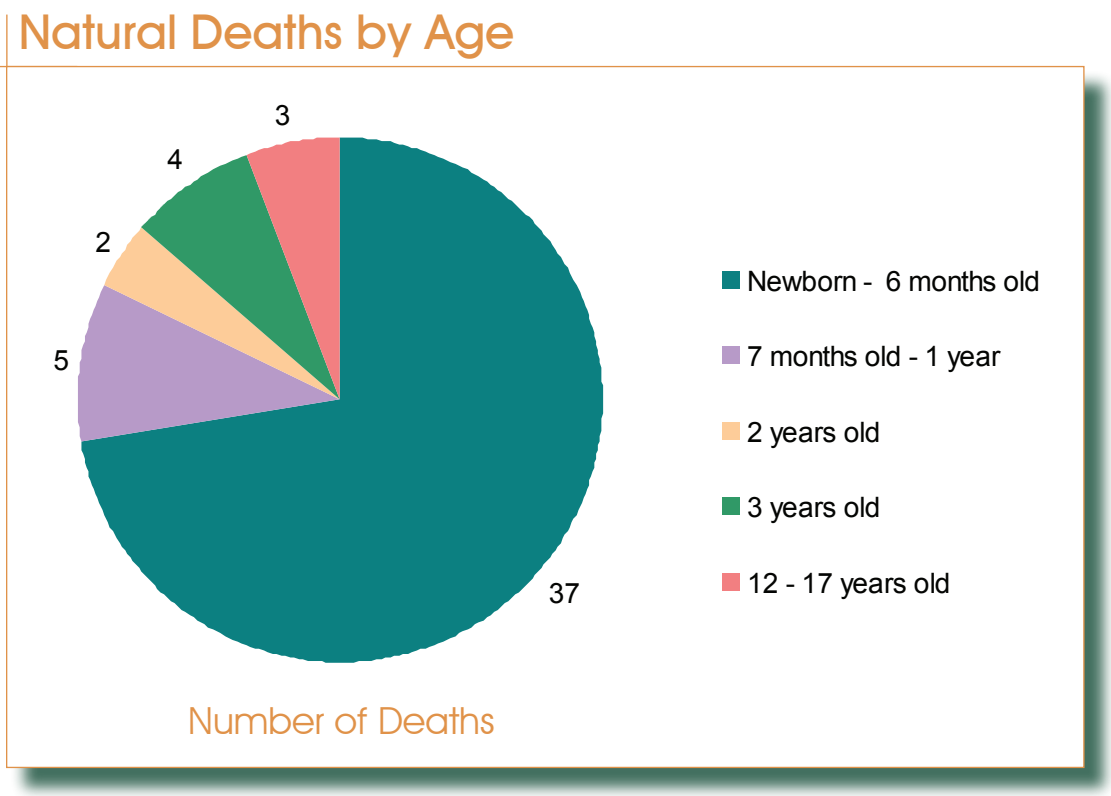
Natural Deaths

33% (51) of all the 2009 deaths reviewed by the CFNFRB were determined to be by natural manner. 26 of those deaths were due to medical causes such as (asthma, respiratory distress, pneumonia, meningitis, illness related to prematurity, end stage encephalopathy and genetic disorders from birth), and 49% (25) were due to a Sudden Unexpected Infant Death (SUID).

Significant Findings As it Relates to Age and Race

According to the CFNFRB data findings, the children at greatest risk of dying of a natural death are children one year of age or younger, and even more at risk are children six months of age or younger.

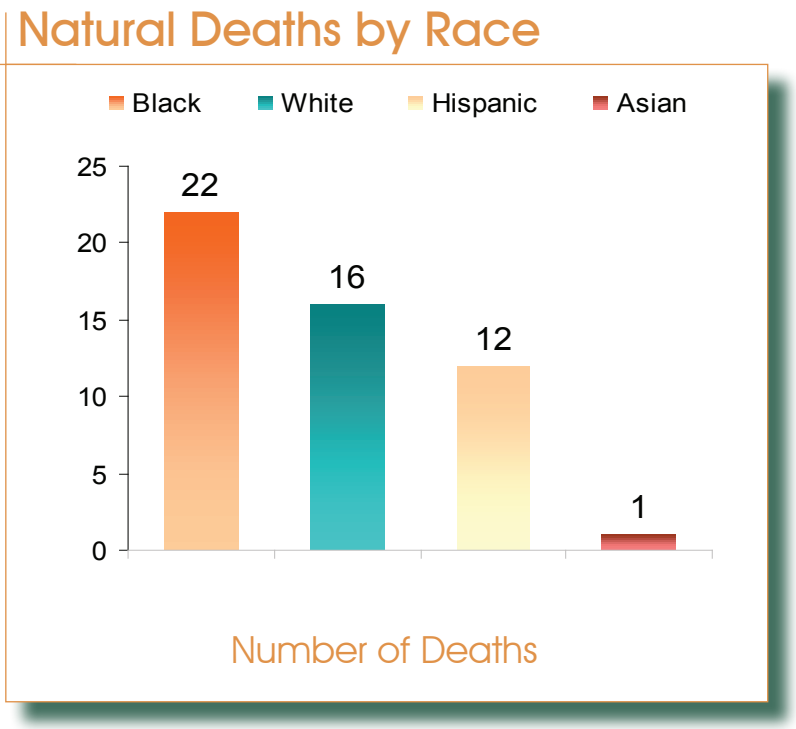
Figure 2-1



Of the 51 natural deaths by age 80% (42) occurred at one year of age or earlier, and 51% (25) of the 51 natural deaths occurred at three months of age or earlier.

Of the 51 natural deaths 10% (5) were less than one month old, 8% (4) were one month old, 19% (10) were two months old, 13% (7) were three months old, 11% (6) were four months old, 2% (1) was five month old, 8% (4) were six months old, 4% (2) were eight months old, 2% (1) was eleven months old, 4% (2) were one year olds, 5% (2) were age two, 8% (4) were three years old, 2% (1) was age 12, 2% (1) was age 13 and 2% (1) child was age 17.

Figure 2-2



Of those children who died a natural death, the greatest risk was Black (Non-Hispanic) children under one year of age. These children made up almost half of the deaths (22 of the 51). Of the 51 natural deaths, 22 were Black, 16 White, 12 Hispanic and one Asian.

Safe Sleep Concerns

There were 25 natural deaths where the cause of death was SIDS or SUID, safe sleep concerns were indentified in 72% (18) of the deaths. Safe sleep concerns shown to be risk factors of SUID and SIDS include bed sharing, inappropriate or cluttered bedding, and placing an infant in a prone sleep position.

The most common safe-sleep risk factor of the 25 deaths was unsafe bedding, where 68% (17) of the 25 children were either placed on a couch to sleep, placed on blankets/comforter or pillows to sleep, placed in crib with multiple items including stuffed toys, and being placed to sleep on an adult bed with an adult or sibling.

Twelve of the 25 deaths had two or more risk factors which included bed sharing, inappropriate bedding, prone sleep position, premature birth, and/or lack of prenatal care. It is important to note that the status/history of prenatal care was not identified in investigation reports in 16 of these deaths.

The cause of death was determined to be SIDS in 14 natural deaths, and in nine deaths the cause was SUID. There was one death that was deemed a SUDC (Sudden Unexplained Death of a Child), and one death was caused by Severe Combined Immunal Deficiency (SCID).

In most cases, the risk factors that may contribute to the death may be preventable through outreach and safe-sleep education.

Undetermined Deaths

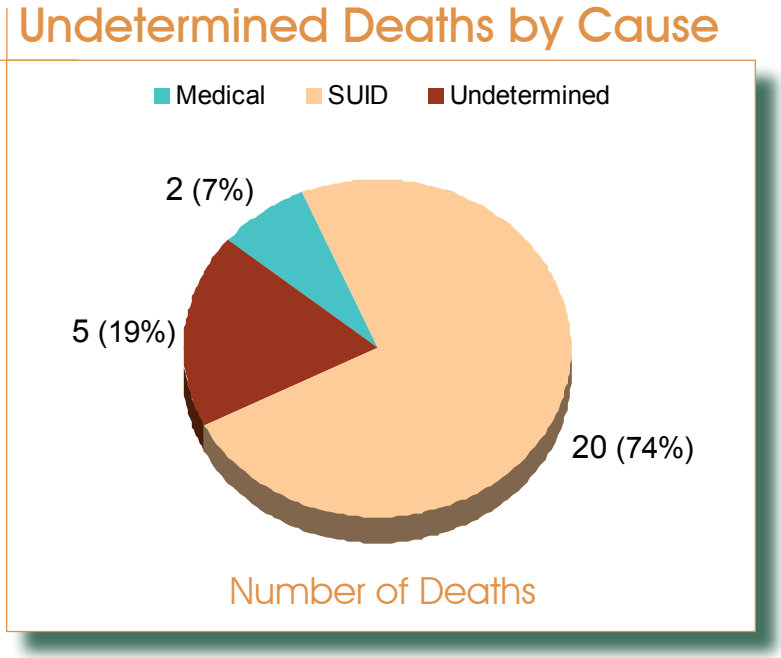
An undetermined cause or manner of death is the result of insufficient or conflicting information from the death scene investigation, the clinical history or the autopsy findings.

Per N.J.S.A. 9:6-8.90, all deaths with an undetermined cause or manner are reviewed by the CFNFRB.

Of the 153 fatalities reviewed in 2009, 18% (27) of those deaths were due to an undetermined manner. In comparison, of the 2008 prevention of deaths, the CFNFRB reviewed 33 deaths of undetermined manner.

For those children who died due to an undetermined manner, the causes of death include Sudden Unexplained Infant Death (SUID), Undetermined, and medical conditions. Of the 27 undetermined deaths, 74% (20) died of SUID, 19% (5) were undetermined causes and 7% (2) were due to medical causes. See Figure 3-1.

Figure 3-1



Undetermined Cause and Manner

In 19% (5) of the fatalities, both the cause and manner were classified as undetermined. The circumstances of these fatalities were as follows:

- A two year old female child fell out of a pack and play and was found unresponsive. A blood toxicology screen was positive for benzodiazepines and fentanyl; however, quantity was not sufficient for confirmation. Four months prior to death, the victim was diagnosed with a subdural hematoma and a skull fracture. DYFS substantiated for an unknown perpetrator and the medical examiner noted that no anatomic, histologic or toxicologic causes could be determined.

- A 17 year old female adolescent was found unresponsive in her bedroom after ingesting opiates and benzodiazepines. The medical examiner concluded the death to be undetermined because although the child tested positive for opiates in the hospital, the child later tested negative for opiates via post mortem toxicology results. There was no foul play indentified and an internal autopsy was not performed because of family objection. The victim had a history of drug use.
- A 13 year old female adolescent was found dead in her bed. The child was healthy but reportedly had one seizure prior to her death and there was no suspicious or foul play identified. An autopsy was not completed due to the family's religious objection.
- A six month old female infant who was born prematurely, was found unresponsive lying on her stomach. The infant was diagnosed after birth as having developmental delays and microcephaly with abnormal muscle tone and elevated levels of lactic acid. The infant was seen by her pediatrician two weeks prior to death for an upper respiratory infection and acute conjunctivitis.
- A one month old was co-sleeping with his parents and was found unresponsive. Medical Examiner certified the cause of death as a SUID and the manner of death as undetermined.

Undetermined Manner of Death with Safe Sleep Concerns

Of the undetermined deaths, three were teenagers where safe sleep concerns would not be applicable. Out of the 27 undetermined deaths, 24 were children under the age of two years old, and safe sleep concerns may be applicable.

Of the 24 undetermined deaths, most significant was that more than half, 14 had identified safe sleep concerns such as bed sharing with a parent(s) or caregiver, and or inappropriate bedding (i.e., being placed on an adult bed or a couch, and/or having large blankets or toys in the sleep environment).

