

NEW JERSEY

2012 CHILD FATALITY & NEAR FATALITY REVIEW BOARD ANNUAL REPORT

A REVIEW OF 2010 FATALITIES & TEN YEAR REVIEW

PERSPECTIVE ON TEN YEARS OF CHILD FATALITY REVIEW

New Jersey Child Fatality & Near Fatality Review Board (NJCFNFRB)

The New Jersey Child Fatality & Near Fatality Review Board is in the unenviable position of assessing the lessons learned over the last ten years of child fatality review. A major tenant of our review is the Board's non-partisan position in reviewing cases of suspicious and inflicted deaths. We understand that this retrospective review can be linked to, and may have an unintended and chilling effect on, the progress attained by the current administration. Alternatively, we recognize that each administration has had the opportunity to implement changes in the ways in which the children of New Jersey are protected and as such, each administration has been afforded an opportunity to create a "fresh start" and divorce its approach from that of a previous administration. We nonetheless see major themes that continue to be unchanged over the last decade and across all parts of government.

Positively, the Board's evolution has resulted in a more sophisticated and focused approach to the review of child fatality and near fatality. The government of the Board has been non-partisan and as such, part of the Board's abilities can be attributed to its stability of membership. Each administration has allowed for a consistent approach to review through non-partisan appointments. The Board has created a climate of confidentiality that is not pierced by public access to its deliberations. No child, surviving sibling or family has ever been identified singularly in its annual reports. Each review's findings are part of an annual record that reflects trends in positive and negative approaches across governmental departments.

The Board has initiated actions that are models of best practices:

- The Board has applied for and received an on-going grant from the Centers for Disease Control and Prevention (CDC) that has advanced the study of Sudden Unexpected Infant Death (SUID). In this endeavor, largely through the efforts of its staff from the Department of Children and Families (DCF), New Jersey has a pre-eminent leadership position throughout the nation.
- Each hospital and medical examiner has adopted the standards of the American College of Radiology (ACR). Namely, the State of New Jersey has abandoned the practice of babygrams and replaced it by complete radiological studies that advance the determination and cause of suspected and sustained injury regardless of expense.

- The Board, through the efforts of Gloucester County Prosecutor, Sean Dalton, has initiated and proposed an interdisciplinary approach to child homicide that integrates the advantages of the Multi-disciplinary Team (MDT) process of child abuse investigation with the expertise of major crimes units of law enforcement, medical examiners, and first responders.
- Medicolegal death scene investigations have more routinely utilized the Pediatric Report of Investigation by Medical Examiner (Pediatric RIME) across all types of child deaths, and in cases of unexpected infant death, they more routinely utilized the SUID Investigation form. This change assists in the consistency and quality of death scene investigations.
- The Board communicates directly with various departments and divisions of the state government, as well as with, hospitals, agencies, schools and practitioners, to address concerns regarding practices that may have led to instances of risk of harm to children. These constituencies have responded to these inquiries with clarification and redresses; as a result of this process practices have changed for the better.
- Perhaps the greatest change is the way in which systems have, through self-reflection, implemented quality assurance practices that impact all children and minimize risk. Similarly the Board has also consistently identified the lack of progress in government and frontline programs. These comments reflect long standing resistance to change and self-reflection:
- The State of New Jersey has no capacity to exercise institutional controls over the county based medical examiners offices. The Office of the State Medical Examiner (OSME) has control over counties where the state has assumed control over death scene investigations. County Medical Examiners (CME) remain autonomous in their counties. Therefore, practices remain unchanged in counties where the number and compensation for examinations are controlled by county administration. The Board has proposed a model of control consistent with the law and practices that govern the relationship between the Attorney General and the county prosecutors.
- The State of New Jersey has had no consistent leadership in the OSME. Each appointed state medical examiner has been appointed as “acting,” leading to instability in the office. The Board has also asked the Office of the Attorney General (OAG) and the Department of Health and Senior Services (DHSS) to assess the ideal placement of the OSME so that it would best serve the citizens of New Jersey.

- The courts play a major, in fact, primary role in the protection of children by way of the many types of cases in the jurisdiction of the Family Part as well other courts. The CFNFRB intends to request of the Chief Justice of the State of New Jersey that discussions with the Board commence immediately to develop an effective mechanism for assuring that the authority of the courts is always pursuant to that end, that judges and court personnel be fully aware and trained as to the implications for the safety of children in every type of case, and that accountability for those actions which fall short of that standard be assured.
- The Department of Children and Families (DCF) and its predecessor Department of Human Services (DHS) and the Division of Youth and Family Services (DYFS) currently renamed as Child Protection and Permanency (CP&P) continue to have difficulty in evaluating risk. This trend has been consistent over the last decade regardless of the implementation of change in practices largely influenced by the current Modified Settlement Agreement (MSA) to resolve DCF's court review. There is inconsistency in assessing risk when children are reunified.
- In response to changes in how mental health services are delivered in the State of New Jersey, the Board continues to be concerned about an inadequate service delivery system for serious psychiatric disorders and co-morbid addictive disorders. While the number of children in out of state, hospital-based, psychiatric services has declined, (a tenet of the MSA and an applauded change to our system of care) there exists no viable system of in state, hospital-based beds for this population, especially when the number of in state psychiatric beds have been markedly reduced.

Finally, it is unclear the extent to which the Board's recommendations to specific institutions are implemented by other, similar institutions (i.e. agencies, hospitals, schools, Divisions and Departments of the State) which were not the subject of review.



Anthony V. D'Urso, Psy.D.
Chairman, NJCFNFRB

TABLE OF CONTENTS

Child Fatality and Near Fatality Review Board Membership.....	2
Introduction.....	6
The Mission, Purpose, Mandate, and Scope of CFNFRB.....	6
Case Selection Criteria.....	7
Cause and Manner of Death.....	10
Natural Deaths.....	12
Undetermined Deaths.....	15
Accident Deaths.....	18
Types of Accidental Asphyxia.....	19
Drowning.....	20
Blunt Force Trauma.....	23
Suicide Deaths.....	24
Homicide Deaths.....	26
Child Protection and Permanency (CP&P).....	29
CCAPTA Fatalities by Manner.....	31
CCAPTA Fatalities by Cause.....	31
CCAPTA Near Fatalities.....	32
Ten Years in Review.....	34
Recommendations.....	37

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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 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 is established within the Department of Children and Families, 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, to examine 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.**

Reviewing the circumstances surrounding cases of child fatalities and near fatalities is a critically important task for a multidisciplinary team of state and local professionals working in an array of fields, including child welfare, law enforcement, health, judicial, medical examiner, mental health, domestic violence, 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 by making recommendations 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, domestic violence, or appear preventable. The Board's data is based on this selection.

A central and guiding principle of the CFNFRB is that review enables the community to learn from each child fatality and near fatality and promotes ownership of prevention initiatives and strategies. Accordingly, 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 areas 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 Child Protection and Permanency (CP&P), 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 CP&P involvement at the time of the fatal or near fatal incident. The Sudden Unexplained Infant Death (SUID) Subcommittee reviews the deaths of children under the age of one (1), in which the cause or manner was ruled Undetermined or SUID by the medical examiner.

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 Child Protection and Permanency (CP&P) 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 CP&P**
- **All Sudden Unexpected Infant Deaths (SUID); which include children whose cause of death is Sudden Infant Death Syndrome (SIDS)**

2010 CFNFRB SUMMARY OF FINDINGS

17 of the 25 undetermined deaths had a Cause of Death related to SIDS or SUID.

32 families were under CP&P supervision at the time of the fatality or near fatal incident.

60% of suicide deaths were White (non-Hispanic) youth, 73% of the suicide deaths were male.

Review Process

The CFNFRB is notified of child deaths by 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 CP&P Director's Office. 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 (2) weeks before a scheduled meeting for review in preparation for discussion at the meeting.

Some of the possible actions following each case review may include but are 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.

The CFNFRB reviewed a total of one hundred and sixty (160) fatality and thirteen (13) near fatality cases which occurred in 2010. Table 1-1 below shows the demographics of cases reviewed by the CFNFRB.

Cases Reviewed by Race/Ethnicity, Gender, and Age Group¹

	Reviewed by CFNFRB	2010 Population under age 18
Race/Ethnicity		
White (non-Hispanic)	64	1,067,646
Black (non-Hispanic)	62	295,063
Hispanic (all races)	32	462,647
Other²	9	237,106
Gender		
Male	113	1,055,005
Female	60	1,007,457
Age Group		
<1-4 years old	102	540,620
5-14 years old	16	1,151,029
15-17 years old	36	370,840
TOTAL	173	2,062,462

¹ 2010 NJ Population data was obtained from The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org

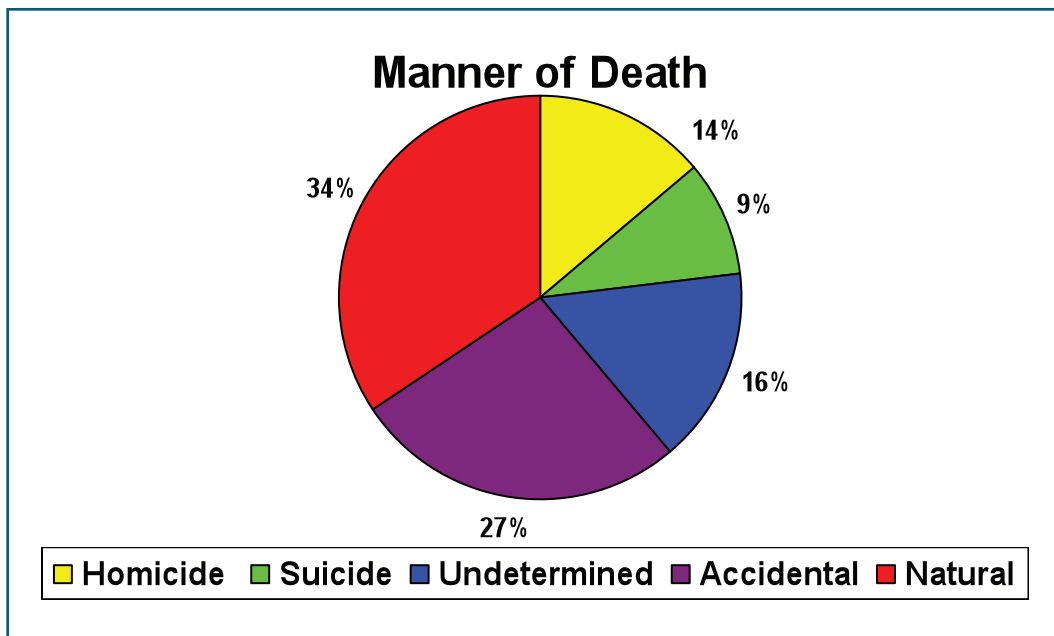
² Other Race/Ethnicity includes American Indian and Alaskan Native, Asian, Native Hawaiian, Pacific Islander, and multi-racial children.

CAUSE AND MANNER OF DEATH

The New Jersey Office of the State Medical Examiner defines "cause of death" as, "the underlying injury or disease that directly eventuates in death," and "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, and undetermined.

The causes of death in the one hundred and sixty (160) fatalities reviewed included, medical illness, trauma and injury, asphyxia, Sudden Unexpected Infant Death, drowning, drug and medication toxicity/ overdose, firearm and weapon injury, and undetermined causes.

The manner of death in thirty-four percent (34%) (55) of the one hundred and sixty (160) fatalities reviewed was natural. In twenty-seven percent (27%) (43), the manner was accident. In sixteen percent (16%) (25), the manner of death was undetermined. In fourteen percent (14%) (22), the manner of death was homicide and in nine percent (9%) (15), the manner was suicide.



County

The Fatalities Reviewed by County Table below illustrates the number of fatalities by manner of death, per county, and reviewed by either the Board, one of its regional teams, or the SUID Subcommittee. 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. No child fatalities in 2010 from Salem County were reviewed giving Salem County the lowest (0) child fatality rate of any county in the state. This was the second consecutive year there were not any fatalities reviewed in Salem County.

