

2014 CHILD FATALITY & NEAR FATALITY REVIEW BOARD ANNUAL REPORT

NEW JERSEY



ISSUED 2015

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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 CFNFRB 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. As each case is reviewed, a story is told of how the child lived and how they died. Whether the death was from a tragic accident, an unsafe sleeping environment, or a fatal blow from a caregiver, each death is reviewed to have a clear understanding of trends within communities. Identifying these trends allow for a better understanding and identification of potential risk factors to surviving siblings and other children.

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 the Division of 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, 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 the supervision of the CP&P at the time of the fatal or near fatal incident or within twelve 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 within 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 eighteen 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)**

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. Near fatal incidents are identified for review through the CP&P Assistant Commissioner'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, law enforcement, educational, mental health, medical, and social service records. The CFNFRB has the authority to subpoena and secure the required materials as necessary. 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 and subsequently this report, is based on this selection.

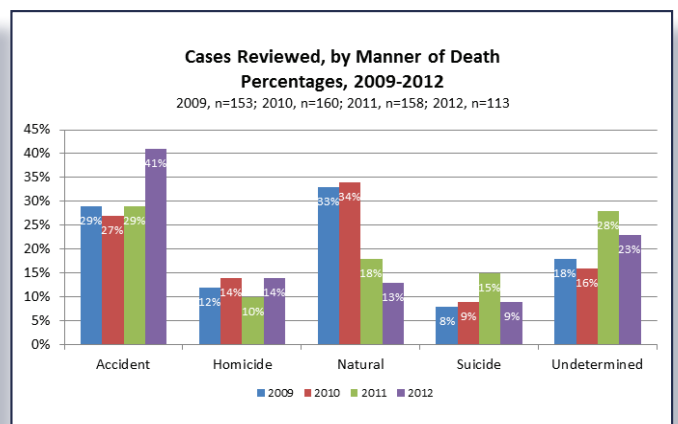
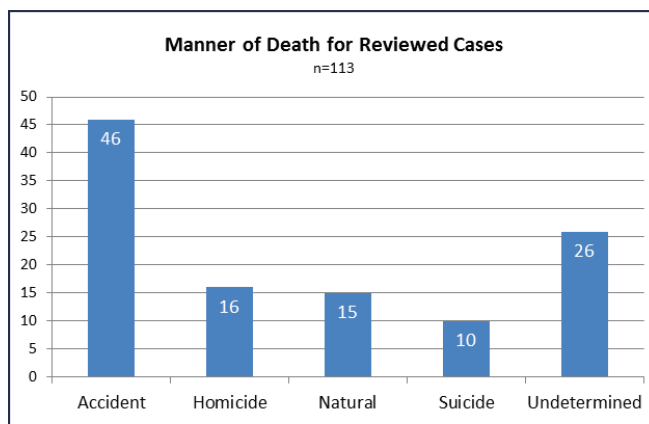
All relevant documentation is posted in an on-line library so that members of the review teams are able to access for review, approximately two weeks before a scheduled meeting for review in preparation for discussion at the meeting.

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.

CAUSE AND MANNER OF DEATHS

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, and undetermined.

The CFNFRB reviewed 113 child deaths that occurred in 2012. The manners of death in 46 (41%) of the 113 fatalities reviewed were certified as an accident. In 16 (14%) the manner was certified a homicide, in 15 (13%) natural, in ten (9%) suicide and in 26 (23%) the manner was certified as undetermined.



Deaths by County

The 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 Camden and Essex Counties; however, with county child population factored in, Atlantic County has the highest reviewed child fatality rate with 14.4 children dying per 100,000. No child fatalities in 2012 from Gloucester County were reviewed by the CFNFRB giving Gloucester County the lowest (0) child fatality rate of any county in the state.

Reviewed Fatalities by County ¹								
COUNTY	MANNER OF DEATH					% Total Fatalities	Child Population ² (< 18 Years)	County Reviewed Fatality Rate ³
	Accidental	Homicide	Natural	Suicide	Undetermined			
ATLANTIC	4	2	1	0	2	8.0%	62,521	14.4
BERGEN	6	1	1	0	1	8.0%	201,236	4.5
BURLINGTON	1	0	2	0	1	3.5%	101,099	4.0
CAMDEN	5	2	0	0	5	10.6%	121,709	9.9
CAPE MAY	0	0	0	0	1	0.9%	17,527	5.7
CUMBERLAND	0	1	1	0	1	2.7%	37,553	8.0
ESSEX	5	1	1	0	5	10.6%	192,997	6.2
GLOUCESTER	0	0	0	0	0	0.0%	68,342	0.0
HUDSON	3	1	3	0	2	8.0%	133,070	6.8
HUNTERDON	1	0	1	1	0	2.7%	28,078	10.7
MERCER	3	1	1	1	0	5.3%	81,763	7.3
MIDDLESEX	3	0	0	0	4	6.2%	183,538	3.8
MONMOUTH	3	2	0	3	0	7.1%	144,129	5.6
MORRIS	1	1	0	3	1	5.3%	114,042	5.3
OCEAN	2	0	3	1	0	5.3%	134,669	4.5
PASSAIC	2	0	1	0	1	3.5%	122,704	3.3
SALEM	1	0	0	0	0	0.9%	14,223	6.7
SOMERSET	2	0	0	0	1	2.7%	78,650	3.8
SUSSEX	1	1	0	0	0	1.8%	33,027	6.1
UNION	3	3	0	0	1	6.2%	130,554	5.4
WARREN	0	0	0	1	0	0.9%	24,222	4.1
STATE TOTAL	46	16	15	10	26	100%	2,026,361	5.6