Eleven of the 24 undetermined deaths exhibited bed sharing as a risk factor, and seven of the deaths noted both bed sharing and unsafe bedding as risk factors. Lastly, in six of these deaths there were more than two risk factors noted as it relates to safe sleep. These risk factors include bed sharing, unsafe bedding, second hand smoke exposure, prone sleep position, high ambient room temperature, obesity of caregiver while bed sharing, and alcohol use.

More specifically, in two of three deaths where alcohol was used by the caregiver, bed sharing was also identified as a risk factor. In the three deaths where the caregiver was identified as obese, bed sharing existed.

Infants under the age of one month old may be at greater risk for deaths related to safe sleep concerns, but the data reveals that only three of the 24 undetermined deaths were under one month old, but bed sharing existed in all three deaths.

Accidental Deaths

In 2010, CFNFRB review findings were consistent with national trends noted by the Center for Disease Control and Prevention with respect to accident deaths. Accidental manner of death comprised 28% (43) of the total 153 deaths occurring in 2009, reviewed by the CFNFRB in 2010.

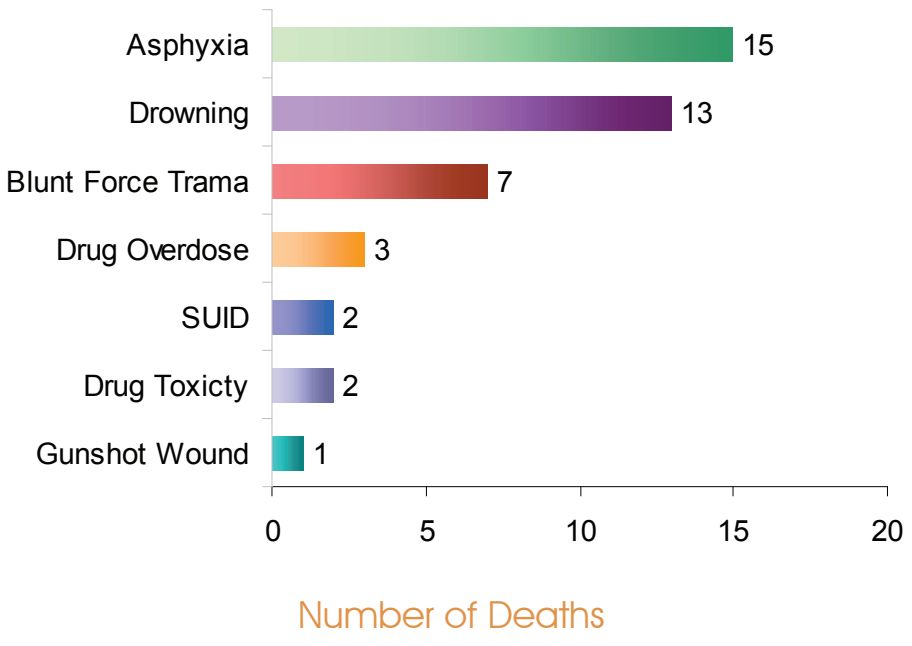
The leading cause of accidental deaths was asphyxia with 35% (15), as detailed below in Figure 4-1. Drowning was the second leading cause of accidental death, with 30% (13). In 16% (7) of the accidental deaths the cause was attributed to blunt force trauma.

Drug overdose was the cause of accidental death for 7% (3). These three accidental overdose deaths involved 17 year old adolescents who all had histories of substance abuse. Two of the cases were a result of poly-substance use including heroin, marijuana, prescription drugs, and alcohol. One of the two youths involved with poly-substance use died seven days after admission while still receiving inpatient treatment.

Drug toxicity was the cause of death for 5% (2) children. One child ingested methadone which he found underneath a bed in the home where he resided with his mother and maternal grandparents. One adolescent with a history of marijuana, heroin, and oxycodone use died from a cause determined to be acute heroin toxicity. She had also been receiving individual psychotherapy and joint family sessions due to a recent history of self-mutilation caused by relationships with the opposite sex.

Figure 4-1

Accidental Deaths by Cause



In 5% (2) of the accidental fatalities the cause was determined to be Sudden Unexpected Infant Death and bed sharing with overlay was a contributing factor in both cases.

A gunshot wound was the cause of 2% (1) of accidental deaths; one child and his brother were playing with a loaded gun when a shot accidentally went off striking the child in the head and killing him.

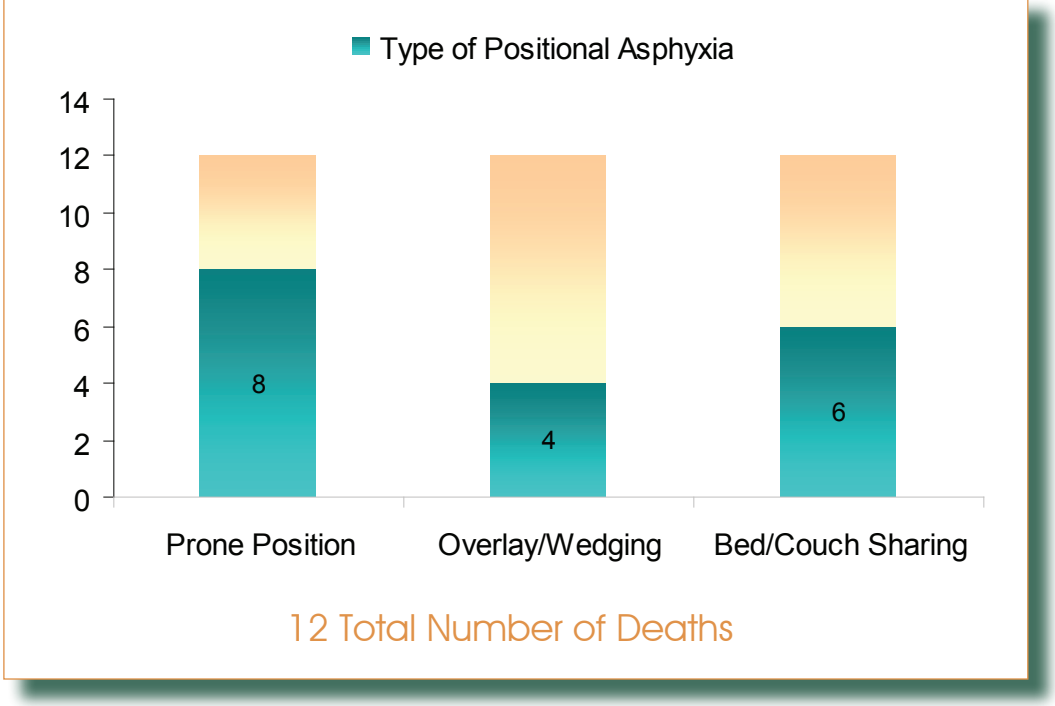
Accidental Asphyxia

There were 15 accidental asphyxia cases reviewed. In 20% (3) of accidental asphyxia fatalities, the children died due to choking or an obstruction of their airway. An 11 month old female choked on cereal while her mother was feeding her sibling. A four year old male was playing in his backyard and fell head first in a muddy hole which he could not pull himself out of. And in another case a one year old female was medically disabled and her home care nurse administered a nebulizer treatment improperly through her tracheotomy resulting in her suffocation and death.

Positional asphyxia was the cause of death for 80% (12) of the (15) accidental asphyxia cases reviewed. Safe sleep concerns were noted in all 12 of the cases. All of the infant victims were under eight months old with 83% of positional asphyxia cases occurring prior to three months old. In 6 of the 12 cases an infant was sharing a bed or couch with a parent, caregiver, or sibling and overlay or wedging was determined to be a contributory factor in four of the cases. In eight of the 12 cases the infant was found unresponsive in the prone position.

Figure 5-1

Types of Positional Asphyxia



Drowning Fatalities

The CFNFRB reviewed 16 drowning and drowning related fatalities and one near drowning which occurred in 2009. The near drowning occurred when a one year old child was being cared for by her babysitter and the babysitter left the child unattended for approximately 15 minutes in a bathtub. The child survived but with severe brain damage, she is receiving long-term special medical care. Nonfatal drowning can cause brain damage that may result in long-term disabilities including memory problems, learning disabilities, and permanent loss of basic functioning.

Many of the drowning fatalities 81% (13) were determined to be accidental in manner; however, homicide was the manner of death for 12% (2) of the drowning fatalities. In the first homicide incident, a newborn infant was drowned by his mother; she placed his body in a plastic bag and then in a toilet bowl. In the second homicide, a three year old child was thrown off of a bridge and into a river where she drowned. In one case reviewed the child died of end stage encephalopathy due to his near drowning and the manner was natural.

Location of Drowning Fatalities

Most of the drowning deaths in New Jersey occurred in open water (ocean, river, pond, etc.) accounting for 50% of drowning fatalities with eight total. Six of these fatalities occurred in open water and involved mostly adolescents. Two fatalities occurred in the ocean, a 15 year old youth drowned in an inlet section just off the ocean shore. There were no lifeguards patrolling the inlet and she was caught in a strong current and could not swim back to shore. Another 17 year old youth was swimming in the ocean with a friend and they were caught in a riptide. Lifeguards were able to rescue the friend but not this youth; his body was found by the coast guard two days later. The river claimed three victims of drowning, a 15 year old youth was fishing and fell off of a boat into the river and drowned. A 16 year old youth was under the influence of marijuana and jumped 14 feet off of a bridge and into a river although he could not swim and therefore drowned. A 17 year old youth was found in a river after drinking alcohol with his friends. A three year old child was thrown into a river by a relative. Two drowning deaths occurred in a smaller open body of water involving two one year old children who were not properly supervised. One child drowned in a Koi pond as her childcare provider was distracted with caring for other children. The second child fell into a quarry by her home while her mother was talking with a neighbor and she died due to delayed complications of asphyxia after drowning.

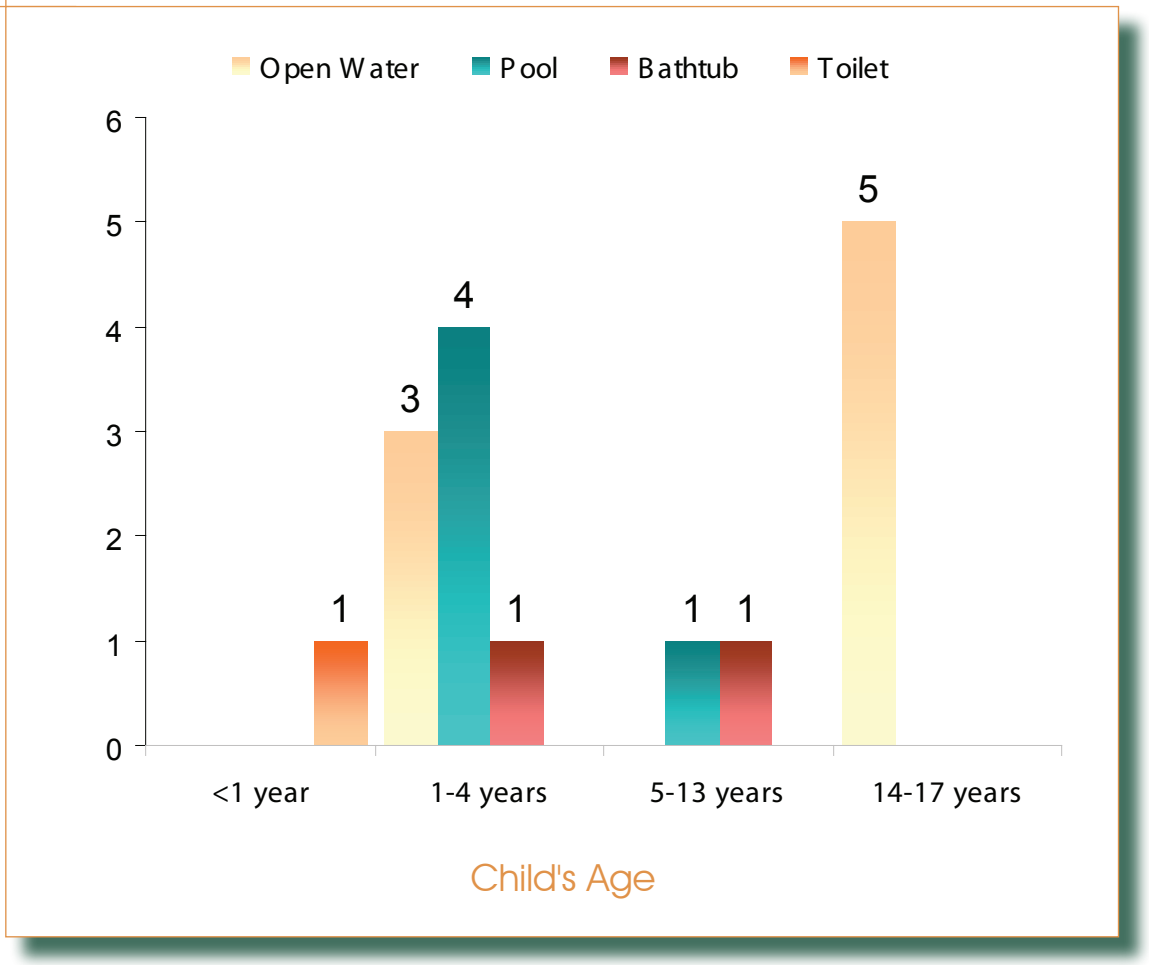
Drowning in a pool comprised the second most deaths by location at 31% (5). A seven year old child was swimming with his family in a hotel in-ground pool and was left unattended in the deep end of the pool and died of anoxic encephalopathy due to his near drowning. Residential in-ground pools accounted for three fatalities and there was one drowning in an above-ground pool. The children (ages 1, 1 ½, 3, and 6) were all left unattended and had easy access to the pool located in their backyard.