Reviewed Fatalities by County ³									
COUNTY	MANNER OF DEATH						% Total Fatalities	Child Population ⁴ (< 18 Years)	County Reviewed Fatality Rate ⁵
	Accidental	Homicide	Natural	Suicide	Undetermined				
ATLANTIC	4	2	1	1	0	5.00%	63,888	12.52	
BERGEN	0	1	2	1	3	4.38%	204,405	3.42	
BURLINGTON	1	1	4	0	5	6.88%	104,243	10.55	
CAMDEN	4	3	6	1	1	9.38%	125,117	11.99	
CAPE MAY	1	1	1	0	1	2.50%	18,349	21.80	
CUMBERLAND	1	0	1	1	1	2.50%	37,705	10.61	
ESSEX	6	3	11	2	2	15.00%	194,918	12.31	
GLOUCESTER	0	1	4	1	1	4.38%	70,261	9.96	
HUDSON	2	1	2	0	3	5.00%	131,162	6.10	
HUNTERDON	0	0	0	0	1	0.63%	30,217	3.31	
MERCER	3	0	5	0	0	5.00%	82,982	9.64	
MIDDLESEX	2	0	6	0	0	5.00%	185,457	4.31	
MONMOUTH	6	1	1	3	1	7.50%	150,299	7.98	
MORRIS	2	0	3	3	0	5.00%	117,695	6.80	
OCEAN	3	1	2	1	0	4.38%	134,919	5.19	
PASSAIC	0	4	2	1	1	5.00%	124,613	6.42	
SALEM	0	0	0	0	0	0.00%	15,510	0.00	
SOMERSET	2	0	1	0	1	2.50%	80,835	4.95	
SUSSEX	0	0	1	0	1	1.25%	35,773	5.59	
UNION	5	3	1	0	3	7.50%	131,258	9.14	
WARREN	1	0	1	0	0	1.25%	25,608	7.81	
STATE TOTAL	43	22	55	15	25	100.00%	2,055,214	7.75	

³ Reviewed Fatalities - fatality cases occurring in 2010 reviewed by the CFNFRB

⁴ Population <18 – from United States Census Bureau, 2010 Website: <http://quickfacts.census.gov/qfd/states/34000.html> and from The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org

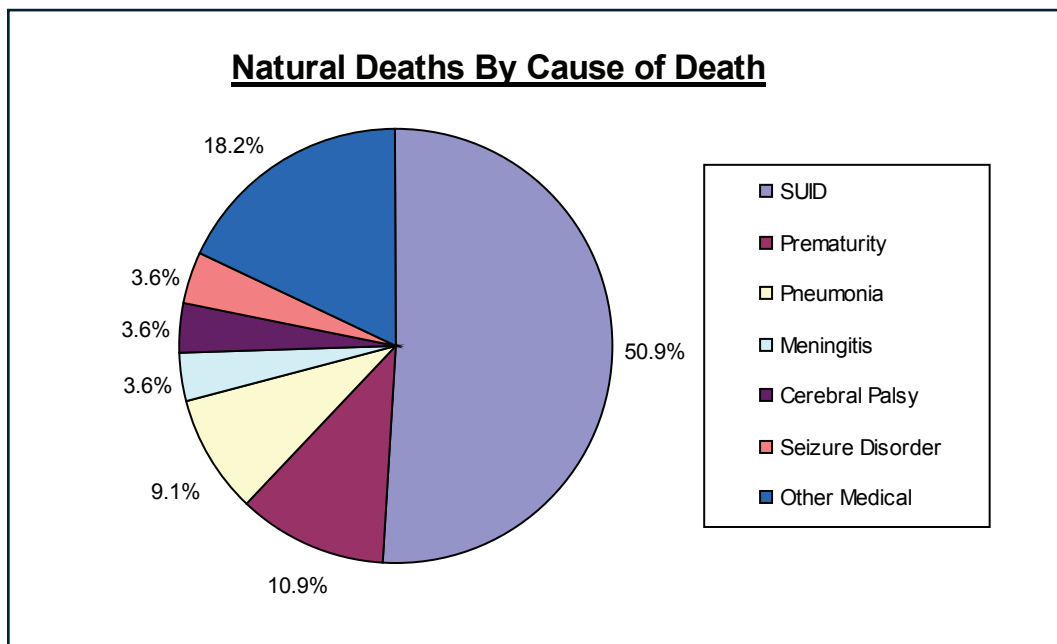
⁵ Reviewed Fatalities per County * 100,000 / County Child (<18) Population

NATURAL DEATHS

Of all the deaths reviewed by the CFNFRB in 2010, 34.4% (55 out of 160) were determined to have a manner of death of natural.

50.9% (28 out of 55) of these deaths were due to Sudden Unexplained Infant Death (SUID), Sudden Unexpected Infant Death, Sudden Unexpected Death or Sudden Infant Death Syndrome (SIDS).

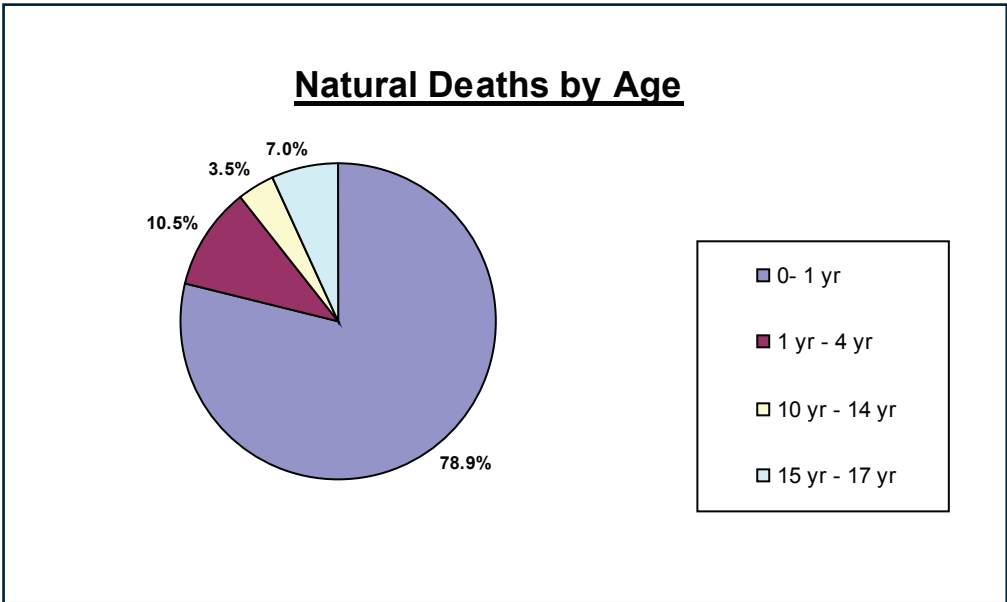
10.9% (6 out of 55) of these deaths were related to premature birth and the remaining 38.2 % (21 out of 55) were due or related to medical causes, such as: Pneumonia, Meningitis, Cerebellar Infarction (Stroke), Cerebral Palsy, Renal Disease, Sarcoma (cancer), sepsis, seizure, metabolic and congenital disorders.



Age

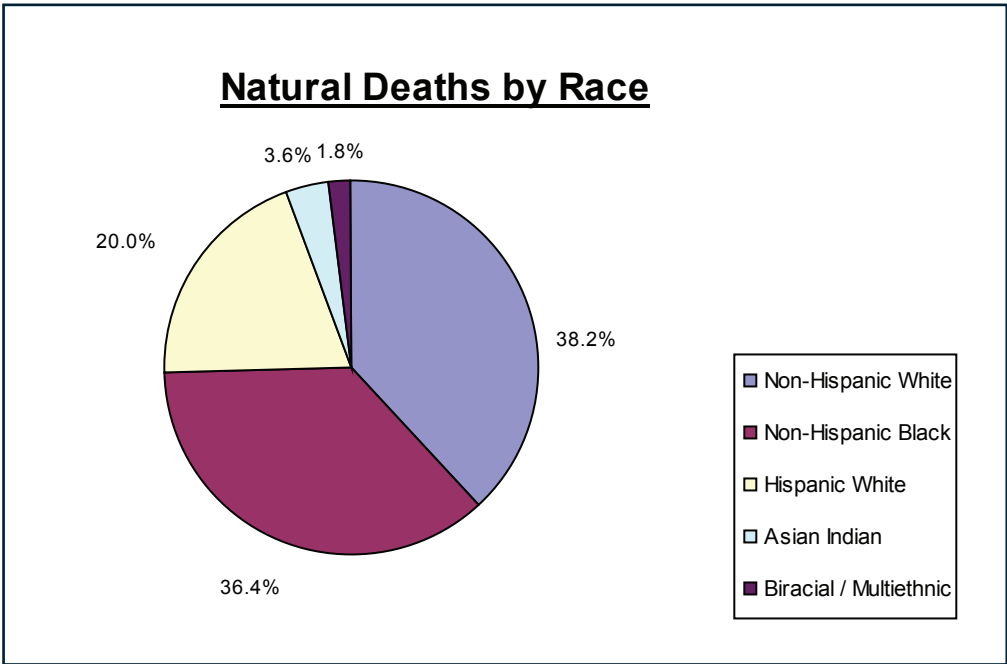
As has been shown in previous years, the CFNFRB data findings show that children under six (6) months of age are at a considerably higher risk of dying a natural death than children in any other age group (74.5%).

Children between birth and one (1) year old comprise 79.9% of the natural deaths reviewed. Children between one (1) and four (4) years old comprise 10.5%. The next largest group is from fifteen (15) to seventeen (17) years old (7.0%) then ten (10) to fourteen (14) years old (3.5%). No children between the ages of five (5) and nine (9) that were reviewed died of natural causes in 2010.

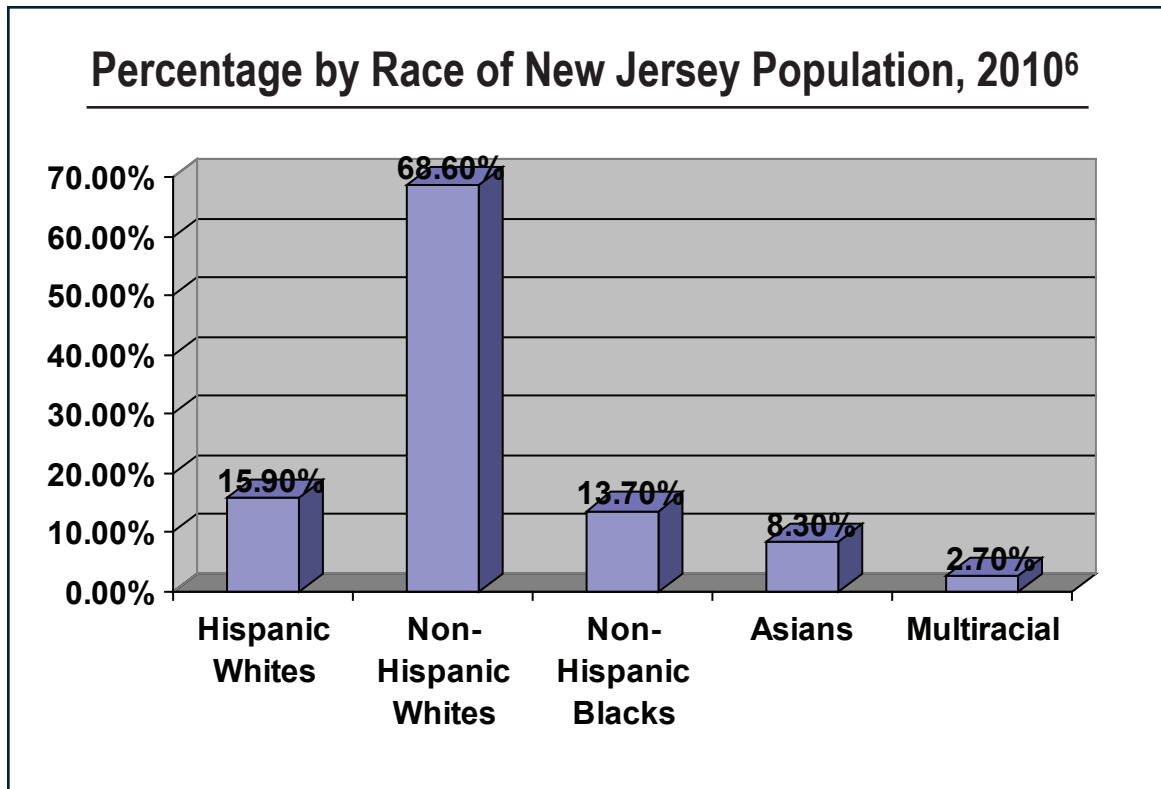


Race

Of those children who died a natural death, nearly equal numbers of Non-Hispanic White and Non-Hispanic Black children were represented (38.2% and 36.4%, respectively). Hispanic White children represented 20.0% of natural deaths; no Hispanic Black natural deaths were reported. Asian Indian and Biracial (Black / White, Hispanic) represent 3.6 and 1.8% of natural deaths, respectively.



When these rates are compared to the State of New Jersey's 2010 Census rates for race, we see that natural deaths of Non-Hispanic Blacks and Hispanic Whites are over-represented, while those of Non-Hispanic Whites are under-represented. Asians and multi-racial natural deaths are also under-represented, but less so.