Bath tubs were the location of 13% (2) of the drowning fatalities reviewed. One 12 year old child who had a history of autism and seizure disorder was taking a bath alone when he succumbed to a seizure and drowned in the bathtub. The second child, a 2 year old was left unattended in a bathtub and died due to complications of near drowning.

In 6% (1), a toilet was utilized by a mother to intentionally drown her newborn infant after putting her inside a trash bag.

Drowning Deaths by Age and Location

Figure 6-1



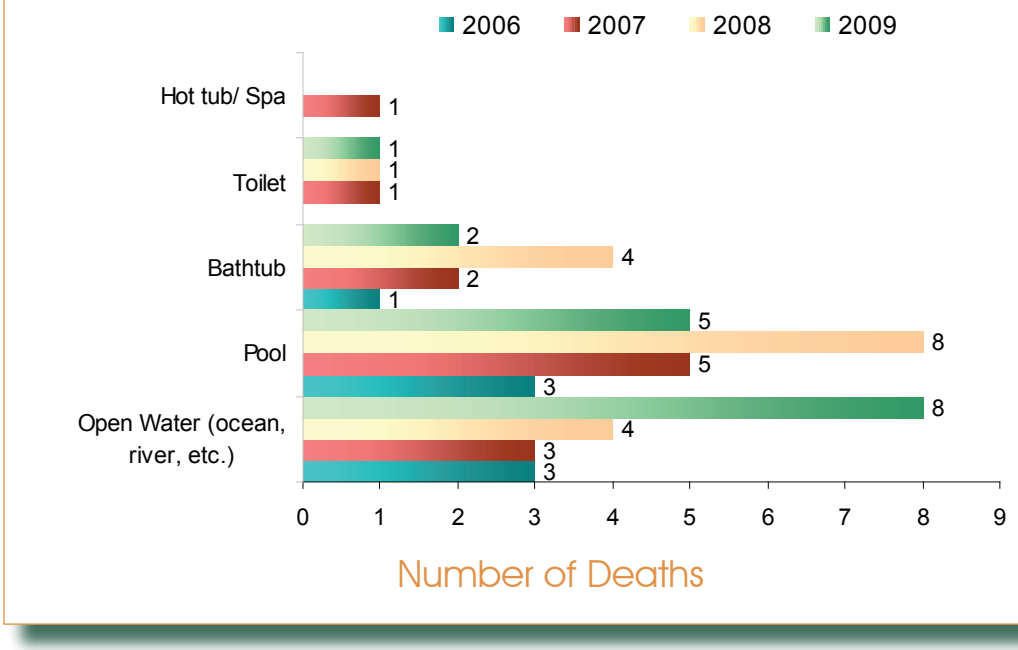
Trends in Location of Drowning

When comparing statistics over the last four years, the CFNFRB's figures illustrate that more fatalities occur as a result of drowning in a residential pool or open body of water than any other location. There were 18 drowning deaths occurring in open water and 21 drowning deaths occurring in pools from 2006 to 2009. Out of the 21 pool drowning deaths, 15 were in pools located in family backyards and six were in community pools. The CFNFRB noted that in those 15 residential drowning deaths, the children drowned in either their own pool or at the home of a friend or relative. Children did not wander off and accidentally fall into a neighbor's pool as is often speculated. In 10 (67%) drowning incidents from 2006 to 2009, there was no fencing around the perimeter of the pools. In four drowning deaths the investigators responding to the death scene did not document what, if any, barriers existed to prevent

access to the pool. There was one incident where there was a fence around the perimeter of the pool but the fence was left open, allowing easy access for the child who drowned. See Figure 6-2 for a comparison of drowning locations from 2006 to 2009.

Comparing Trends in Drowning Locations

Figure 6-2

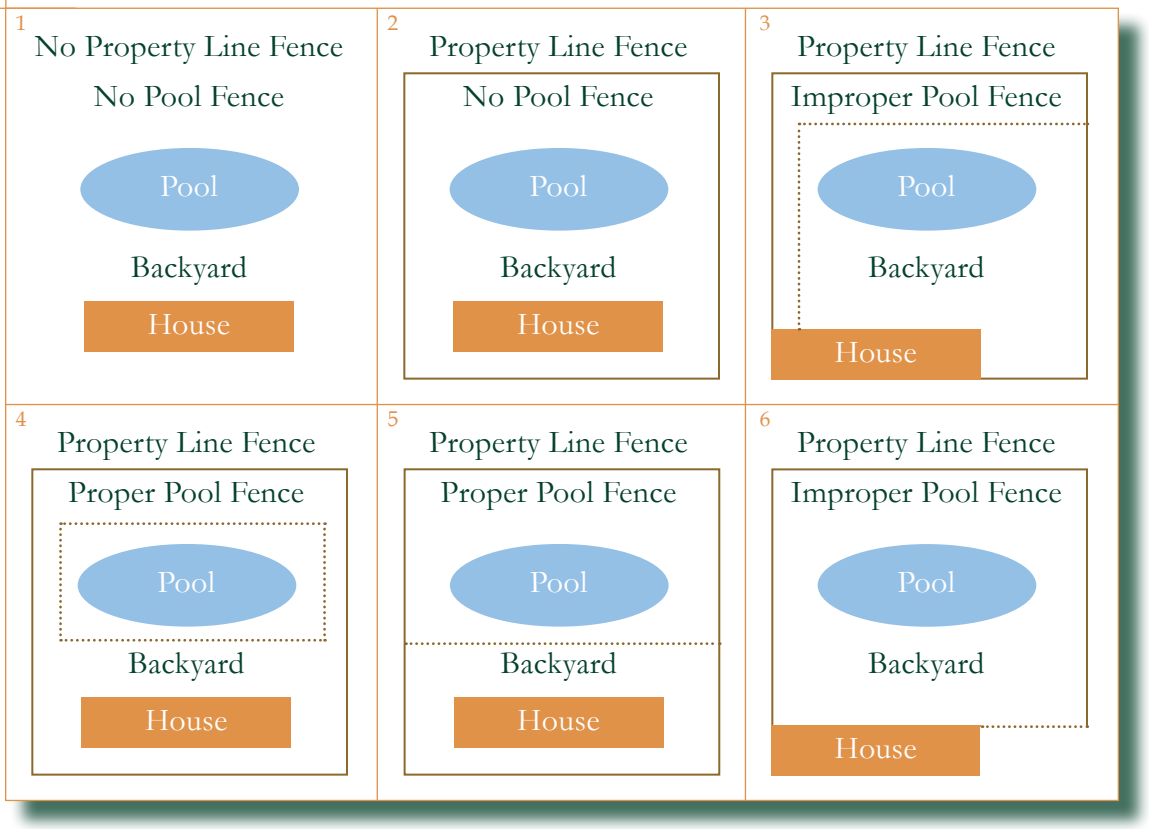


In the residential pool drowning fatalities from 2006 to 2008, seven of the 15 victims were last seen playing in the yard, four were thought to be inside the home but left the home and accessed the yard and pool, three were last seen in the pool, and no one other than the teenager who drowned was home during one incident. This information indicates that if there were a locked gate or fence around the pool itself, 11 of the 15 children may not have drowned. Two conclusions can be drawn from the above information; first, it especially important for municipal ordinances to mandate fencing around the perimeter of a pool and not just around the yard and second, it is important that the side of the house not be used as the fourth side of the perimeter around a pool. This information also reaffirms the importance of water safety and that parents and caregivers must be vigilant in their supervision of children while in or near water, even when there are other adults around and/or a lifeguard on duty.

In 2009, four children (ages 17 months to six years old) drowned in residential pools with no barriers, safety alarm, pool cover or fencing around the perimeter of the pool. While the residences did have a fenced in yard to prevent neighborhood children from entering the pool, there was no barrier to prevent their own children from entering the pool from the back yard entrance of the home. (See Figure 6-3, diagram numbers 4 and 5 illustrates proper fencing around all four sides of the pool perimeter).

Differences in Property Line and Pool Fence

Figure 6-3



Drowning Trends in Age and Gender

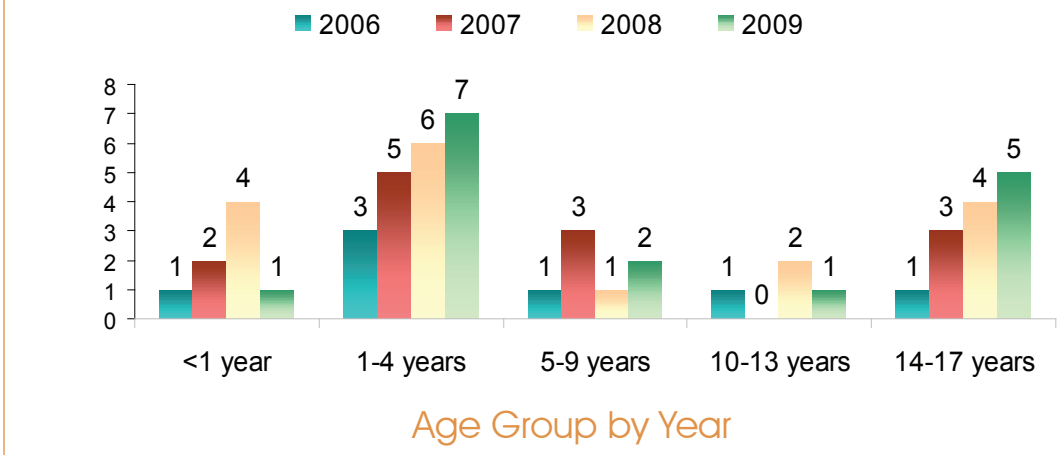
The CFNFRB analyzed data from 2006 through 2009 to determine whether New Jersey had trends similar to national studies. On average, it appears that New Jersey's statistics are comparable to national statistics regarding most trends, including age and gender.

Age

As shown in Figure 6-4, New Jersey has repeatedly experienced the highest number of fatalities in children ages four and under. In 2009, the number of drowning victims age four and younger made up 50% of the drowning fatalities. This trend continues to grow each year. The CFNFRB found that there were significant spikes in children who drowned between the ages of one to four and 14 to 17. In reviews of 2009 drowning fatalities, 75% of the victims were between one to four and 14 to 17 years old. The percentage of children who died in each of the age groups; < one year old, one to four year old, and 14 to 17 year old outnumbered the five to nine year old and 10 to 13 year old age groups combined.

Comparing Trends in Age Groups

Figure 6-4

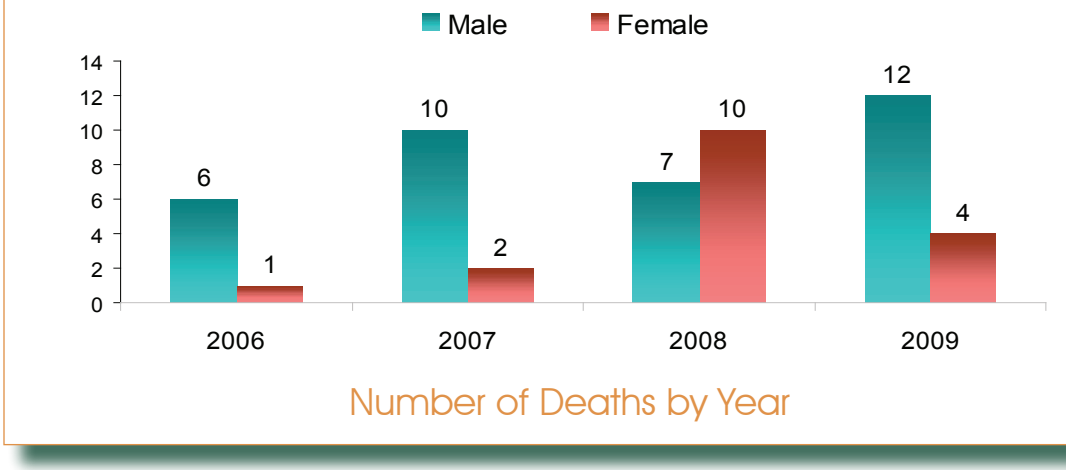


Gender

In 2006, 2007, and 2009, there were more male drowning deaths than female, but in 2008, there were more female drowning deaths than male. See Figure 6-5. With data from the last four years taken as a whole, male drowning fatalities outnumbered female drowning fatalities two to one. In 2009, male children comprised the majority of drowning fatalities with 75% (12) while 25% (4) of the drowning deaths were female.

Comparing Gender Trends

Figure 6-5



Reasons Why Children Drown

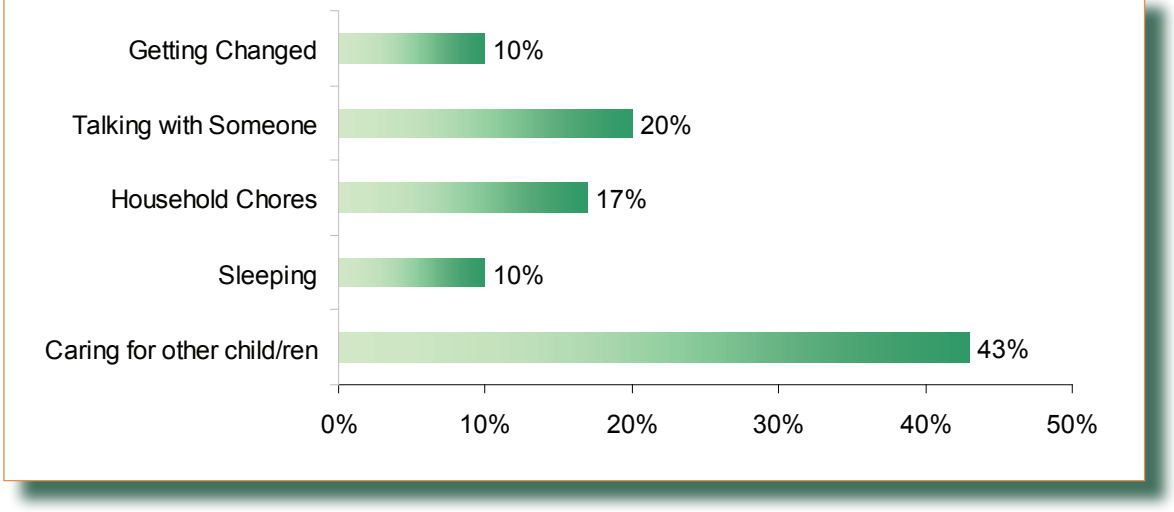
- weak or no supervision
- no barriers (covers on hot tubs, fencing with self latching gates around perimeter of pool, pool alarms, exposed ladders and diving boards, open containers of water within a child's reach)
- weak or no CPR skills
- weak or no swimming ability
- lack of life jacket use
- youths involved in risky behavior when swimming in water including but not limited to the use of drugs and alcohol swimming in prohibited public areas of water

Supervision

Supervision plays an important role in the prevention of child drowning fatalities. Of the 16 drowning fatalities reviewed in 2009, 56% (9) were due to inadequate supervision. Many parents and caregivers often engage in distracting activities while they passively supervise their children in or near water. Some of these activities included talking with someone, napping, doing home chores, or caring for another child. Figure 6-6 below reflects the nine drowning fatalities in which inadequate supervision was a key element in the fatality and the percent of caregivers who admitted to partaking in each activity when their child was drowned.

Figure 6-6

Distracting Activities by Caregivers



Safety Precautions

There are a number of safety precautions that pool owners can take to minimize drowning incidents. These include, but are not limited to, fencing around the perimeter of a pool, self-closing/self-latching gates, alarms on doors leading directly to pools, pool alarms, and lifeguards.

Blunt Force Trauma

In 2009, fatalities involving motor vehicle accidents accounted for 43% (3) of the seven blunt force trauma fatalities reviewed. In one case, a 16 year old male was killed when the ATV (All Terrain Vehicle) that he and a friend were riding, struck a tree. His cause of death was blunt force trauma to his head and torso. In another fatality a one year old male was struck by an SUV driven by a neighbor who was backing out of a driveway. The child's father was in the same vicinity when this occurred, however he was attending to a wounded bird and lost track of his son during this short time. The child's cause of death was blunt trauma injuries of the head due to a motor vehicle accident. In the last case involving a vehicle, a 17 year old female was involved in a fatal car accident while driving under the influence of Oxycodone. Her cause of death was multiple traumatic injuries.

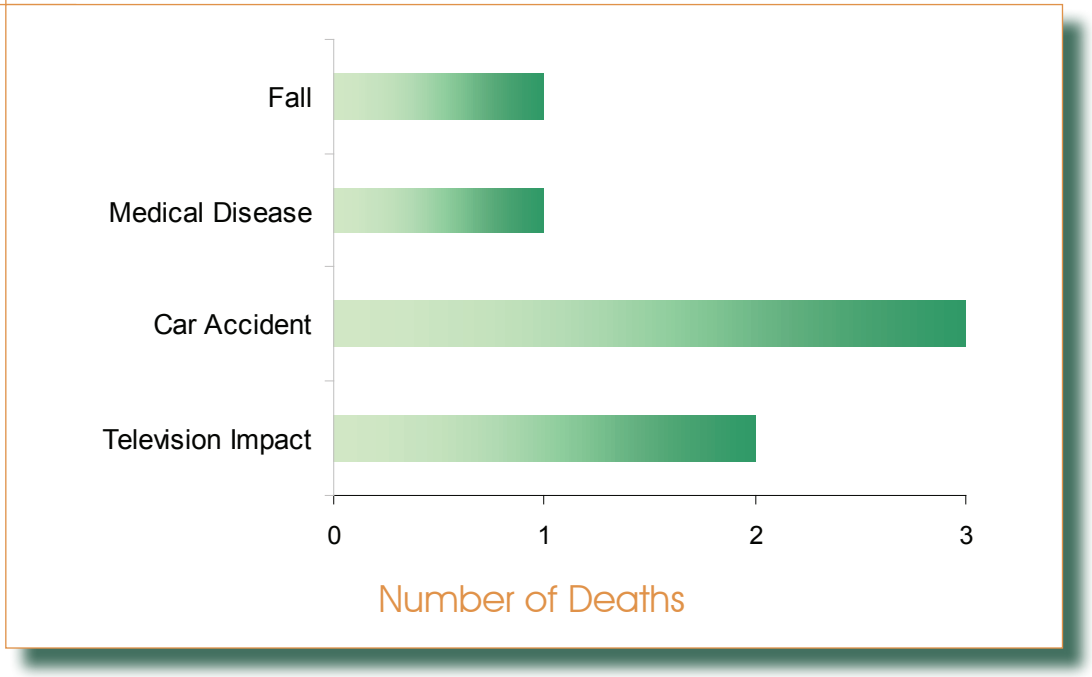
In two of the cases reviewed, a television fell on top of the child, fatally injuring them. In one case, a three year old female was being supervised by her 16 year old sister, however she left the room briefly and a television fell on top of the child. In the other case, a heavy dresser and large television fell on top of a two and a half year old male when he pulled on the dresser drawers.

In one fatality, a six month old male fell approximately two feet from a bunk bed onto hardwood floor.

In another case, a three year old male died due to complications of Williams Disease and a vascular defect that may have provided him with a higher tolerance for pain. He was found by his mother unresponsive in his crib. Healing bruises were observed on the child's forehead, however no child abuse was suspected and the medical examiner certified the cause of death as blunt head trauma and the manner as accident.

Figure 7-1

Blunt Force Trauma by Accidental Manner



Suicide Deaths

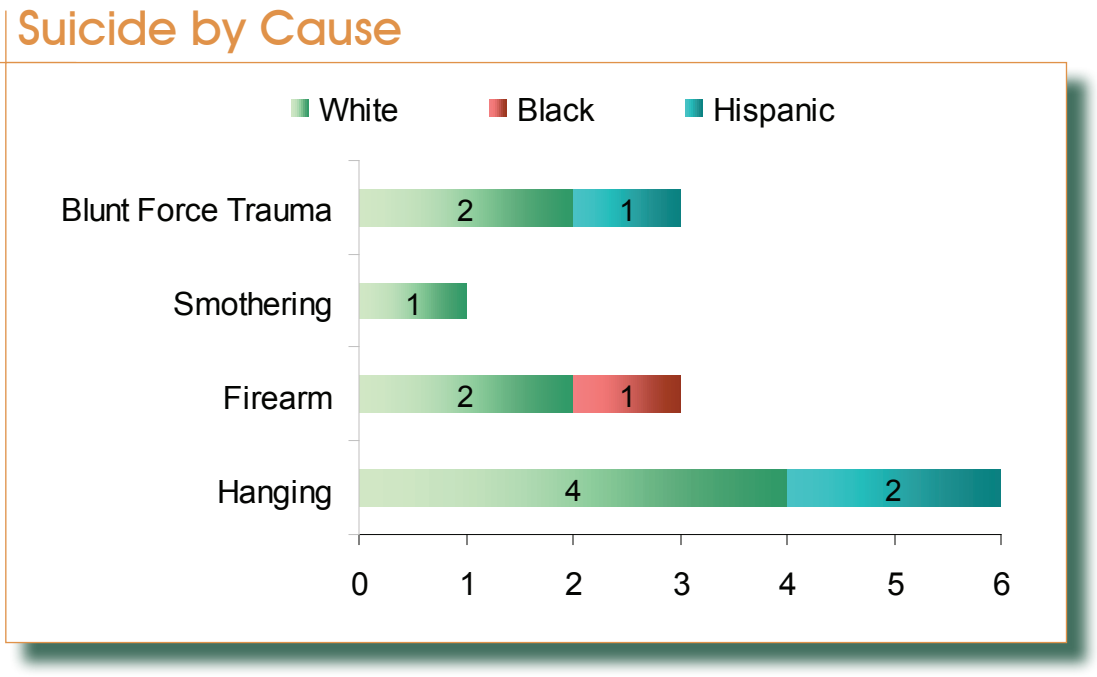
Mental health issues appear to be a risk factor for adolescent suicides. In 54% (7) of the suicide deaths the victim had a history of mental health diagnosis. Four of the victims were involved with out-patient mental health treatment in the past and at the time of their death. Three victims received out-patient mental health treatment in the past, but were not engaged in services at the time of their death. And three victims had no mental health treatment history. In three cases it was unknown whether the child had any mental health treatment (but in one case there was known past history but not known for the time of death).