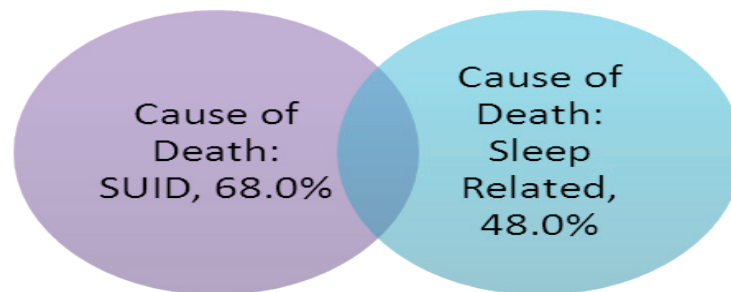
Sex

Female and male children were almost equally represented among the natural deaths: females were fifty-two point seven percent (52.7%), twenty-nine (29) out of fifty-five (55), and males were forty-seven point three percent (47.3%), twenty-six (26) out of fifty-five (55). No inter-sexed children were reported to have died naturally in 2010.

⁶ United States Census Bureau Website: <http://quickfacts.census.gov/qfd/states/34000.html>

UNDETERMINED DEATHS

Fourteen point five percent (15.6%), twenty-five (25) out of one hundred and sixty (160), of the deaths reviewed by the CFNFRB in 2010 had a manner of death of undetermined. Of these, forty-eight percent (48.0%), twelve (12) out of twenty-five (25), were related to sleeping conditions per the cause of death. Sixty-eight percent (68.0%), seventeen (17) out of twenty-five (25) had a cause of death with some form of SUID⁷ listed. Ten (10) of these, eighteen point two percent (18.2%), have sleep-related contributing causes. When taken together, deaths that were either attributed to SUID or safe sleep issues, the whole number is nineteen (19) out of twenty-five (25) or seventy-six percent (76.0%).



There were two (2) child deaths that had causes of death that related to safe sleep but were not SUID: Follicular Bronchiolitis, Contributing: Overlay cannot be ruled out; and, Undetermined; Co-sleeping, history of prematurity & apnea.

Other manners of death include: Hanging/Asphyxia via Hanging (2), Blunt Force Head Trauma (1), Opiate Toxicity (1), Undetermined (1), and Ischemic Encephalopathy (1).

Hanging: The first is of an eleven (11) year old White male, who was found hanging by a dog leash in his basement. The child had no history of depression and the death was considered a possible accident. Since the intent of this child placing the dog leash around his neck could not be determined, it was deemed an Undetermined Manner of Death.

The second is a twelve (12) year old Black male who was found hanging by a cloth belt in his bedroom. Although it was considered highly probable that this was a suicide, upon further investigation it was learned that the child may have participated in the "Choking Game" with some of his peers. The "Choking Game," also known as the "Fainting Game," is a thrill-seeking behavior in which some children and adolescents engage for a variety of reasons. The most common reason is to experience a sense of euphoria or to "get high" without spending money on illegal substances⁸. Although none of the child's peers admitted to engaging in this activity with the child, many of the child's peers were speculating

⁷ There is no uniformity among New Jersey's Medical Examiners with regard to how they describe Sudden Unexpected Infant Death (SUID). Some use Unexplained instead of Unexpected, some invert Infant and Death, some use Neonate instead of Infant, some include contributory causes after SUID, e.g. SUID with unsafe bedding, Sudden Unexplained Infant Death with Contributory Co-Sleeping, while others include the contributing cause within the SUID, e.g. Sudden Unexplained Death of Co-sleeping Infant.

⁸ <http://chokinggame.net/>

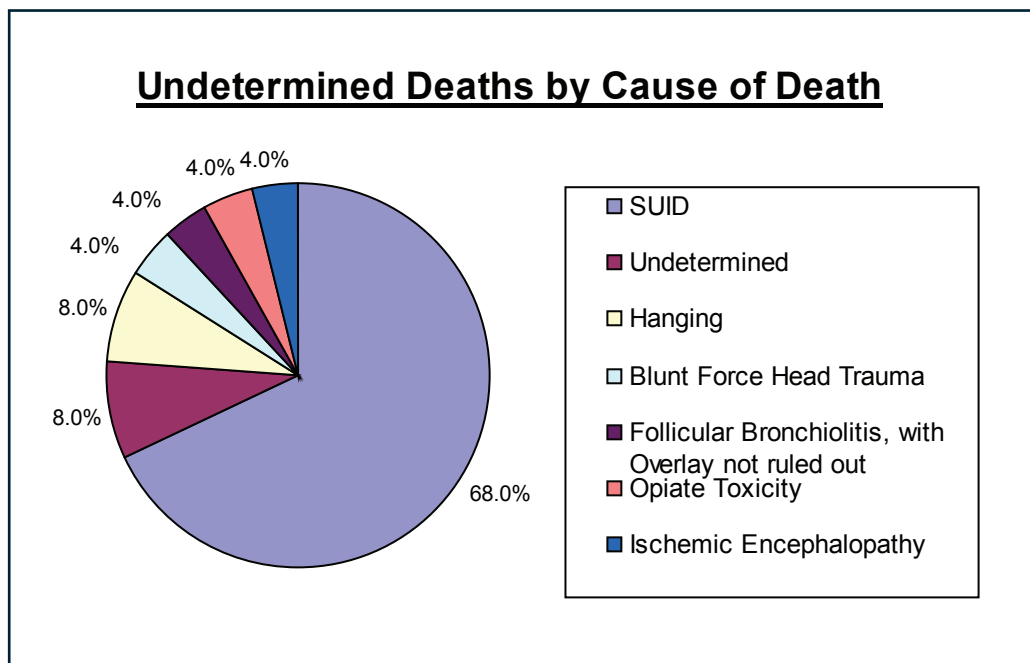
that this was the cause of his death, not suicide. The child had a history of behavioral problems and AD/HD but not of Depression. Ultimately the Medical Examiner chose to deem the Manner of Death: Undetermined, Cause of Death: Asphyxia via hanging.

Blunt Force Head Trauma: This was a seventeen (17) year old Black male who was found on a city sidewalk with a head wound. Although it is likely that this wound was inflicted during a robbery (his iPod and cell phone were missing), the Manner of Death was deemed Undetermined because circumstances surrounding this death remain unclear.

Opiate Toxicity: This was a seventeen (17) year old white female who overdosed on heroin while her father was out getting dinner. As this child had an extensive history of both substance abuse and mental illness, including suicide attempts, this death was coded Undetermined because it could not be determined if she overdosed intentionally or accidentally.

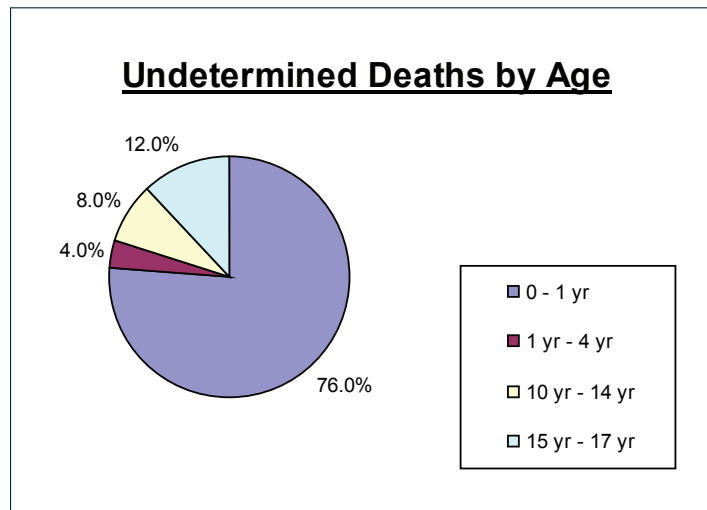
Undetermined: This was a sixteen (16) year old Black male with a history of Cerebral Palsy as a result of Abusive Head Trauma in infancy. He was found in bed. Due to the child's age and medical history, it would not be appropriate to include this child under the category of sleep-related.

Ischemic Encephalopathy: This child had a brain-bleed that ultimately caused brain death. She was removed from life-support and passed away. Autopsy found that a diagnosis of Abusive Head Trauma could not be made. The exact full cause of death reads as: Ischemic encephalopathy due to intra-cerebral hemorrhages and cerebral infarctions due to hemorrhagic disease of newborn. This child had a disease like hemophilia, where she was unable to stop bleeding. The manner of death was considered undetermined instead of natural because the exact disease was not discovered.



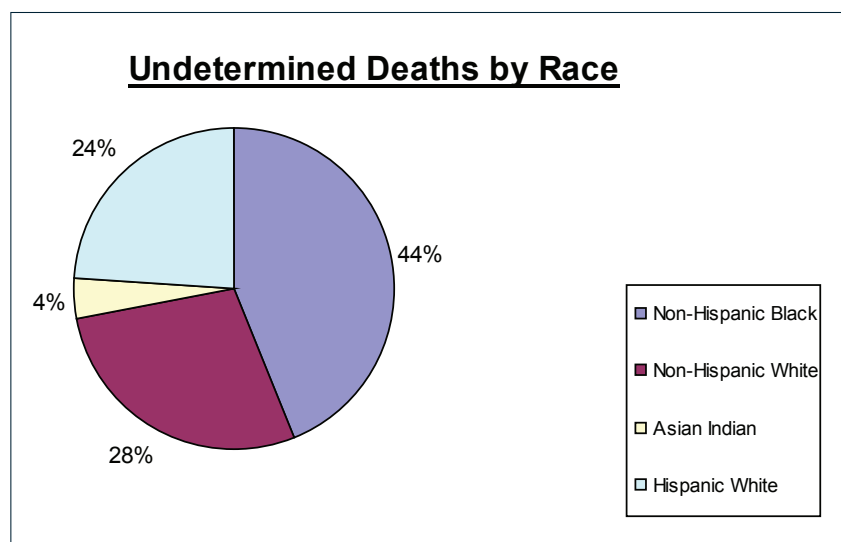
Age

Of the twenty-five (25) cases reviewed with an undetermined manner of death, nineteen (19) or seventy-six percent (76%) of the children were less than one (1) year old. Between the ages of one (1) and four (4), only one (1) child, or four percent (4%), had an undetermined manner of death. Between ten (10) and fourteen (14) years old, two (2), or eight percent (8%) of the children had an undetermined manner of death. Finally, between the ages of fifteen (15) and seventeen (17), three (3), or twelve percent (12%), had an undetermined manner of death. No children between the ages of five (5) and nine (9) had an undetermined manner of death.



Race

Undetermined deaths reviewed by race give the following percentages: Non-Hispanic Black: Forty-four percent (44%), eleven (11) out of twenty-five (25); Non-Hispanic White: Twenty-eight percent (28%), seven (7) out of twenty-five (25); Asian Indian: Four percent (4%), one (1) out of twenty-five (25); Hispanic White: Twenty-four percent (24%), six (6) out of twenty-five (25). Given the 2010 Census data on race within the general population of New Jersey, White and Asian children are under-represented while Black and Hispanic children are over-represented.



Sex

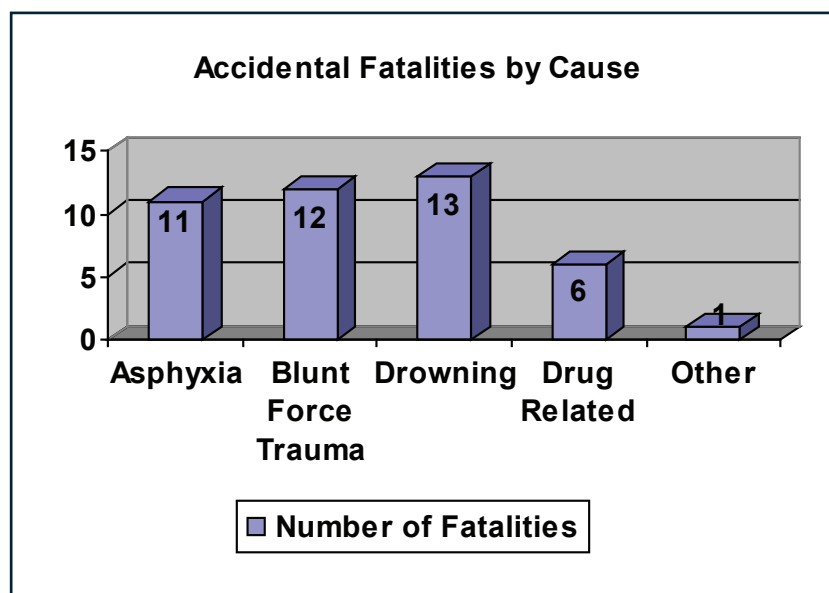
Of the twenty-five (25) child deaths reviewed in 2010 with an undetermined manner of death, seven (7) or twenty-eight percent (28%) were female and eighteen (18) or seventy-two percent (72%) were male, showing once again that male children are at higher risk than female children.

ACCIDENTAL DEATHS

The leading cause of accidental fatalities was drowning with thirteen (13) cases. Twelve (12) cases involved fatal blunt force trauma injuries. In eleven (11) cases, the cause of death was due to asphyxia or was asphyxia-related. Six (6) cases were drug related fatalities, and one (1) case was due to cervical compression.

In five (5) cases, male teenagers died as a result of drug-related causes. One seventeen (17) year old male died due to the adverse effect of drugs. He tested positive for cocaine, methadone, Xanax and alcohol. Another seventeen (17) year old male died due to Oxycodone toxicity with contributory Hypertonic Cardiomyopathy. A seventeen (17) year old male died due to acute heroin intoxication. A seventeen (17) year old male died due to acute Fentanyl and ethanol intoxication. A sixteen (16) year old male died due to an adverse reaction to prescription drugs. He also tested positive for methadone and benzodiazepines. The sixth drug-related fatality was of a 2 month old infant who died suddenly in the Emergency Department after being brought in for a fever. Lab results indicated that the child died from acute diphenhydramine (antihistamine) toxicity. The child was given 25 mg of Benadryl in the hospital after the child entered cardiac arrest and CPR was initiated.

In one (1) case, a two (2) year old child was pinned between two (2) portable cribs and a bedroom wall. The child died due to cervical compression.



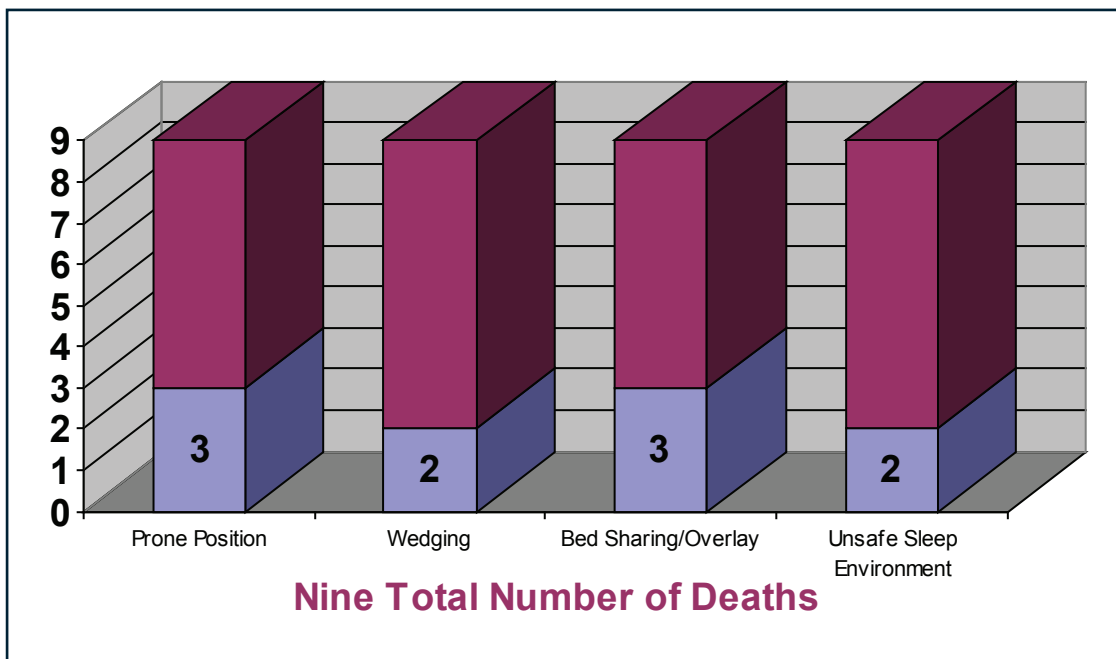
POSITIONAL ASPHYXIA

Of the eleven (11) asphyxia cases, nine (9) had a cause of death of positional asphyxia⁹ (the other two (2) cases were due to choking on, or aspiration of, food). That means that twenty-one percent (21%) of all accidental cases were due to positional asphyxia. Seven (7) of these cases were of children under the age of one (1); the other two (2) children were under the age of two (2).

Three (3) of the children were placed to sleep in the prone position; three (3) were co-sleeping with adults and were either certified as due to overlay, or overlay could not be ruled out; two (2) were the result of wedging, and two (2) due to unsafe sleep practices (a blanket was found over the child's face in one instance; in the other there was both soft bedding and prone position).

Types of Positional Asphyxia

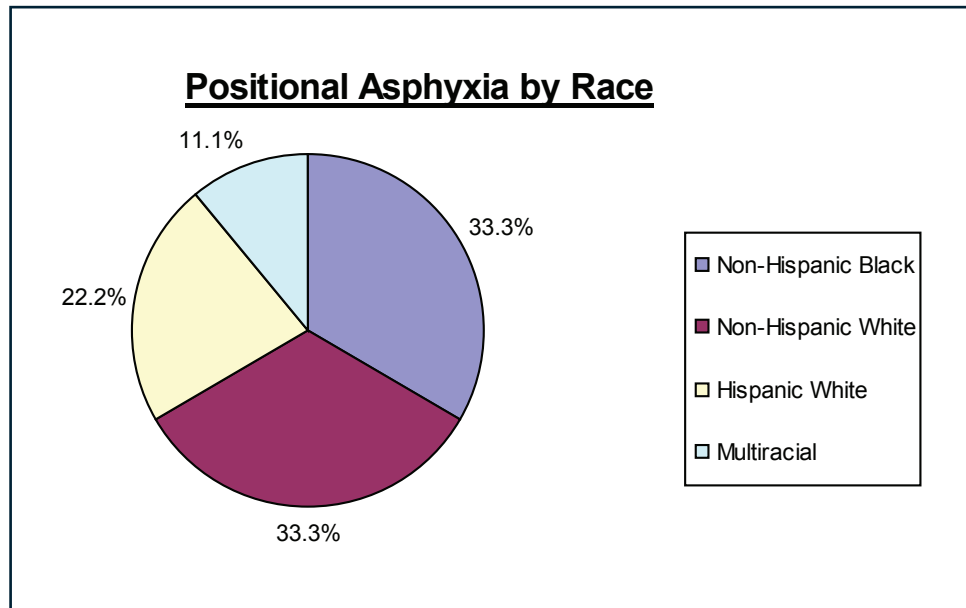
Positional asphyxia was the cause for 80% (12 of 15) of the accidental asphyxia cases reviewed. Safe sleep concerns were noted in all 12 of the cases. All of the infant victims were under eight months old with 83% of positional asphyxia cases occurring prior to three months old. In 6 of the 12 cases an infant was sharing a bed or couch with a parent, caretaker, or sibling and overlay or wedging was determined to be a contributory factor in 4 of the cases. In 8 of the 12 cases the infant was found unresponsive in the prone position.



⁹ One of these cases was classified as "SUID with blanket over face."

Race

Thirty-three point three percent (33.3%) of the positional asphyxia deaths were Non-Hispanic Black children and thirty-three point three percent (33.3%) were Non-Hispanic White children (three (3) children of each race). Twenty-two point two percent (22.2%), two (2) out of nine (9) were Hispanic (White) and eleven point one percent (11.1%), one (1) out of nine (9) were multiracial (in this case, the child had one (1) Black parent and one (1) White parent).



Sex

Only one (1) of the nine (9) children was female, making eighty-nine percent (89%) of the child deaths due to positional asphyxia male.

DROWNING FATALITIES

The CFNFRB reviewed fifteen (15) drowning fatalities which occurred in 2010. In two (2) of the cases reviewed, the children were residents of other states (Pennsylvania and New York), and in one (1) case, the child resided in another country (England).

Thirteen (13), or eighty-seven percent (87%), of the drowning fatalities were determined to be accidental in manner; however, homicide was the manner of death for two (2), or thirteen percent (13%), of the drowning fatalities. In one (1) of the homicide cases, the father wrapped his child in a blanket and threw her out of the passenger side window while driving. The child was thrown over the rail of a bridge into a

river. She died of asphyxia due to drowning and blunt force impact of the head. In the second homicide case, the child was involved in a confrontation where gunshots were fired. Attempting to flee, the child jumped over a railing and landed in a river. The child was unable to swim, and bystanders and police were unable to rescue him. The child sustained gunshot wounds of the torso prior to drowning.

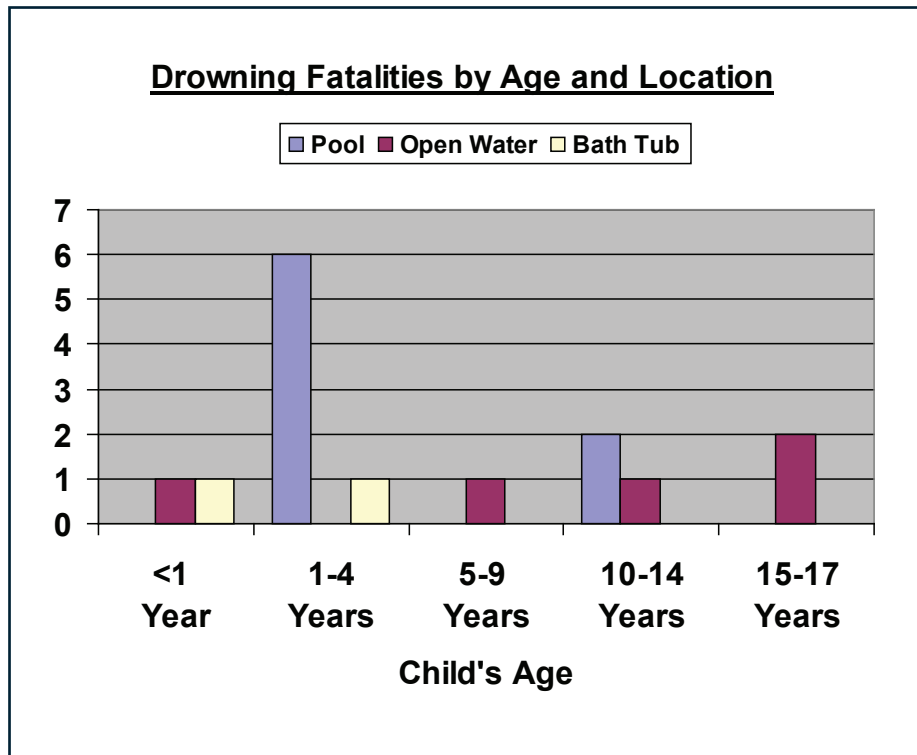
Location of Drowning Fatalities

Eight (8) or fifty-three percent (53%), of the drowning fatalities reviewed in New Jersey occurred in a pool. Six (6) of the eight (8), or seventy-five percent (75%), of pool drowning fatalities occurred with children ages one (1) to four (4) years old. The majority, seventy-five percent (75%), of the pool drowning fatalities happened in a residential pool. Only two (2), twenty-five percent (25%), occurred in a non-residential, in-ground pool. A ten (10) year old child was attending a family member's birthday party at a hotel where he drowned. A three (3) year old child was accompanied by a neighbor to a community pool. The child was left unsupervised and drowned.

Of the six (6) residential pool drowning fatalities, five (5), or eighty-three percent (83%), took place in an in-ground pool. One (1) child, age thirteen (13), was playing with his cousin in a relative's pool. The family was nearby the pool. They thought the children were playing and did not recognize that he was in distress. Four (4) other children were able to obtain access to an in-ground pool and drown. Only one (1), or seventeen percent (17%), of the residential pool drowning fatalities occurred in an above-ground pool. In that instance, the three (3) year old child was being cared for by a relative. While the relative was watching television, the child was able to get out of the house, ascend the pool's ladder, and drown. The pool's safety ladder was installed improperly thus allowing the child to climb it and gain access to the pool.

Five (5) or thirty-three percent (33%), of the drowning fatalities reviewed in New Jersey occurred in open water (i.e.: lake, river, pond, ocean, etc.). Two (2) fatalities occurred in a river, two (2) occurred in a pond, and one (1) occurred in a lake. An eight (8) year old autistic child exited his home and drowned in a retention pond behind his home while his father was inside taking a nap. A seventeen (17) year old child and his father were steering remote control boats when the child jumped unexplainably into the pond. The father jumped into the water after his child and also drowned. Both individuals tested positive for marijuana. A fourteen (14) year old child drowned in a lake while on vacation with a friend and his family. The children were swimming in the lake when the child asked for help. The other children thought he was joking, but the child did not make it back to shore and drowned.