Suicides by Cause

The cause of death in 46% (6) of the suicide deaths was due to hanging, 23% (3) were due to self inflicted gunshot wounds, and 23% (3) were due to blunt force trauma, while there was only 8% (1) due to asphyxia caused by a smothering.

In all three gunshot wound suicide deaths, the victim obtained the firearm from inside their residence and the weapon was owned by and registered to a caregiver. In two of the three cases the CFNFRB deemed the deaths as preventable because the guns were accessible to the adolescent.

Figure 8-1

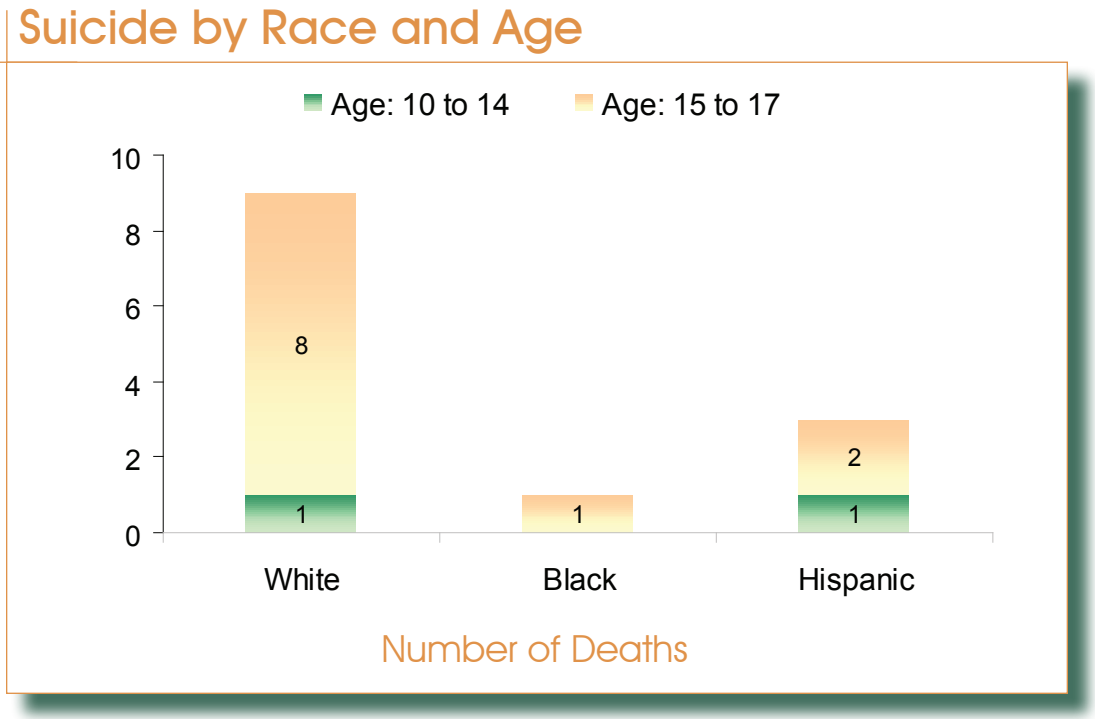


Suicides by Race and Age

In 2009, there were 13 deaths due to suicide. Most significantly, 100% of the suicide victims were male. Of these fatalities 69% (9) were white (Non-Hispanic), 23% (3) were Hispanic and 8% (1) was Black (Non-Hispanic).

Also significant was that all children were between the ages of 11 and 17, with the majority (54%) of the children being 17 years of age. 22% (3) were age 16, 8% (1) was age 15, 8% (1) was age 13, and 8% (1) was age 11. See Figure 8-1. The data reflects a much higher risk of suicide for White (Non-Hispanic) male adolescents who are age 17.

Figure 8-2



Geograhic Area

Of the 13 suicide deaths, 11 occurred in suburban communities, while only two occurred in rural areas and there were no suicide deaths in the southern part of the state (Camden, Gloucester, Atlantic, Cumberland, Ocean and Cape May Counties).

Adolescent Suicide Risk Factors

Substance Use: In less than half, 38% (5), of the suicide deaths past or current drug or alcohol use was noted. In three of these five cases, alcohol or drugs were found at the scene and the victims tested positive for illegal substances. In the remaining two deaths, both victims had a past history of drug use.

Family/Relationships: In five of the 13 suicide deaths there were issues identified in regards to crisis and or conflict with girlfriends and or family members.

Prior Attempts: In only one suicide death was the victim identified to have at least one suicide attempt. This child had an extensive mental health history dating back to his pre-teen years and he was in out-patient treatment at the time of his death.

Physical Abuse: There was no reported physical abuse for all 13 suicide cases, and in fact, only one case had any previous DYFS involvement.

School Problems: In more than half of the suicide deaths, 54% (7) had identified school problems including discipline, truancy, academic or behavioral.

Juvenile Criminal History: Of all 13 suicide deaths, there were only two cases in which a juvenile/criminal history was identified for the victim. In one case, the victim was on house arrest for marijuana possession at the time of his death, and one other child had been charged with assault after setting a girl's hair on fire at school. The incident occurred just prior to the suicide.

Lack of Investigative Evidence Regarding Mental Health History

In 85% (11) of the child suicides there was no information ascertained by first responders regarding the family history of suicide, and in 31% (4) cases there was no information ascertained about the victim's history of mental illness and in 46% (6) deaths there was no information ascertained about the victim being in mental health treatment.

In 92% (12) of the suicide deaths there were was no information ascertained about sexual abuse of the victim, but in one case when the victim's friend was interviewed regarding the death, there appeared to be a possibility that the victim was sexually assaulted by a family member.

In addition, in 85% (11) of the suicide deaths there was no information ascertained about current or past domestic violence in the home. In only one case was there information obtained about domestic violence, the family did acknowledge domestic violence and it was a contributing factor in the suicide.

In several of these cases the CFNFRB noted that information on family history of suicide, victim's history of mental illness, the victim's most recent form of mental health treatment, sexual abuse of the victim and the family's history of domestic violence needs to be ascertained in order to appropriately determine preventability and to develop future prevention efforts. The CFNFRB recognizes that sensitivity training may be needed by first responders attempting to obtain this information.

Of the 13 suicide deaths, there was only one child who had received services from the Department of Child Behavioral Health Services (DCBHS); that child was not actively receiving services from DCBHS at the time of his death.

Homicide Deaths

The CFNFRB reviewed 19 homicide deaths occurring in 2009. Six deaths were the result of blunt force trauma. Seven deaths involved a gunshot wound. Two deaths involved a child drowning; one child was drowned in a toilet and the other child drowned after being thrown into a river. Another child died due to a sharp blade injury to her neck and chest. Three children died of asphyxia due to being suffocated or smothered by their parent. Of the 19 homicide cases reviewed, DYFS was or became involved with the families of 16 fatality victims to investigate the death and/or provide services. Five children and their families had an open DYFS case at the time of their death; two children were killed by a firearm and three were killed due to some form of blunt force trauma. Another five children had previous involvement with DYFS but only two of those children's cases were reopened at the time of their death; these two children were shot and killed by their parent. Of the 16 cases investigated, nine were either new cases or cases reopened with DYFS as a result of the child's death.

Age of Homicide Victim

The majority of homicides, 37% (7) occurred with infants (under one year of age) and these cases involved blunt force trauma, drowning, smothering/suffocation and the use of a firearm. This was followed by homicides exclusively by firearms involving adolescents age 17 years old, which comprised 26% (5) of the homicide cases reviewed. One year old children accounted for 11% (2) of the homicide cases reviewed involving multiple injuries. A two year old child was stabbed with a knife, 5% (1). In 11% (2), the victim was three years old; in one case, the victim was drowned and in the other fatality, the victim experienced battered child syndrome. A four year old victim 5% (1) was asphyxiated and an eight year old child 5% (1) was shot by a caregiver using a firearm.

Gender of Homicide Victim

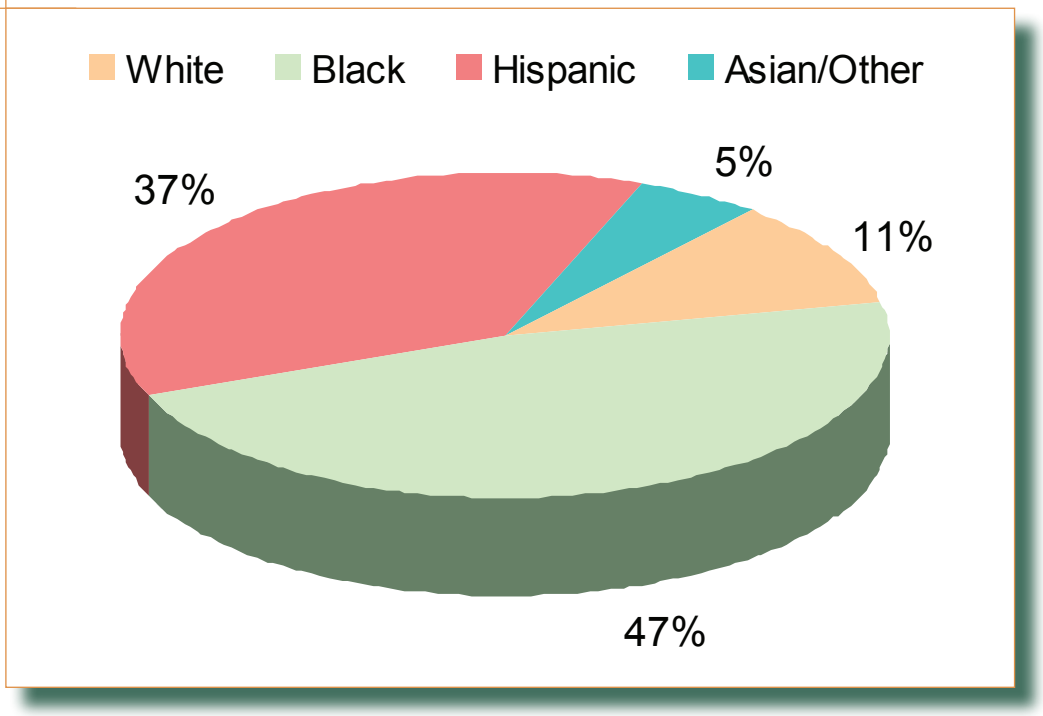
In 2009, nine children who were killed were female while the other 10 children were male. However, in past years the majority of the homicide victims were male.

Race of Homicide Victim

The majority of the homicides reviewed are of Black (Non-Hispanic) and Hispanic children. In 2009, 47% (9) of victims were Black (Non-Hispanic), 37% (7) were Hispanic, 11% (2) were White (Non-Hispanic), and 5% (1) were of Asian/Middle Eastern decent.