Two (2) or thirteen percent (13%), of the drowning fatalities occurred in a bathtub. A (4) year old, multiply disabled child drowned while in the care of a CP&P resource home provider. The child accessed the bathroom where the tub was half filled with water. An eleven (11) month old child drowned in the bathtub while his mother was talking on the telephone.



Reasons Why Children Drown

- Weak or no supervision
- No barriers (i.e.: covers on hot tubs, fencing with self-latching gates surrounding pool, pool alarms, exposed ladders and diving boards, open containers/areas of water within child's reach)
- Weak or no CPR skills
- Weak or no swimming ability
- Lack of life jacket use
- Youth involved in risky behavior while swimming in water including, but not limited to, the use of drugs and alcohol and swimming in prohibited public areas of water

Supervision

Supervision plays an important role in the prevention of child drowning fatalities. Of the fifteen (15) drowning fatalities reviewed in 2010, three (3) of the caregivers were substantiated for inadequate supervision by CP&P. In eight (8) additional cases, the CFNFRB noted concerns regarding the caregiver's 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, watching television, doing home chores, or caring for other children.

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, and alarms on doors leading directly to pools, pool alarms, and lifeguards.

BLUNT FORCE TRAUMA

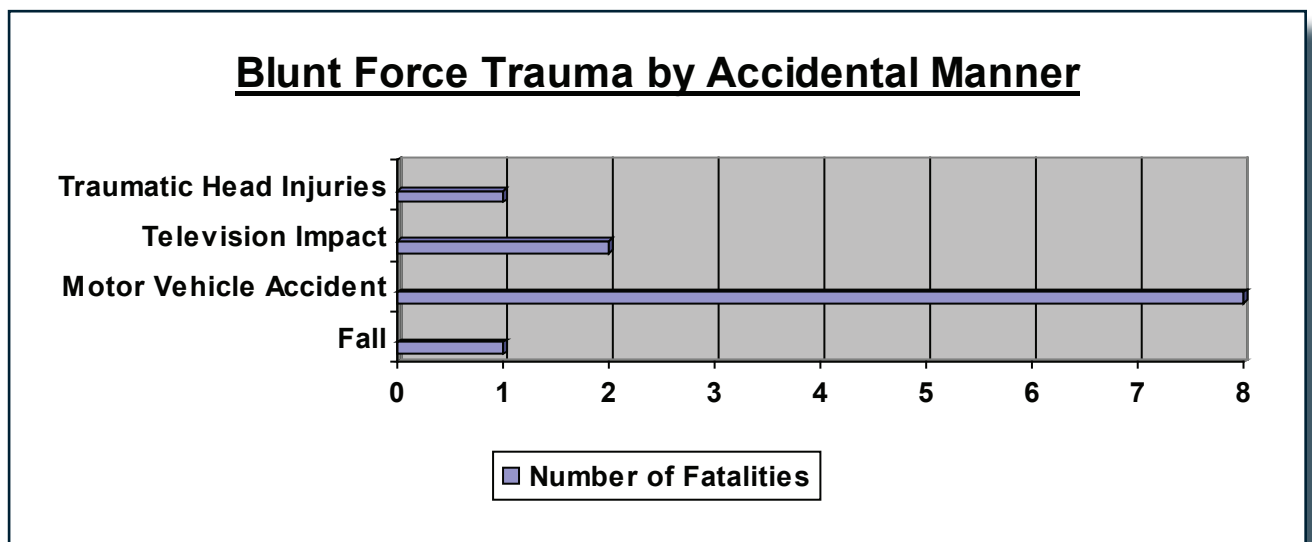
In 2010, the CFNFRB reviewed twelve (12) fatalities in which the manner of death was accident, and the cause was blunt force trauma. Eight (8) or sixty-seven percent (67%), of these cases involved motor vehicles. Five (5) cases involved a motor vehicle accident. In one (1) case, a seventeen (17) year old male's vehicle was struck by a truck. The child was unrestrained. A seventeen (17) year old female struck a tree while driving at high speeds. The child was under the influence of various illegal substances. A sixteen (16) year old female was a passenger in a fatal motor vehicle accident. She was under the influence of alcohol. A sixteen (16) year old unrestrained male was under the influence of marijuana at the time of his fatal accident. A seventeen (17) year old male lost control of his vehicle, and it overturned. This child's autopsy toxicology report showed trace amounts of marijuana in his system.

Three (3) cases involved a child being struck by a motor vehicle. In one (1) case, a seventeen (17) year old was struck by a vehicle while riding his bicycle. The child was under the influence of alcohol and marijuana. Two (2) children were unknowingly struck by a vehicle their grandparent was operating.

In two (2), or seventeen percent (17%), of the cases reviewed, a television fell on a child causing fatal head injuries. In one case, three (3) year old child climbed a dresser causing it to fall along with the twenty-four inch (24") television which was situated on top of it. In the other case, a three (3) year old child caused a table to tip over with a twenty-five inch (25") television on it.

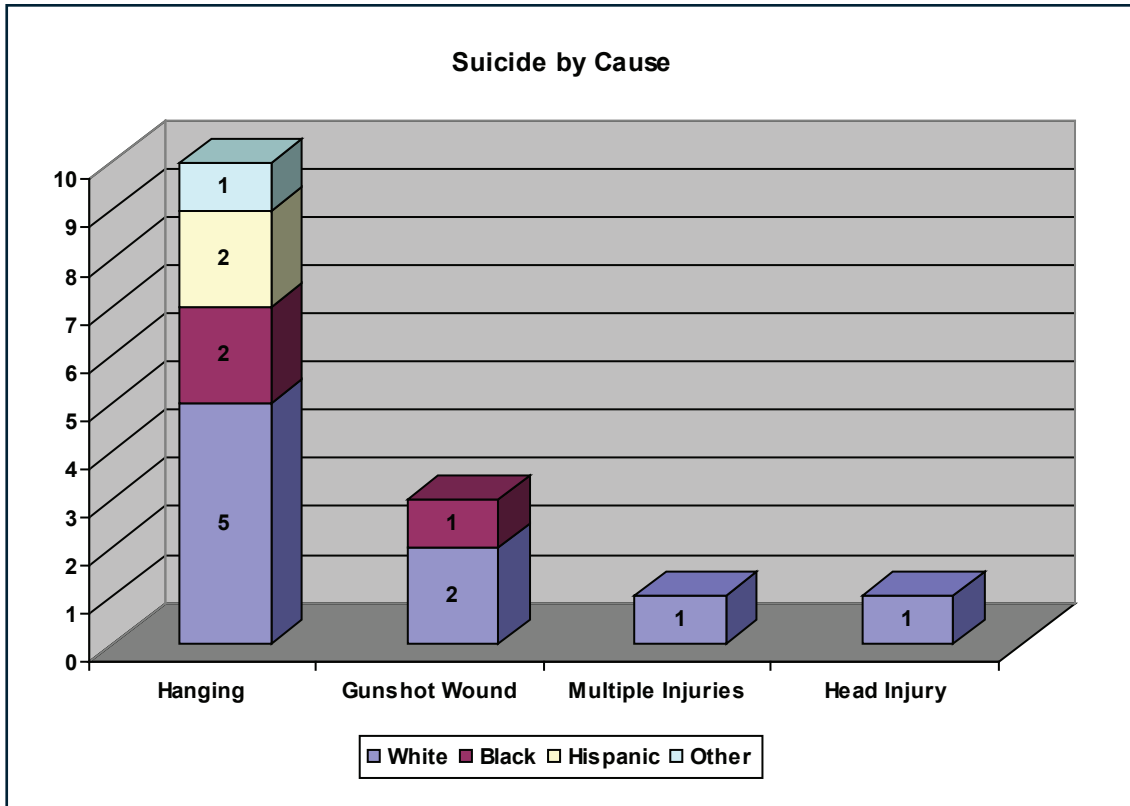
In one (1) case, or eight percent (8%), a two (2) year old child fell out of the family's second story window. The child suffered blunt trauma to the head due to the fall.

In another case, a six (6) month old child suffered traumatic head injuries while in the care of his father: the father was playing with the child by throwing him up into the air; the father lost his grip on the child and the child hit his head on a headboard of a bed. The father was substantiated by CP&P for child abuse.



SUICIDE DEATHS

The cause of death in ten (10), sixty-seven percent (67%), of the suicide deaths was due to hanging. Three (3), twenty percent (20%), were due to self inflicted gunshot wounds. In one (1) case, the child attempted to play Russian roulette, and he shot himself in the head. One (1), seven percent (7%), was due to cranio-cerebral injuries, where the child jumped off the roof of a residential home. One (1), seven percent (7%), was due to multiple injuries where the child was hit by a tractor trailer upon running onto a highway.



Suicides by Race and Age

In 2010, there were fifteen (15) fatalities due to suicide. Eleven (11), or seventy-three percent (73%), of these victims were male, and four (4), or twenty-seven percent (27%), were female. Of these fatalities, nine (9), or sixty percent (60%), were White (Non-Hispanic), three (3), or twenty percent (20%), were Black (Non-Hispanic), two (2), or thirteen percent (13%), were Hispanic, and one (1), or seven percent (7%), was Multi-racial, (Black, White and Native American).

All of the children were between the ages of thirteen (13) and seventeen (17) years old. The majority of the children, forty percent (40%), were age seventeen (17). Three (3), or twenty percent (20%), of the children were age sixteen (16), two (2), or thirteen percent (13%), were age fifteen (15), three (3), or twenty percent (20%), were age fourteen (14), and one (1), or seven percent (7%), was age thirteen (13).

Adolescent Risk Factors

Mental health: In seventy-three percent (73%), or eleven (11), of the suicide deaths the victim had a history of mental health diagnosis. Eight (8) of the victims were involved with out-patient mental health treatment in the past and at the time of their death. Five (5) victims received out-patient mental health treatment in the past, but were not engaged in services at the time of their death. Two (2) victims had no mental health treatment history or the history was unknown.

Substance Abuse: In less than half, forty percent (40%), of the suicide fatalities, past or current drug or alcohol use was noted. In three (3) of these six (6) cases, autopsy reports show that the victims tested positive for illegal substances. In the remaining three (3) cases the victims admitted to using alcohol or illegal drugs in the past.

Family/Relationships: In five (5) cases family conflict was noted prior to the suicide. In four (4) cases relationship troubles with a boyfriend or girlfriend were noted. In three (3) cases the children had experienced a significant loss in their life. One (1) child's cousin committed suicide, one (1) child's mother and two (2) uncles died, and one (1) child's grandmother died.

Prior Attempts: Five of the victims had previously attempted to commit suicide. An additional three (3) victims previously admitted to having suicidal ideations.

Physical Abuse: There was only one (1) case where physical abuse was noted. However, six (6) cases had a previous DCP&P history.

School Problems: In one third (1/3) of the suicide fatalities, school problems (i.e.: disciplinary, truancy, academic or behavioral) were identified. Four (4) children were classified by a Child Study Team.

Juvenile Criminal History: Three (3) of the victims of suicide were on probation. One (1) victim had a criminal history of theft, and one (1) victim had an upcoming court case regarding a drug charge.

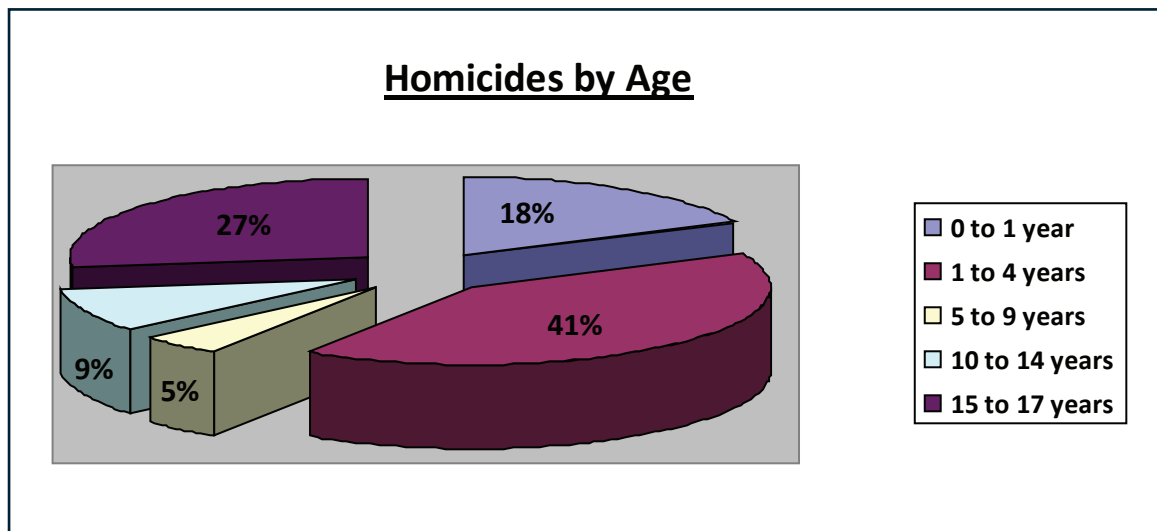
HOMICIDE DEATHS

The Child Fatality and Near Fatality Review Board reviewed twenty-two (22) homicide fatalities that occurred in 2010. Nine (9) victims suffered various fatal blunt force trauma injuries, eight (8) victims suffered fatal gunshot wounds, one (1) victim died from multiple stab wounds, another victim died from asphyxia by smothering, one (1) child suffered blunt force trauma and drowned, another child suffered a gunshot wound and drowned, and one (1) child died from morphine toxicity.