Homicide by Race

Figure 9-1



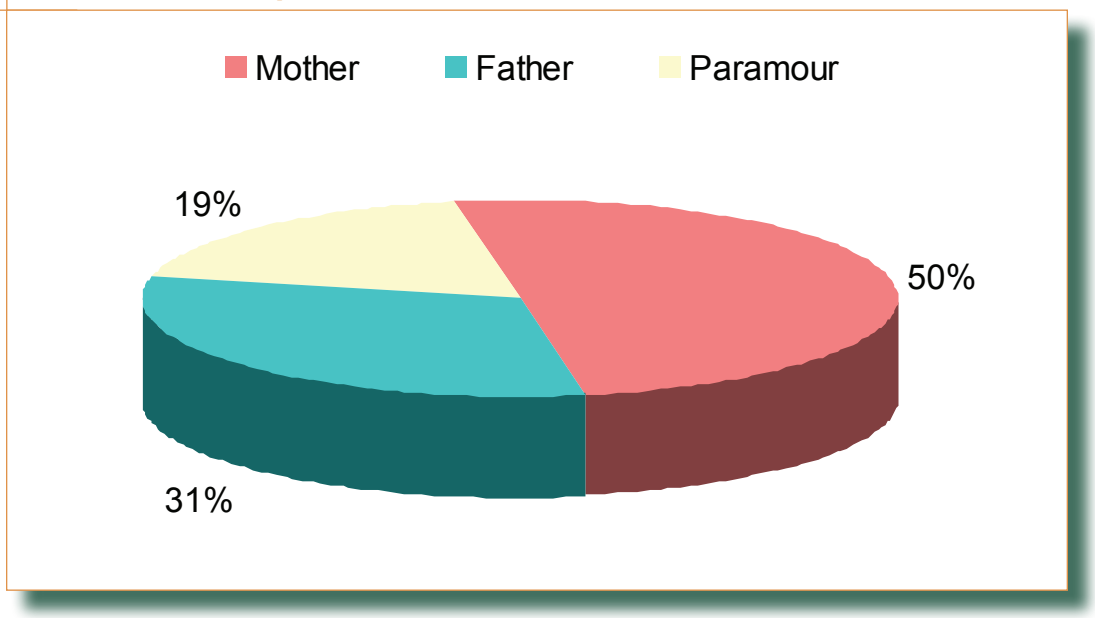
CCAPTA Perpetrators of Child Abuse and Neglect

The majority of the homicides reviewed involved the caregiver inflicting the fatal injury to the child. Thirteen of the child deaths were classified as CCAPTA cases and were all substantiated for abuse or neglect. The mother of the child comprised eight of the perpetrators, five of the perpetrators were the father and three of the perpetrators were the parent's paramour. The mother and father were both perpetrators in one homicide death. There were two homicide deaths in which there was a combination of perpetrators, one with the mother and paramour as perpetrators and in the other homicide the father and his paramour were the perpetrators.

- Two children died of a gunshot wound; a seven month old infant was shot and killed by his mother who then committed suicide and a father shot and killed his eight year old son; the father also shot the child's surviving mother and sibling.
- A two year old child's neck and chest were cut with a blade by her father who then committed suicide.
- Six children were killed due to blunt force trauma inflicted by their parents. Two children died of head injuries, two children died of multiple injuries to the body, one child died of blunt force trauma to the torso and one child was physically abused repeatedly over an extended period of time and was diagnosed with battered child syndrome. The children's ages were between six months old and three years old.
- A four year old child was suffocated by her mother with a pillow.

- There were three cases in which a mother placed her full term newborn infant inside a bag and suffocated the infant. In two of the cases the mother was 16 years old; both kept the pregnancy a secret from their family and friends. One newborn was placed inside a bag by her 16 year old mother who then placed her inside a toilet and drowned her. Another full term newborn was wrapped in a towel and placed inside a plastic bag by her 16 year old mother. In the last case the newborn was found deceased in a garbage bag behind an apartment complex.

Figure 9-2



Non-CCAPTA Homicides

In 2009, 31.5% (6) of the homicides were cases where the perpetrator was not a parent or a caregiver. One out of the six non-CCAPTA homicides involved a three year old child who was thrown off of a bridge and into a river by a relative who was not in a caregiver role. Of the six cases, five homicides by a non-caregiver were committed using a firearm and the children who were shot and killed were all 17 years of age. Only one of the fatalities was reported to DYFS but it did not create a CPS or CWS report because the youth who was under DYFS supervision at the time, was shot and killed by someone who was not his caregiver.

Risk Factors for Victims of Homicide

In 2009, there was a greater risk for youths to become a victim of homicide by a non-caregiver when firearms were easily accessible. All five children who were shot by a non-caregiver had one or more of the following risk factors; criminal activity, drug dealing and/or substance abuse, gang member, mental illness, runaway behavior, no active caregiver, anger and behavior issues. All five children were on probation at the time of their death and two children were on home confinement and needed to wear monitoring devices on their ankles. Two of the children were involved with YCM (Youth Care Management) and receiving substance abuse treatment, and another child was involved with CMO (Care Management Organization) where he was linked with a juvenile intensive supervision program due to mental health issues and aggressive behavior.

Division of Youth and Family Services (DYFS)

The Division of Youth and Family Services (DYFS), is New Jersey's child protection and child welfare agency within the Department of Children and Families (DCF). DYFS' mission is to ensure the safety, permanency and well-being of children and to support families. DYFS is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment. DYFS is comprised of a Central Office, 12 Area Offices overseeing 47 Local Offices, and the state Child Abuse/Neglect Hotline known as the State Central Registry (SCR).

SCR (Statewide Central Registry) receives approximately 17,000 reports each month[7] of possible child abuse and neglect 24 hours a day, seven days a week. Of these calls, approximately 5,000 to 6,000 referrals each month statewide are forwarded to one of the 47 DYFS Local Offices for investigation or assessment of child welfare needs, or one of the four Institutional Abuse Investigation Units (IAIU), responsible for the investigation of alleged abuse or neglect occurring in child care centers, schools, resource homes, residential treatment centers, and correctional facilities.

As of December 2010, there were approximately 44,954 children whose families were receiving DYFS services.[8] The Child Fatality and Near Fatality Review Board (CFNFRB) and its regional teams identified and reviewed a total of 153 fatalities and 9 near fatalities which occurred in 2009.

In 26% (42 of 162) cases reviewed, DYFS had an open case with the family at the time of the death or near fatality and were offering some type of family intervention (child welfare assessment, protective service investigation, or care and supervision).

DYFS had terminated involvement with 11% (18) of the families within the 12 months preceding the death or near fatality.

Seven (4%) of the families had a history with DYFS greater than 12 months prior to the child's death.

In 30% (48) of the cases, DYFS responded to a call on or after the date the child was near fatally injured (5) or died (43).

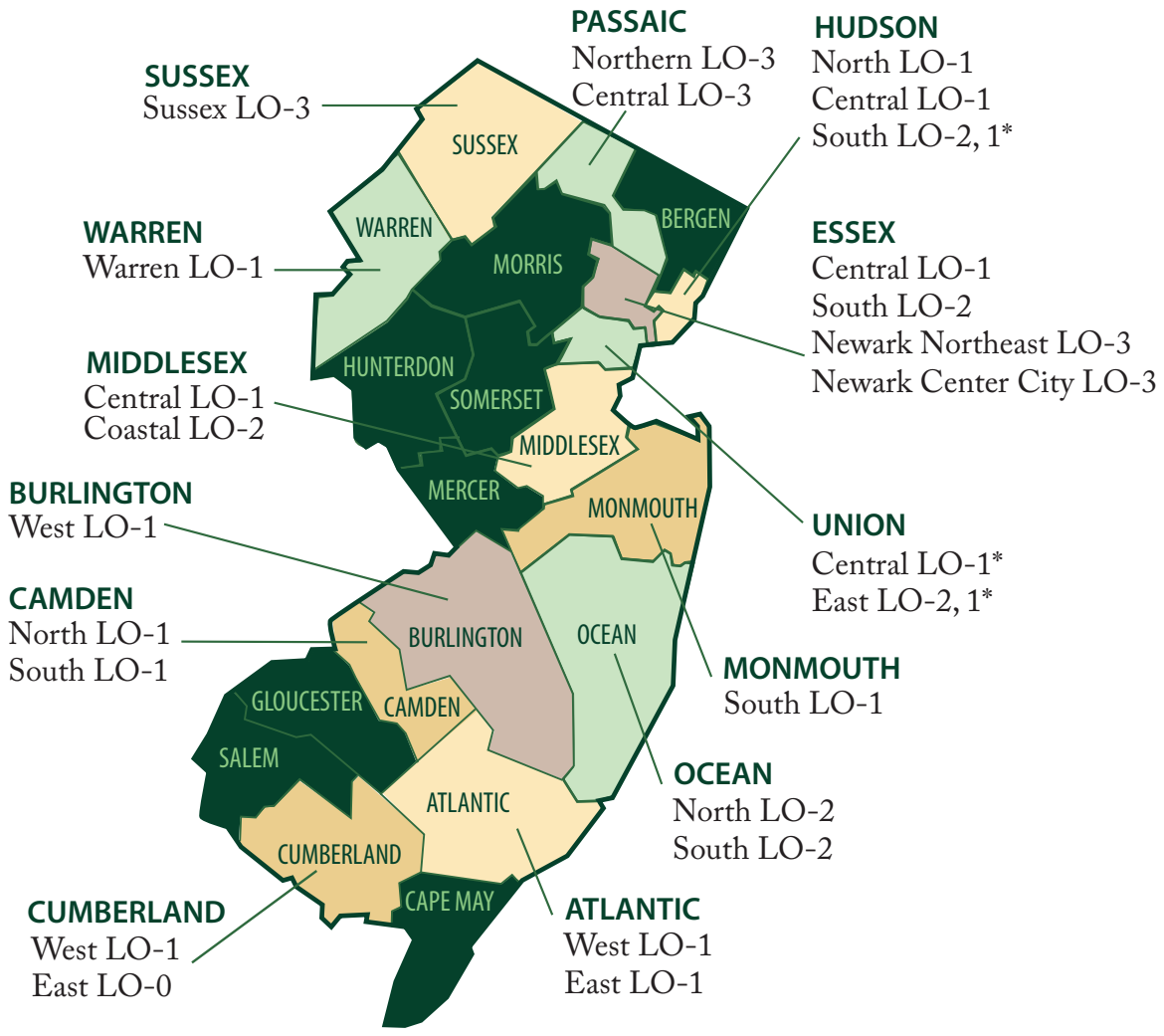
Forty-seven (29%) of the 162 cases reviewed had no DYFS involvement prior to the child's death. These cases include fatalities which were either not reported to SCR (33) or were reported, but did not rise to the level of completing a child protective service (CPS) investigation or a child welfare service (CWS) assessment (14).

7 Department of Children and Families (2009) Annual Agency Performance Report, New Jersey Department of Children and Families. Retrieved from nj.gov/dcf/about/DCFAnnualAgencyPerformanceReport_12.15.09.pdf, Pg. 5
8 Department of Children and Families (2009) Annual Agency Performance Report, New Jersey Department of Children and Families. Retrieved from nj.gov/dcf/about/DCFAnnualAgencyPerformanceReport_12.15.09.pdf, Pg. 7

In 2009 CFNFRB found a higher incidence of fatalities with open DYFS cases in Essex County. See Figure 10-1.