Of the twenty-two (22) homicide fatalities reviewed, CP&P had an active case with seven (7) of the families. Seven (7) cases were opened as a result of the child's homicide. Two (2) cases were closed over a year prior to the homicide, and two (2) cases were closed within a year of the fatality. In four (4) cases, the families were not known to CP&P.

Age of Homicide Victim

Nine (9) children ages one (1) to four (4) years old were killed as a result of homicide. Six (6) children ages fifteen (15) to seventeen (17) were killed. Four (4) children under a year old were killed. Two (2) children between ten (10) and fourteen (14) years old and one (1) child between five (5) and nine (9) years old were killed.



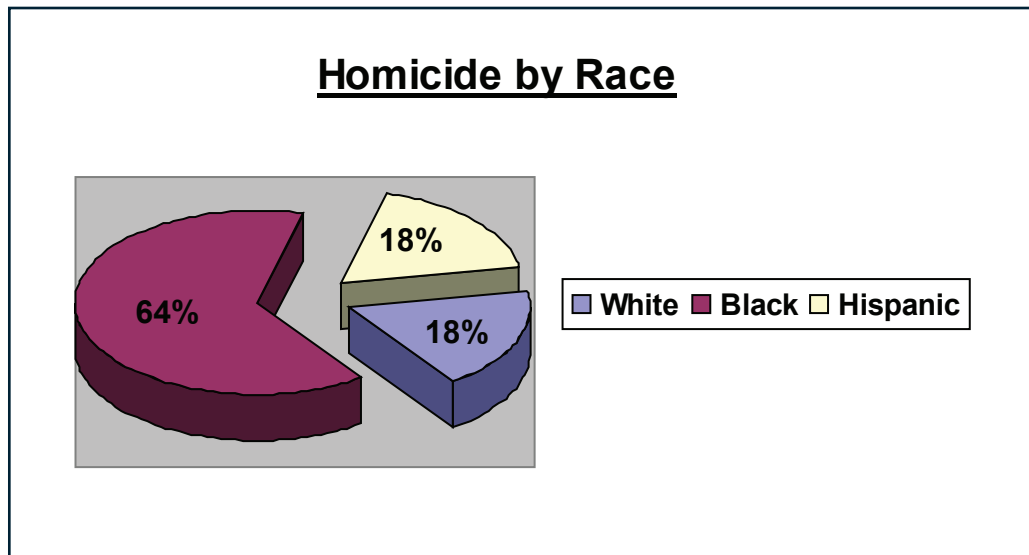
Of the homicide fatalities, fifty-eight percent (58%) of the children whose death was ruled to be related to child abuse and neglect were aged one (1) to four (4) years old. Children whose death was not ruled to be due to child abuse and neglect were primarily age fifteen (15) to seventeen (17), sixty-three percent (63%). In the majority, eighty percent (80%), of these homicides the victim suffered fatal gunshot wounds.

Gender of Homicide Victim

Of the twenty-two (22) homicide fatalities of 2010, thirteen (13), or fifty-nine percent (59%), of the victims were male. Nine (9), or forty-one percent (41%), of the victims were female.

Race of Homicide Victim

The majority, sixty-four percent (64%), of the victims of homicide were Black, Non-Hispanic. Four (4) of the victims were Hispanic, and four (4) were White, Non-Hispanic.

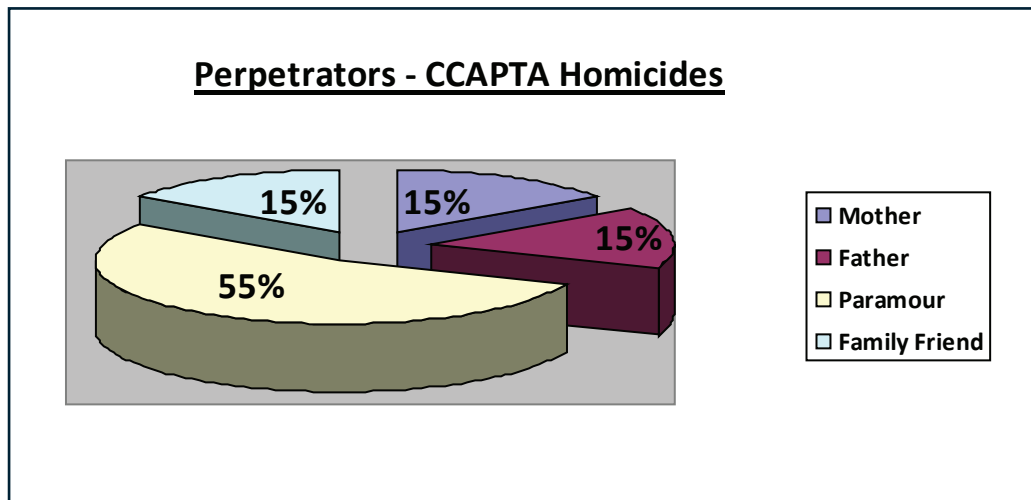


CCAPTA Perpetrators of Child Abuse and Neglect

The majority of homicides reviewed involved the caregiver inflicting a fatal injury to the child. Twelve (12) of the child fatalities were classified as CCAPTA cases and were all substantiated for abuse or neglect. Fifteen (15) perpetrators were substantiated in the twelve (12) cases. The parent's paramour comprised seven (7) of the perpetrators. In six (6) cases, the child suffered fatal blunt impact injuries due to the paramour. Another child was fatally shot by a paramour.

Two (2) of the perpetrators were the child's father. One (1) child suffered from asphyxia due to smothering. A second child was thrown over a bridge into a river by her father. Two (2) perpetrators were the mother. In both cases, the mother and her paramour were substantiated for the child abuse or neglect. These children both suffered fatal blunt impact injuries.

Two (2) perpetrators were family friends acting in a caregiver role for the child at the time of his fatality. Two (2) perpetrators were babysitters. The two (2) children suffered fatal head injuries.



Non-CCAPTA Homicides

In 2010, ten (10) homicide cases were non-CCAPTA cases. Six (6) of these homicide fatalities reviewed involved a perpetrator who was not a parent or caregiver. In another of the homicide fatalities reviewed, the perpetrator was unknown. The child died as a result of acute morphine toxicity. In an additional case, a father fatally shot his pre-teen son. Another father fatally shot his two (2) children, and then he killed himself.

Eight (8) of the ten (10) fatalities resulted in deaths due to gunshot wounds. In one (1) of these cases, the child died from both a gunshot wound and drowned. In another case, one (1) child was stabbed during an argument with another teenage girl over a boy.

Risk Factors for Victims of Homicide

In 2010, there was a greater risk for youths to become a victim of homicide by a non-caregiver when firearms were easily accessible. All five (5) children who were shot by a non-caregiver had one (1) or more of the following risk factors: criminal activity, drug dealing and/or substance abuse, gang membership, mental illness, runaway behavior, no active caregiver, anger and behavioral issues. Two (2) children were on probation at the time of their death. The child stabbed to death tested positive for illegal substances as a result of autopsy toxicology results.

CHILD PROTECTION AND PERMANENCY (CP&P)

As of January 2011, approximately forty-four thousand eight hundred and seven (44,807) children were receiving services from CP&P.¹⁰ The Child Fatality and Near Fatality Review Board (CFNFRB) and its regional teams identified and reviewed a total of one hundred and sixty (160) fatalities and thirteen (13) near fatalities which occurred in 2010.

In thirty-three (33), or nineteen percent (19%), of cases reviewed, CP&P had an open case with the family at the time of the fatality or near fatality, and they were offering some type of family intervention (i.e.: child welfare assessment, protective service investigation, or care and supervision).

CP&P had terminated involvement with eleven (11), or six percent (6%), of the families within the twelve (12) months preceding the fatality or near fatality.

Eleven (11) or six percent (6%), of the families had a history with CP&P longer than twelve (12) months prior to the child's fatality or near fatality.

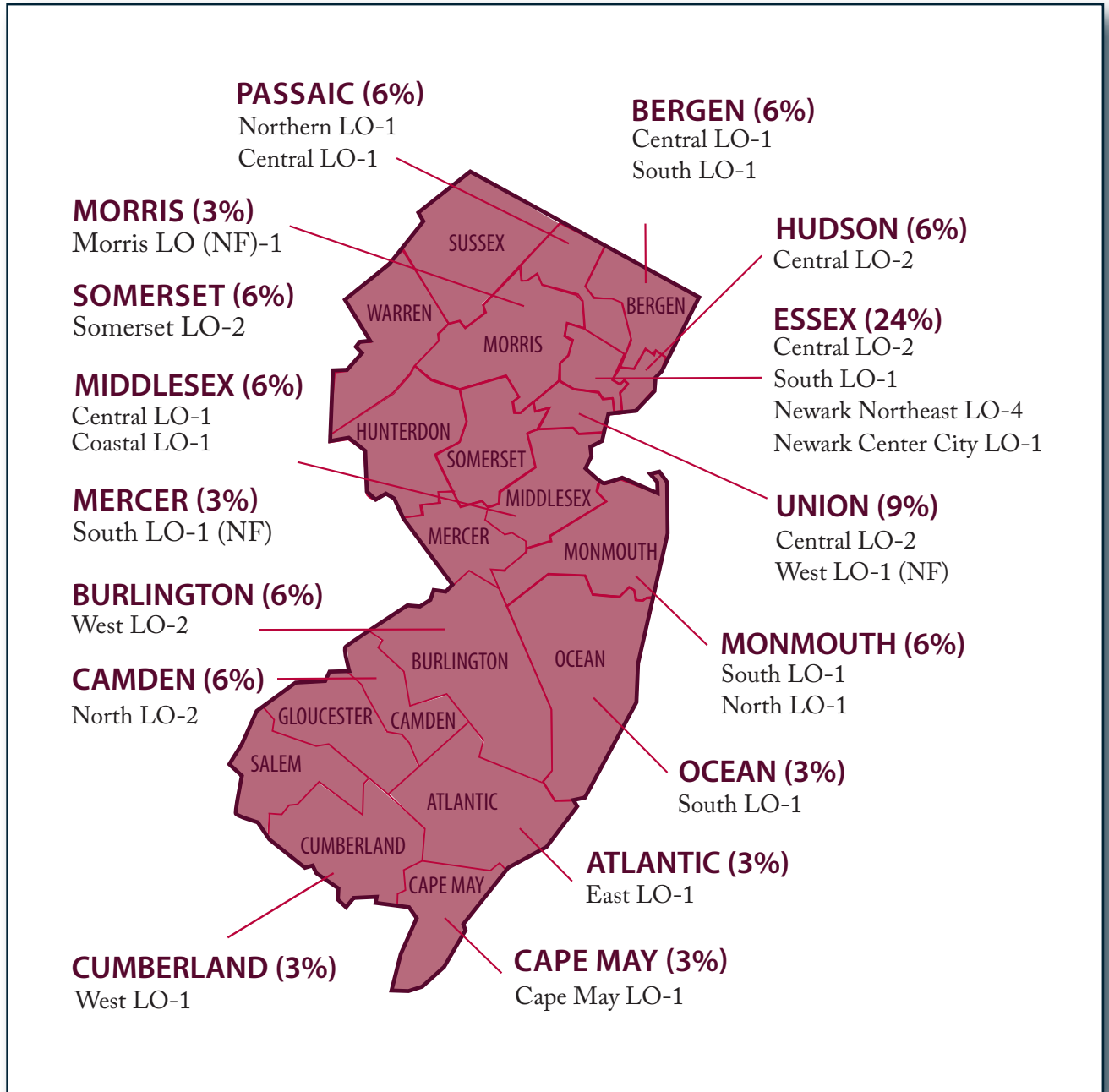
In fifty-one (51), or twenty-nine percent (29%), of the cases reviewed, CP&P responded to a call on or after the date of the child's injury or death.

Sixty-seven (67) or thirty-nine percent (39%), of the cases reviewed had no CP&P involvement prior to the child's injury or death. These cases include fatalities which were either not reported to SCR, forty-four (44), or were reported but did not rise to the level of abuse or neglect required to complete a child protection services (CPS) investigation or a child welfare service (CWS) assessment, twenty-three (23).

¹⁰ http://www.state.nj.us/dcf/childdata/dcppdemo/DCPPchildrenJan06-Jun12_080612.pdf

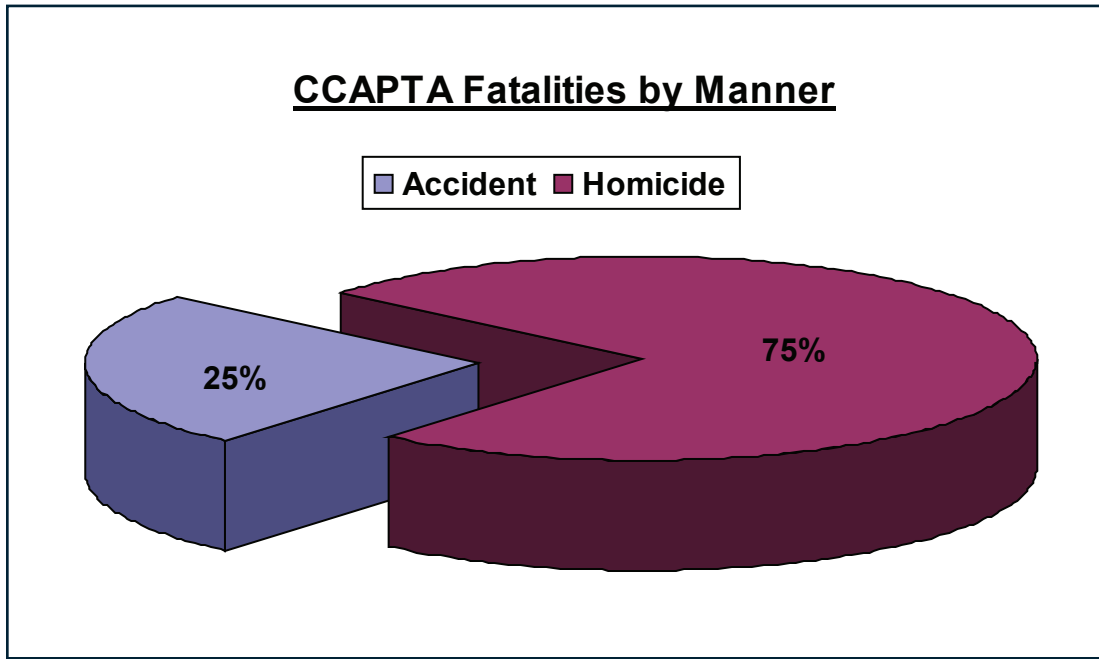
Fatalities with Open CP&P Cases by County

In 2010 the CFNFRB found a higher incidence of fatalities with open CP&P cases in Essex County.



CCAPTA Fatalities by Manner

Of the sixteen (16) CCAPTA fatalities reviewed, homicide was determined to be the leading manner of death with twelve (12), or seventy-five percent (75%), while four (4), or twenty-five percent (25%), of incidents were classified as accidents.



CCAPTA Fatalities by Cause

Blunt impact injuries and/or head trauma were the leading cause of death for the CCAPTA fatalities reviewed with ten (10), or sixty-three percent (63%), of the total cases. The manner of death in nine (9) of these cases was homicide; in one (1) case the manner was accident.

Drowning was the second leading cause of death with four (4), or twenty-five percent (25%), of the cases. Three (3) were accidents, and one (1) was a homicide. The child who died due to drowning also suffered blunt force impact injuries to the head. The child was thrown over a bridge into a river.

One (1) child, six percent (6%), died as a result of gunshot wounds. The mother's paramour murdered the child, his mother, and maternal uncle. One (1) child, six percent (6%), died due to asphyxia by smothering. In other case, the child died due to acute morphine toxicity. The manner of death in these two (2) fatalities was homicide.

CCAPTA Near Fatal Incidents

The CFNFRB reviewed twelve (12) near fatalities which had been designated as CCAPTA cases, and all twelve (12) were substantiated for either abuse and/or neglect. Of the twelve (12) cases reviewed, seven (7), or fifty-eight percent (58%), involved near fatal head injuries and/or other non-accidental trauma to the body. In five (5) of the seven (7), or seventy-one percent (71%), of near fatal traumatic injuries, the mother was indicated as a substantiated perpetrator. The child's father was substantiated in three (3), or forty-three percent (43%), of these cases as well as one (1) unknown perpetrator and one (1) paternal grandfather, each fourteen percent (14%).

The other five (5) near fatalities include:

- Two (2) children who suffered from an overdose: one (1) from methadone ingestion and one from clonidine ingestion. The child's mother was substantiated in one (1) case, and both parents were substantiated in the other.
- One (1) child who suffered from dehydration and malnourishment as well as sustaining other injuries. The child's adoptive parents were substantiated for abuse and neglect.
- One (1) child who nearly drowned in a bathtub. The mother was substantiated for neglect, inadequate supervision.
- One (1) child who received multiple serious injuries when a dining room table fell on him. The mother was substantiated for neglect.

CCAPTA Substantiated Perpetrators

The CFNFRB found that in the twenty-eight (28) CCAPTA cases there were a total of thirty-six (36) substantiated perpetrators. Twenty-one (21) of the thirty-six (36), or fifty-eight percent (58%), substantiated perpetrators were parents. The mother, acting alone or with a significant other, accounted for twelve (12) of the substantiations; the father, acting alone or with a significant other, accounted for nine (9) substantiations. In four (4) of these incidents, it was both the mother and father who were substantiated as perpetrators in the child's fatality or near fatality.

Seven (7) or nineteen percent (19%), of the perpetrators were the mother's paramour. In five (5) of these seven (7) cases, the paramour acted alone. In one (1) case, the paramour murdered the child, mother, and maternal uncle. In the other four (4) cases, the children suffered blunt impact trauma resulting in their deaths.

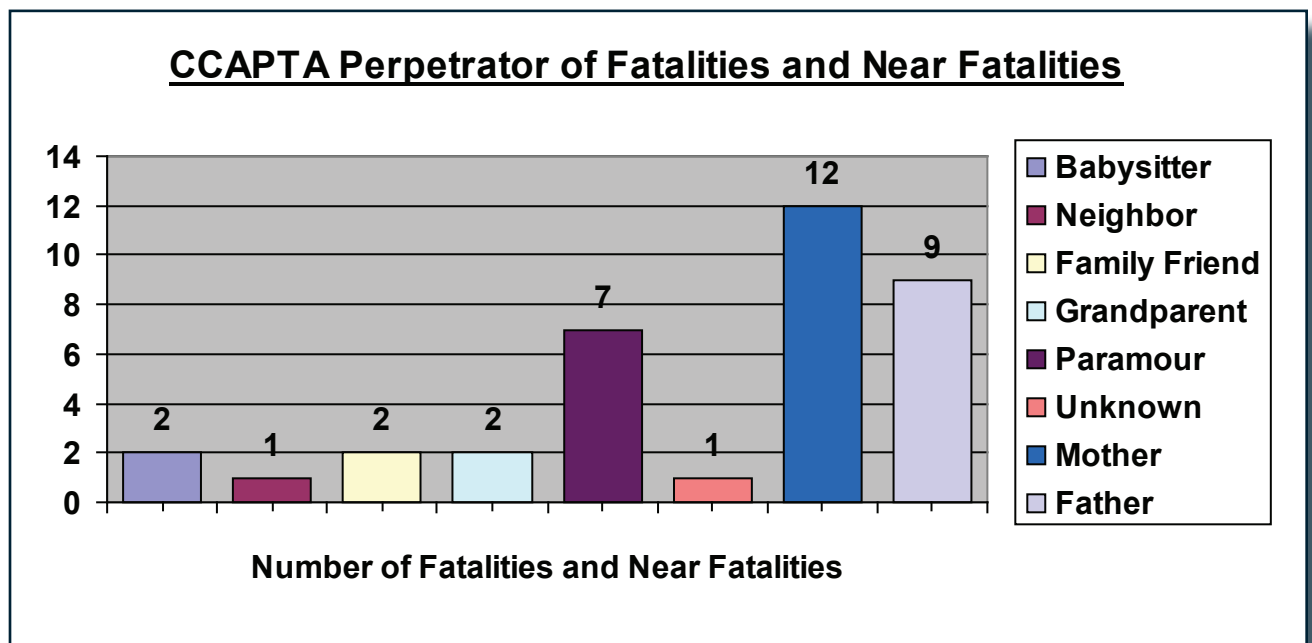
The mother and her paramour were substantiated in two (2), or seven percent (7%), of the cases. In both cases, the children died due to receiving blunt impact injuries.

Grandparents were perpetrators in two (2), or seven percent (7%) of cases. In one (1) case, the maternal grandmother was substantiated due to lack of supervision. Her grandchild drowned while in her care. In another case, the paternal grandfather was substantiated along with the child's father for physical abuse. The child suffered near fatal injuries.

In one (1), or four percent (4%), of the cases, the perpetrator was unknown. A child suffered abusive head trauma; however, the medical examiner, law enforcement and CP&P were unable to determine who inflicted these injuries to the child.

Two (2) babysitters were substantiated for abuse in two (2) different cases; seven percent (7%). One (1) child died as a result of blunt head trauma, and one (1) child died of complications of acute cerebrospinal trauma.

A neighbor was substantiated for neglect in one (1) case, four percent (4%). The child in her care drowned at a local community pool. A family friend and her spouse were substantiated for neglect after the child died of multiple blunt traumatic injuries.



CCAPTA TRENDS, 2001-2010, TEN YEAR DATA FAMILY'S INVOLVEMENT WITH CP&P

Ten (10) years worth of data has been collected with regards to CCAPTA fatalities, children whose fatality was a result of child abuse or neglect. It is interesting to note that the number of families who were involved with CP&P at the time of the fatality has significantly decreased over ten (10) years. In 2001 and 2002, ten (10) and eight (8) families, respectively, were involved with CP&P when a child died as a result of abuse or neglect. In 2009 and 2010, five (5) and three (3) families, respectively, had an open case with CP&P when the fatality occurred.

The data seems to suggest that the number of cases where the family was not previously known to CP&P or had a previous history, but were not currently involved, has remained consistent. Years 2009 and 2010 had the lowest numbers of reported CCAPTA fatalities of the ten (10) years.

CCAPTA TRENDS, 2007-2010, FOUR YEAR DATA PERPETRATOR, MANNER/CAUSE OF DEATH, AND AGE/RACE/GENDER/COUNTY OF VICTIM

Perpetrator

Parents are most frequently named as perpetrators of abuse or neglect for cases resulting in the death of a child. Together, they make up sixty-four percent (64%) of the substantiations. The mother was substantiated for abuse or neglect in thirty-eight percent (38%) of the CCAPTA fatality cases while the father was substantiated in twenty-six percent (26%) of the cases. In nineteen percent (19%) of the cases, the parent's paramour was substantiated for child abuse or neglect. Relatives were substantiated in eight percent (8%) of the CCAPTA cases followed by babysitters at five percent (5%), step-parents and unknown perpetrators at two percent (2%) and neighbors at one percent (1%).

Manner and Cause of Death

In over two-thirds (2/3) of the CCAPTA cases, or seventy percent (70%), the child's death was certified as a homicide. Twenty-five percent (25%) of the cases were certified as an accident. Natural and undetermined manners of death were each certified at a rate of two percent (2%). One (1) case was certified a suicide. The child died due to the adverse effect of drugs that were obtained from her mother's supply.

In half (1/2) of the CCAPTA cases, or fifty percent (50%), the child died as a result of various blunt force traumas. In twenty-one percent (21%) of the cases a child drowned and a caregiver was substantiated for abuse or neglect. In nine percent (9%) of the cases, a child died as a result of gunshot or stab wounds. Asphyxia was the cause of death in eight percent (8%) of the CCAPTA cases reported.

Age/Race/Gender/County of Victim

In just under half (1/2), or forty-seven percent (47%), of the CCAPTA cases reported, the child victim was under the age of one (1) year old. In thirty-seven percent (37%) of the cases, the child was between the ages of one (1) and four (4) years old. Only approximately fifteen percent (15%) of children died as a result of abuse or neglect over the age of five (5) years old.

With regards to race, almost half (1/2), or forty-seven percent (47%), of the children who died as a result of abuse or neglect were Black. White children made up twenty-four percent (24%) of the CCAPTA cases, and Hispanic children were victims in twenty-two percent (22%) of the CCAPTA cases. Two percent (2%) of the child victims were classified as other, one percent (1%) were biracial (white and black), and three percent (3%) were unknown.