Fatalities and Near Fatalities by County with Open DYFS Cases

Figure10-1



*Near Fatalities

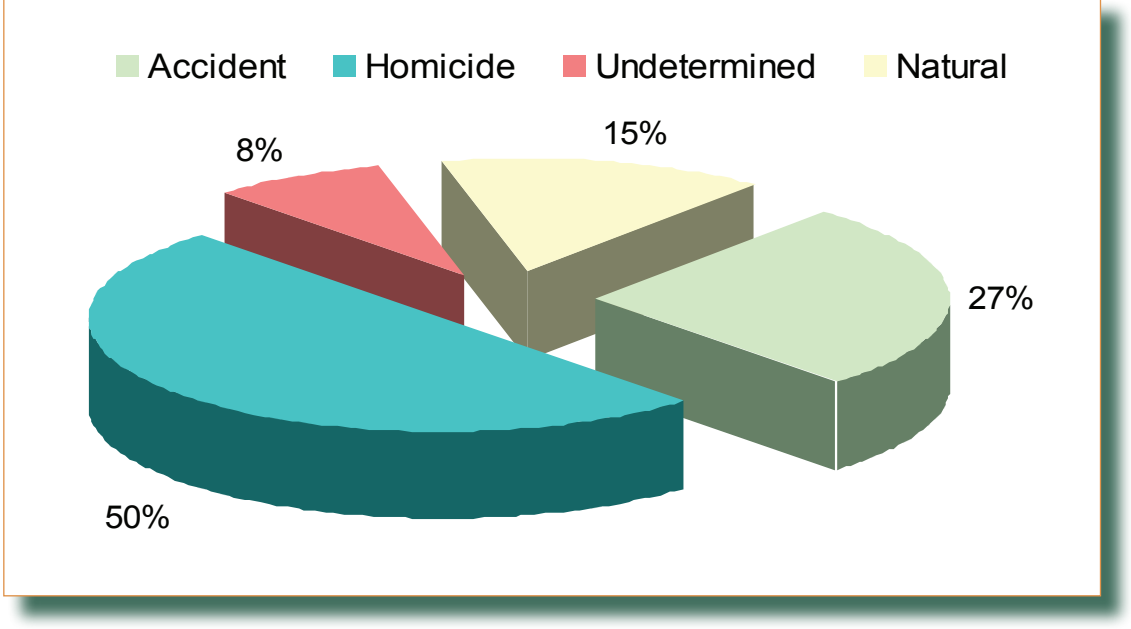
There are fatalities or near fatalities which fall under the aegis of a CCAPTA (Comprehensive Child Abuse Prevention and Treatment Act) legislation due to the circumstances of the death. The CCAPTA definition of child abuse and neglect is "any act or failure to act by parents or caretakers resulting in death, serious physical or emotional harm, sexual abuse or exploitation, or acts or failures to act presenting an imminent risk of serious harm." For the purpose of distinguishing between fatalities and near fatalities due to abuse and neglect by parents, caregivers, and other causes, the Board will refer to theses cases as CCAPTA fatalities and near fatalities.

DYFS responded to and investigated 79 fatalities and nine near fatalities. Of these investigations, 35 were designated CCAPTA; 26 were fatal and nine were near fatal. A parent(s)/caregiver(s) was substantiated for abuse and/or neglect in all 35 investigations.

CCAPTA Fatalities by Manner

Of the 26 CCAPTA fatalities reviewed, homicide was determined to be the leading manner of death, with 50% (13), followed by accident with 27% (7), 15% (4) of the manners were natural and 8% (2) were undetermined.

Figure 10-2



CCAPTA Fatalities by Cause

Blunt force trauma was the leading cause of death for CCAPTA fatalities reviewed with six cases in total; physical abuse was involved in all six of the fatalities. Out of the six fatalities reviewed, five involved head injuries and one was the result of injuries to the ribs and torso. The manner was homicide in all six cases.

In five CCAPTA fatalities reviewed, the children died as a result of drowning or complications related to a near drowning event; the second leading cause of death. Four children died due to a lack of supervision by their caregiver; three of the four children died of hypoxic encephalopathy due to drowning. Out of the five drowning fatalities, one newborn died as a result of homicide when the mother placed the infant in a plastic bag and then the toilet and he drowned.

In four CCAPTA fatalities reviewed, the manner of death was natural. In each of the following four cases the mother was substantiated for neglect.

- In one case the mother placed her child at substantial risk of harm by administering an IV solution of saline without any lab work or consulting first with a doctor; the child developed bacterial meningitis and died.
- In a second case the cause of death was sudden unexplained infant death and the child's mother was substantiated due to driving under the influence while the deceased was a passenger in the car, this occurring just a day prior to the child's death. Neglect was also substantiated due to the physical conditions of the infant's body at the time of death and the conditions of his sleeping arrangement and home.
- In a third case an infant died of respiratory failure due to staphylococous and sepsis two and a half months after being born with cocaine and opiates in her system.
- The last case was regarding a premature newborn with methadone in her system, who subsequently died seven days after birth.

Asphyxia was determined to be the cause of death in four CCAPTA fatalities reviewed. The manner of death for three of the four cases was homicide; two children were smothered and in the other case, the cause was determined to be neonaticide due to an absence of neonatal care and asphyxia due to being wrapped in a towel and placed inside a plastic bag. In one of the four cases the cause of death was asphyxia and the manner was accidental; a four year old male who was playing unsupervised in his backyard fell head first into an unscured muddy hole and could not pull himself out.

A fatal gun shot wound was the cause of death in three CCAPTA fatalities reviewed. In one case, the mother shot and killed her son, then shot and injured the father before ending her own life with the gun. In another case, the father shot and killed his son and then committed suicide. The manner of death for these two cases was homicide. In the third case, an adopted child and his adopted brother were playing with a loaded gun when a shot accidentally went off striking the child in the head and killing him. The adoptive mother's biological adult son was the owner of the gun. The manner of death was determined to be accidental.

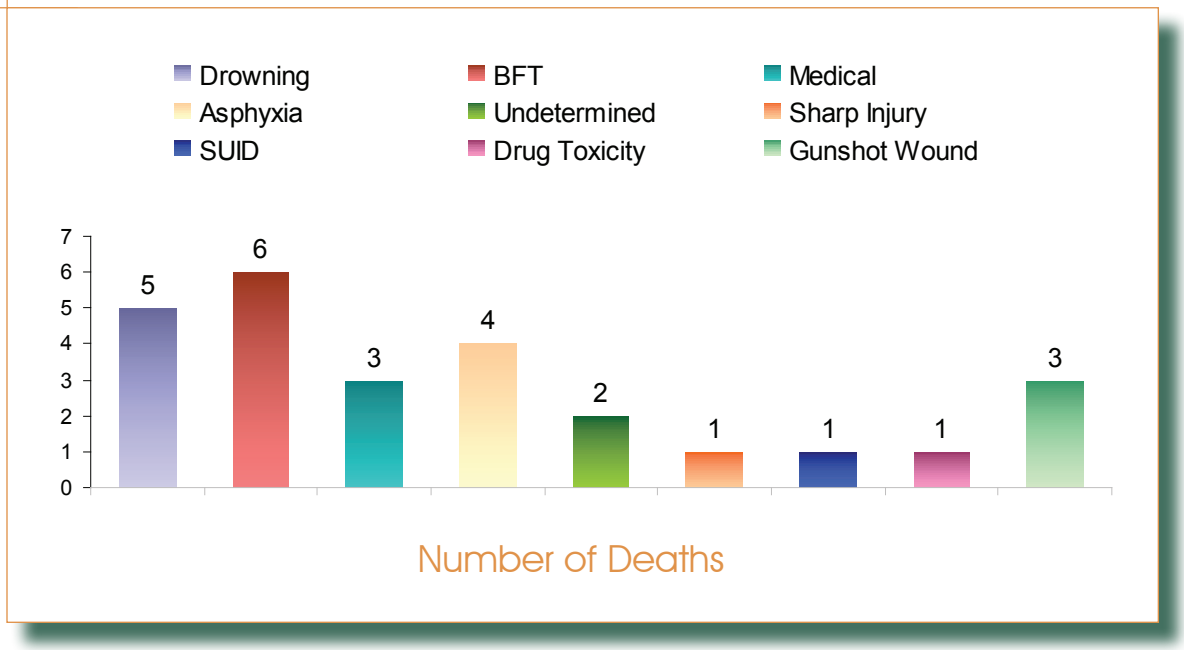
In one CCAPTA fatality reviewed, the child died due to suffering a sharp injury to her neck and chest after her father cut her neck with a knife. The manner of death was homicide.

An undetermined manner was indicated for two CCAPTA fatalities reviewed. The cause of death could not be determined in one case in which it appeared the child suffered injuries to the head; however, a perpetrator was never identified and the autopsy completed on the child was inconclusive. In the other case the cause of death was determined to be diabetic ketoacidosis and the DYFS investigation determined that the child's mother failed to provide the proper care needed for her daughter's diabetes, resulting in the child's death.

Drug toxicity was the cause of death for one child after ingesting methadone which he found underneath a bed in the home where he resided with his mother and maternal grandparents.

CCAPTA Fatalities by Cause

Figure 10-3



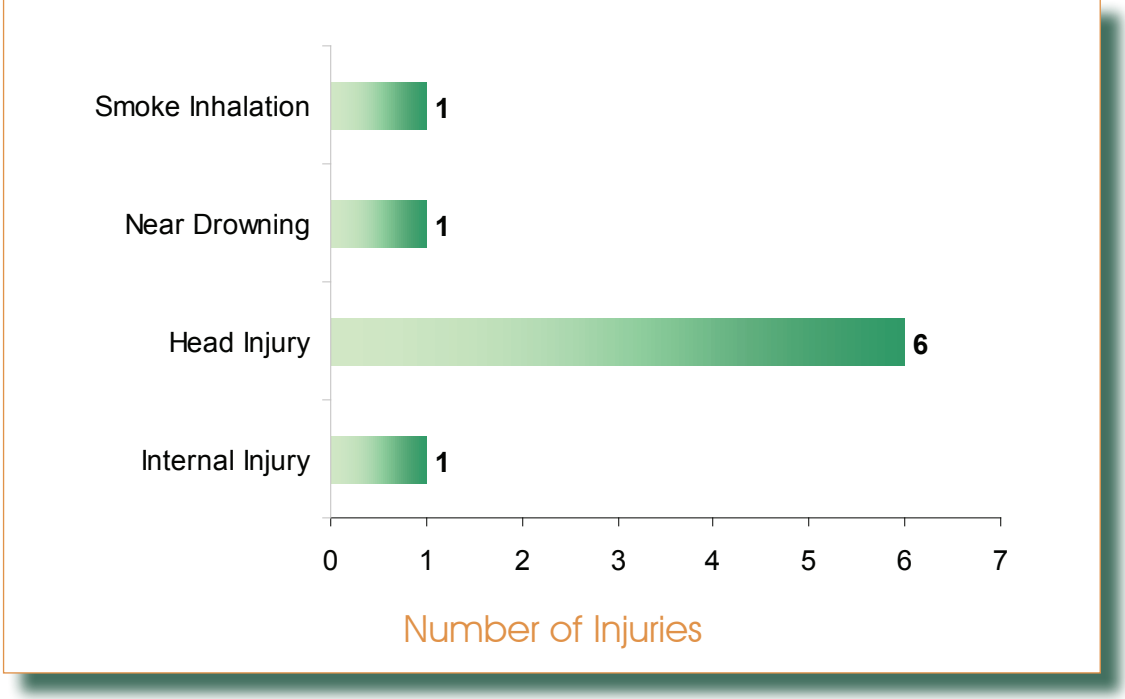
CCAPTA Near Fatal Incidents

The CFNFRB reviewed nine near fatalities which had been designated as CCAPTA cases and all nine were substantiated for either abuse and/or neglect. Of the nine cases reviewed, six involved near fatal head injuries. In five of the six near fatal head injuries, the father was indicated as a substantiated perpetrator; there was only one substantiated perpetrator of head injuries whose identity was unknown. The three other near fatalities include:

- A child who suffered internal injuries due to physical abuse at the hands of his mother's paramour.
- A child had to be hospitalized for treatment of smoke inhalation after the maternal grandmother left him home alone and the home caught fire due to an electrical malfunction.
- A child who nearly drowned and had to be hospitalized because her babysitter was under the influence of drugs and was not appropriately supervising her.

Near Fatal Injuries

Figure 10-4



CCAPTA Substantiated Perpetrators

The CFNFRB found that in the 35 CCAPTA cases there were a total of 44 substantiated perpetrators. Thirty-three of the 44 substantiated perpetrators were parents. The mother, acting alone or with a significant other, accounted for 48% (21) of substantiations; the father, acting alone or with a significant other, accounted for 27% (12) of substantiations. In five incidents, it was both the mother and father who were substantiated as perpetrators in the child's death.