In a majority of the cases, or fifty-eight percent (58%), the child victim was male. In 2007 and 2008, the victims were evenly divided by gender. However, in 2009 and 2010, males were disproportionately more often the victim. In 2010, male victims accounted for seventy-five percent (75%) of the CCAPTA cases.

Every county in New Jersey had reported at least one (1) child fatality between 2007 and 2010 with the exception of Hunterdon County. Essex County had the most CCAPTA fatalities with eighteen (18) cases; however, if child population is considered, Cumberland County reported the most CCAPTA fatalities with five (5) cases. Camden County reported the second highest number of total CCAPTA fatalities with ten (10) cases; however, Atlantic County reported the second highest when child population is considered with eight (8) cases.

RECOMMENDATIONS AT A GLANCE

Over the last ten (10) years, the CFNFRB made numerous recommendations with a variety of successes and with some recommendations still pending.

In the first few years of reviews, the Board recommended an Annual progress report, by 2005 this became a standard report and in 2009 the Board began to review cases within the year the death occurred unless unable to do so, i.e.: cases of homicide, or later in the calendar year, so that reports are timely and, consequently, so are the recommendations. Over the years, the data collected and the reports issued have evolved. One of the recommendations that made this possible is that the Department of Children and Families, the Office of the State Medical Examiner, as well as the Department of Health and Senior Services all notify the Board support staff within twenty-four (24) hours to thirty (30) days of a child fatality.

In 2002, 2007, and 2008 the Board made various recommendations in regards to Safe Sleep education in an attempt to discourage bed sharing and unsafe sleep environments. In 2009, in a Memorandum of Understanding with the Department of Health and Senior Services and the Department of Children and Families, New Jersey became one (1) of six (6) states to collect and analyze data and create a prevention action plan to minimize Sudden Unexpected Infant Deaths under a grant through the Centers for Disease Control and Prevention. Every CP&P worker, Office of Licensing (OOL), and resource worker are trained in Safe Sleep practices now.

Recommendations with regard to improving case practice, caseload size, training availability and how to assess safety in homes were identified over the years as concerns for Child Protection and Permanency, New Jersey's Child Protective Services agency. The Safety Decision Making (SDM) tool, Risk Assessment tool, New Jersey Spirit (state automated child welfare information system), mandated case load caps, Domestic Violence protocol and training and the new case practice model meet these recommendations and were implemented over the years.

The one continuing recommendation that the Board makes with little to no progress is the recommendation to make the Office of the State Medical Examiner a statewide position to ensure uniform and consistent standards in autopsies in New Jersey. While a bill has been introduced many times, it has not passed and inconsistencies are still prevalent within the different regions of the state relative to the autopsies of children who have died.

2010 RECOMMENDATIONS

DEPARTMENT OF COMMUNITY AFFAIRS

Pool Legislation

In 2008, New Jersey adopted an International Residential Code (IRC) which defines a barrier as “A fence, wall, building wall or combination thereof which completely surrounds the swimming pool and obstructs access to the swimming pool.” In Section AG105.2 of this code, the requirements of this “barrier” do not include that a fence should not include the home as a fourth wall. New Jersey children who drowned often accessed the pool directly through the back or side door of the home. At this time, local ordinances are unable to enforce requirements more restrictive than the IRC; however, other states have adopted IRC as law and have written addendums to include that the side of a home with any windows or doors shall not be used as the fourth wall in a barrier around a pool.

New Jersey should adopt an addendum to the IRC which specifically requires a barrier around a pool not include the wall of a home which has windows or doors.

Water Drainage Basin Legislation

The CFNFRB recommends that barriers be installed around bodies of water, such as a water drainage basin, similar to those found in condominium and townhouse developments.

DEPARTMENT OF LAW AND PUBLIC SAFETY OFFICE OF THE ATTORNEY GENERAL

Appointment of State Medical Examiner

During its 13 years in existence, the CFNFRB has observed inconsistencies in the practices of different County Medical Examiner offices; some medical examiners exceed the recommended number of autopsies completed per year and some continue to disregard standards set by previous State Medical Examiners. Over 50 letters have been addressed to County Medical Examiners, Regional Medical Examiners, or the Assistant State Medical Examiner In-Charge detailing concerns identified during fatality review meetings. Without appointment of a State Medical Examiner, no uniform forensic investigatory practices can be enforced and results in a disservice to the citizens of New Jersey by impacting the quality and value of autopsies and death scene investigations throughout the State. The “Revised State Medical Examiner Act” was introduced to address this matter.

The CFNFRB continues to strongly recommend that a permanent State Medical Examiner be appointed in order to ensure policies and procedures are consistent throughout all of the medical examiner offices and with the recommendations of the National Association of Medical Examiners (NAME).

Children's System of Care

The CFNFRB recommends that youth who are at high risk due to mental illness, substance abuse, or a combination of both, have access to adequate acute care and hospitalization in New Jersey.

The Department maintains through the Children's System of Care that appropriate in-patient beds exist for extended diagnostic evaluation. The Board has had communication with the System of Care who reinforced the notion that these beds exist in a hospital based setting in both northern and southern New Jersey. The Board sought to outreach to those in-patient settings to understand the focus of their services including length of stay, psychiatric diagnostic capacities and types of treatment that are distinct from non-hospital based services, such as Intensive Residential Treatment Services (IRTS), that the Board deems as insufficient for these psychiatric needs. The Division preferred to review those contracts with the Department of Health and Senior Services who govern hospital admissions. To date, no further information has been received. Therefore, the Board continues to hold its position that these in-patient services are non-existent until such time as the Division provides that documentation.

Child Protection and Permanency - Risk Reassessment

There is a need to standardize what is viewed as risk within the 47 CP&P local offices. The CFNFRB has observed risk assessments that have been completed inaccurately, cases in which the risk level was determined to be high but the case was closed, and cases in which more than one risk assessment was completed in a short period of time and risk levels were determined to be significantly different in the two assessments. The risk assessment tool is a static risk assessment, that is, risk that is based on history. However, a dynamic risk assessment is the continuous process of identifying hazards associated assessing risk, taking action to eliminate or reduce risk and monitoring and reviewing the changing circumstances of the child and family. The Board is now aware that there is a risk reassessment tool, which is dynamic, and does assess for risk on a regular basis during a case and before case closure. Going forward, the Board will be more aware of the use and accuracy of this tool during future case reviews.

Institutional Abuse Investigation Unit

1. The IAIU should consider substantiating environmental neglect when conditions of a provider's home create a danger to the child; depending on the child's developmental age, mobility, and access to unsafe structures in home.
2. The CFNFRB also recommends that a Deputy Attorney General be assigned to each of the four regional offices of the IAIU for consultation purposes.

Policy

1. The CFNFRB recommends CP&P modify policy to reflect that the total number of children in the care of a resource home that is specially trained to accept the placement of medically fragile or developmentally delayed children, regardless of whether those children are placed in the home, should not exceed a certain number. The practice of these resource parents to be emergency/back-up caregivers for each other would have to be avoided to not exceed this number.
2. Current practice of assessing safety hazards in homes does not include checking for window guards, position of beds in relation to a window, or accessibility of cords on window blinds in homes where young children reside.

The CFNFRB recommends CP&P mandates checking for hazards near windows as part of the routine home assessment.

3. The CFNFRB recommends The Department of Children and Families' Statewide Central Registry (SCR) should code all referrals with an immediate response time that are having to do with a child death that falls within the criteria of the CFNFRB mandate below:

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

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

In addition, the CCAPTA mandates the CFNFRB to identify children whose family was under CP&P supervision at the time of the fatal or near fatal incident or who had been under CP&P supervision within 12 months immediately preceding the fatal or near fatal incident. The CFNFRB also examines and identifies approaches to achieve better coordination of efforts regarding child welfare and child protective services cases to promote prevention and the competency of response and investigation of reports of maltreatment.

The CFNFRB is empowered to select cases from among these categories and to conduct a full review.

Business and Contracting Practices

1. The CFNFRB has observed many instances where contracted agencies and providers have furnished substandard evaluations and reports. In regards to substance abuse evaluations, using the short version of the New Jersey Substance Abuse Monitoring System is inappropriate. In regards to psychologists and psychiatrists, reports which do not include substantive information used by the provider to assess the individual, other than the client's report, are not acceptable.

The CFNFRB recommends that DCF provide their practitioners and sister agencies with specific guidelines and standards for conducting evaluations whether it be for substance abuse, mental health, or domestic violence evaluations.

The Board looks forward to the current Department work group delineating such standards. Guidelines for Expert Evaluations: Child Abuse and Neglect Forensic Assessments (Mental Health) is currently in draft form and will be finalized for distribution in October 2012. These guidelines are to be included in each service providers' contract.

Additionally, it should be part of the contract with DCF that clinicians are required to demonstrate evidence of Continuing Education Credits (CEUs) in specific subject matters. The Board recommends a requirement of ten (10) earned CEU credits or equivalent hours approved by the State each year. However, the Board wants to re-emphasize that the CEU credits or hours need to be specific to practice standards and competencies associated with their specific contract (i.e. child maltreatment, domestic violence, mental health or substance abuse).

2. The CFNFRB recommends that CP&P review their contract with the University of Medicine and Dentistry of New Jersey regarding nursing services to allow for services to be provided to children who continue to reside in the home of their parents.

DEPARTMENT OF BANKING AND INSURANCE

Division of Insurance

The CFNFRB recommends that any child without health care, regardless of resident status, be provided with NJ Family Care coverage.

NEW JERSEY JUDICIARY

The CFNFRB recommends that the Judiciary be accountable to requests for information or records in a timely manner. As with all other agencies involved with children, the Judiciary should also be subject to similar review and recommendations.

STATE BOARD OF MEDICAL EXAMINERS

All direct care providers for children, including radiologists, pathologists, medical examiners, pediatricians, emergency medicine physicians, and other primary care providers should be required to take Continuing Medical Education (CME) credits in the field of child abuse and neglect. Currently, there are 16 states that have content specific CME requirements for medical licensure in a variety of topical areas. New Jersey has a requirement for cultural competency. Two states, Iowa and New York, have requirements for child abuse prevention continuing medical education.

JOINT RECOMMENDATIONS

Department of Children and Families and Department of Health and Senior Services

The CFNFRB recommends that the Department of Children and Families and the Department of Health and Senior Services release another Public Service Announcement (PSA) regarding pool safety with the approaching summer season. The PSA should include: training children on pool and safety equipment as standard procedure prior to entering pools; pool operators and lifeguards should be aware of safety procedures; and parents must be vigilant in supervising their children in a pool.

Office of the Attorney General and Department of Children and Families

The Child Fatality Multi-Disciplinary Investigation Protocol is currently being developed by Gloucester County Prosecutor Sean Dalton, with collaboration from multiple agencies. It outlines the expectations, roles, and responsibilities of each agency involved in a child death investigation. This protocol addresses the current predicament where different agencies' roles may be unclear.

The CFNFRB continues to recommend that the Office of the Attorney General and the Department of Children and Families issue a directive mandating The Child Fatality Multi-Disciplinary Investigation Protocol be approved and implemented with the multiple agencies involved in a child death investigation; including emergency medical services, law enforcement, Medical Examiner's Office, hospitals, and CP&P.

Department of Health and Senior Services, Department of Children and Families and Department of Human Services

There is no standardized assessment completed when a woman arrives at a hospital to give birth. No social history questions are routinely asked; therefore, a child can be placed at risk. Although an institution licensed by Department of Health and Senior Services has the ability to obtain information from CP&P regarding termination of parental rights, the onus is on direct care providers to ask these questions.

The Department of Health and Senior Services, the Department of Children and Families, and the Department of Human Services should add social history questions to the Prenatal Risk Assessment (PRA) form currently being used to assess maternal and infant risk. The social history questions should include a previous history of child abuse or neglect for the family and the mother.

SAFE SLEEP RECOMMENDATIONS

1. The Board continues to see SUID deaths related to sharing a sleep surface with adults or other children. Hospitals, health care providers, and child care providers should educate parents on infant safe sleep guidelines.

DCF has already begun implementing infant safe sleep training for CP&P staff, OOL staff, and resource parents; which should be continued. Hospitals, pediatricians, visiting nurses, and other direct care providers should educate parents on safe sleep guidelines, routinely ask about sleeping arrangements, and find out what the barriers are in getting parents to adhere to these guidelines.

2. The Board shall partner with the two SIDS Centers of NJ, the NJ Task Force on Child Abuse and Neglect, and the Department of Children and Families to conduct an infant safe sleep educational presentation in a particular community when a cluster of overlay cases are identified.

DEPARTMENT OF EDUCATION

The CFNFRB recommends that the Department of Education consider mandatory educational efforts regarding the dangers of participating in the “choking game,” ingesting bath salts, or inhaling gases as part of the school’s drug and alcohol prevention program.