The parent's paramour was involved as a perpetrator in 11% (5) of the cases. Out of these five cases, the paramour acted alone in two cases; one fatality due to inadequate supervision resulted in drowning and another child was physically abused by the mother's paramour and suffered head injuries. In one fatality the father and his paramour were substantiated for physical abuse which resulted in head injuries. In another fatality the mother and her paramour were substantiated; the child died due to physical abuse and neglect, his mother neglected to provide him with medical attention after her paramour physically abused him resulting in head injuries and bone fractures which led to his death. An adoptive mother and her paramour were substantiated for inadequate supervision after her adopted child was shot and killed by his adopted brother when they were playing with a loaded gun inside the home.

A relative comprised 5% (2) of the perpetrators; in a near fatal case a child who was being cared for by his grandmother was left home alone during a fire and was admitted to the hospital for smoke inhalation. In a fatal case a child ingested methadone which he found underneath a bed in the home where he resided with his mother and maternal grandparents. The maternal grandparents failed to properly secure their methadone treatment.

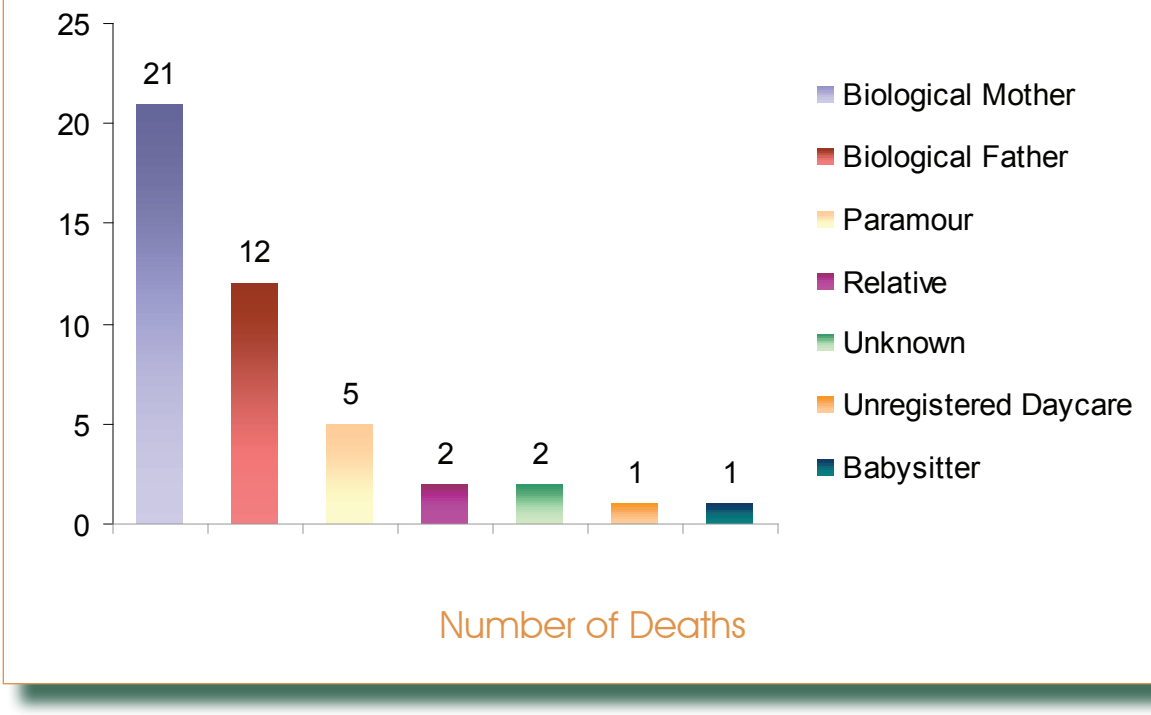
There was an unknown perpetrator involved in 5% (2) of the cases reviewed. In one case, the child suffered fatal head injuries and in another case, the child died of bone fractures and head injuries. Both cases were a result of physical abuse; however, the medical examiner, law enforcement, and DYFS were not able to determine who inflicted these injuries to the children.

An unregistered childcare provider was the perpetrator in 2% (1) of the cases reviewed. A child drowned in a pond located in the backyard of the unregistered childcare provider's home who was also caring for seven other children at the time.

In 2% (1) of the cases, the babysitter was substantiated along with the mother due to being under the influence of drugs while caring for a child who nearly drowned.

CCAPTA Perpetrators of Fatalities and Near Fatalities

Figure 10-5



Recommendations

Recommendation to the Legislature and Governor

NJ Medical Examiner System

The current medical examiner system that has been in existence for over 12 years is inadequate and should be modified in order to better serve the citizens of New Jersey. The Board continues to observe inconsistent practices in county based medical examiner offices with no capacity for mandated remediation and this has impacted the quality of death scene investigations throughout the State. Over the last decade 47 letters have been written by the Board and forwarded to County Medical Examiners, Regional Medical Examiners, or the Assistant State Medical Examiner In-Charge, detailing concerns identified during board and team fatality reviews, and resulting recommendations. This bill would allow the State Medical Examiner to create and enforce uniform forensic investigatory policies and procedures and ensure that these policies and procedures are consistent with the recommendations of the National Association of Professional Medical Examiners.

Senate Bill No. A1837 was introduced by Senator Joseph F. Vitale and sponsored by Craig J. Coughlin regarding The State Medical Examiner. This bill will unify New Jersey's Medical Examiner system by having a true state medical examiner that will have vertical lines of authority and will eliminate the current county medical examiner system. The Board is in favor of the bill and supports the idea of having the Office of the State Medical Examiner supervising authority over county medical examiner offices. At the county level, this bill will have county employees begin to operate as state employees and will consist of a chief medical examiner with four to six regional deputies and their investigators.

Recommendation to the Department of Law and Public Safety

Office of the Attorney General

Child Fatality Investigation/Multidisciplinary Training Protocol

New Jersey currently lacks a statewide, multidisciplinary protocol for the investigation of child fatalities. The Child Fatality Multi-Disciplinary Investigation Protocol developed by Gloucester County Prosecutor Sean Dalton has been submitted for review and approval to the Office of the Attorney General. This protocol outlines the expectations, roles, and responsibilities of each agency involved in a child death investigation. The CFNFRB continues to recommend that the Attorney General issue a directive mandating that there be consistency and collaboration between first responders and multiple agencies (law enforcement, medical examiner's office, EMS, DYFS and hospital) becoming involved in the death of a child. As it stands currently each agency has its own policy or protocol about their responsibilities and involvement in a child death investigation. On occasion, the expectations or role assignment of each agency may not be clear to the other agencies involved. At times DYFS may not

be contacted about a child death, especially if the death is not deemed suspicious for either abuse or neglect. There is a need for uniform structure and role assignment of the multidisciplinary respondents. A standard practice protocol such as this would ensure uniformity of action for those responding to a child death and initiating an investigation. This type of uniform standard would improve the quality and integrity of the information collected at the death scene, and the processing of that information. For example, standard questions such as substance use should always be asked in a child fatality investigation. By clearly defining the roles and responsibilities of all parties responding to a child fatality, there will be greater consistency to systemic processes such as child welfare notification, legal authority collaboration, etc.

Determining preventability in suicide cases remains difficult due to lack of investigative evidence regarding psycho-social mental health issues. If the youth was receiving mental health services, it would have been through a private doctor because there is no involvement with the Division of Child Behavioral Health Services. First responders should utilize a small questionnaire form when speaking to parents/families of suicide victims so that information regarding the victim's mental health history and recent behaviors can be ascertained.

Recommendation to the Department of Children and Families
Division of Youth and Family Services

Criminal Background Checks

DYFS should have access to the system used by law enforcement to conduct criminal background checks and this should be formalized for specific types of referrals. In addition, it was recommended that everything that can be done to immediately obtain comprehensive criminal information for the purpose of an investigation, should be done. However, if the more complete information is unavailable, DYFS should access and obtain all of the information that is immediately available at that time; such as Promis Gavel.

Business and Contracting Practices

It is the Board's experience that contracted practitioners do not always have the knowledge of established guidelines for assessing abuse and neglect. The Board recommends that the Department of Children and Families establish contracting standards that include minimum competencies and requirements for continuing education specifically in the area of child maltreatment, ethics or forensic assessment. The Board also recommends the establishment of specialty guidelines for evaluation of children where abuse or neglect is alleged. This recommendation results from the Board's review of multiple psychiatric or psychological reports that fail to assess risk as a result of inadequate practices.

Recommendation to Regional Diagnostic Treatment Centers

Diagnostic Treatment Assessments

It is recommended that the Regional Diagnostic Treatment Centers fulfill the core services stipulated in the law and requested by DYFS including the assessment of risk of all children being evaluated rather than solely focusing on treatment recommendation.

Recommendation to the Department of Health & Senior Services

Safe Sleep Education

Every year the Board has identified numerous overlay deaths; therefore, the Board recommends that agencies such as the Division of Prevention and Community Partnerships, the Department of Children and Families, the Department of Health and Senior Services, and the SIDS Center of New Jersey collaborate to provide educational opportunities on safe sleep to the public.

Hospitals should be provided with the most recently updated material on safe sleep instruction. Safe sleep instruction provided by some hospitals is outdated and informs the mother to have their baby sleep on his/her side instead of on his/her back and also encourages swaddling the baby. Safe sleep education should include discussion regarding the risks of co-sleeping but some safe sleep instruction does not include the dangers and risks associated with bed sharing.

Safe sleep material should include encouraging mothers to place infants back in their cribs after feeding. It is also recommended that the safe sleep material be made available in several languages, not just in English.

It is important to note that Safe Sleep training recommended by the Safe Sleep Ad Hoc Committee in 2009 will now be implemented and the agencies receiving training will include DYFS (Division of Youth and Family Services), DCBHS (Division of Child Behavioral Health Services), IAIU (Institutional Abuse Investigation Unit) and the Office of Licensing.

Recommendation to the Department of Children and Families
Division of Child Behavioral Health Services

Suicide Prevention

The CFNFRB does recognize that the NJ Youth Suicide Prevention Advisory Council issues ongoing recommendations to the Division of Child Behavioral Health Services but the Board would like to ensure that suicide prevention education include some of the ambiguous warning signs throughout the child's time in school, i.e., unexcused absences for an extended number of days out of the school year. High school students also need to be educated about reporting suspicious or concerning behavior posted on social internet sites, i.e., reports of bullying, suicidal or homicidal ideation.

Short Term or Long Term Acute Psychiatric Care

Availability of long-term or short-term acute psychiatric care and hospitalization for children and juveniles with suicidal ideation or other psychiatric illness remains a concern in New Jersey. Children and juveniles can be seen at inpatient or outpatient hospital psychiatric units multiple times in a short period. Children or juveniles who are at high risk should have access to acute psychiatric care. The current system of care in New Jersey is inadequate for the needs of such children and juveniles.

Recommendation to the National Rifle Association Institute for Legislative Action in New Jersey

Firearm Recommendation

The Board supports education on risks pertaining to gun safety and children accessing firearms and is recommending that the education should also include statistics on suicides and accidental child fatalities due to firearms.

Currently NJ firearm law states the following:

2C:58-15. Minor's access to a loaded firearm; penalty, conditions
a. A person who knows or reasonably should know that a minor is likely to gain access to a loaded firearm at a premises under the person's control commits a disorderly persons offense if a minor gains access to the firearm, unless the person:
(1) Stores the firearm in a securely locked box or container;
(2) Stores the firearm in a location which a reasonable person would believe to be secure; or
(3) Secures the firearm with a trigger lock.
b. This section shall not apply:
(1) To activities authorized by section 14 of P.L. 1979, c. 179, (C.2C:58-6.1), concerning the lawful use of a firearm by a minor; or
(2) Under circumstances where a minor obtained a firearm as a result of an unlawful entry by any person.
c. As used in this act, "minor" means a person under the age of 16.

List of Tables and Figures