¹ Reviewed Fatalities - fatality cases occurring in 2012 reviewed by the CFNFRB

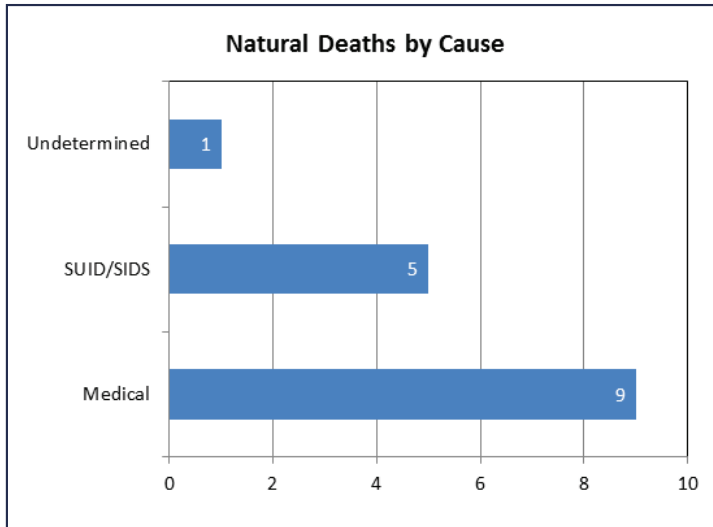
² Population <18 – from US Census Bureau Website: <http://quickfacts.census.gov/qfd/states/34000.html>

³ Reviewed Fatalities per County * 100,000 / County Child (<18) Population

NATURAL DEATHS

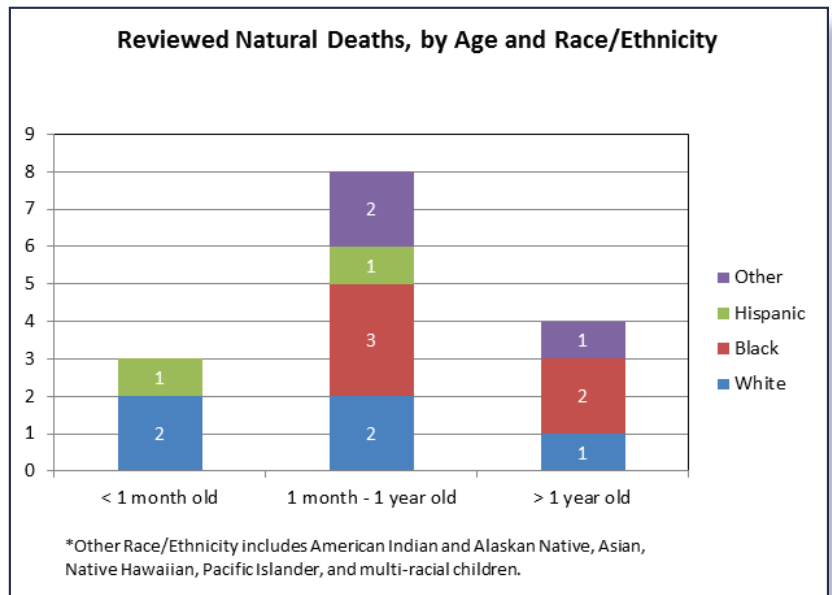
Of all the deaths reviewed by the CFNFRB in 2012, 15 (13%) of 113 were determined to have a manner of death certified as natural.

Of the natural deaths, nine (60%) were due to medical issues, five (33%) were due to SUID/SIDS, and one (7%) was deemed undetermined. Of the nine medical-related fatalities, six were due to ongoing medical issues. Three were due to acute illnesses including infections.



Age, Race and Gender

Children less than one year old comprise 73% of the natural deaths reviewed. In one third of the natural cases reviewed, the child was white; in one third of the cases, the child was black. Two-thirds of the natural deaths reviewed were males.



UNDETERMINED DEATHS

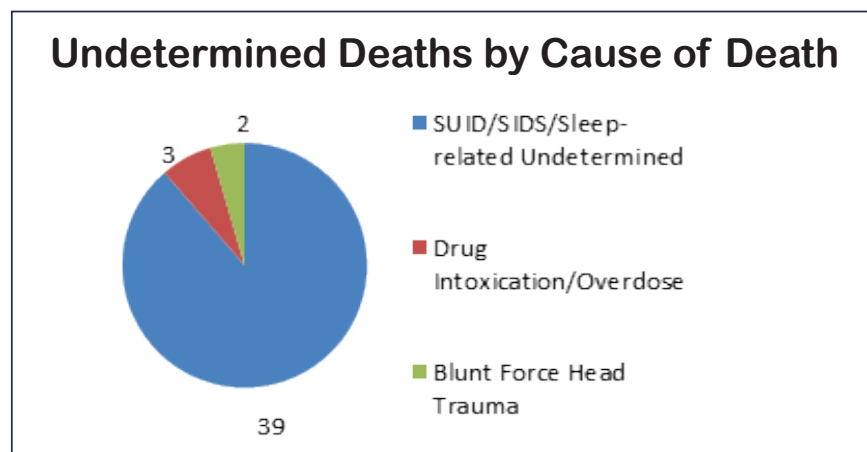
Twenty-six (23.0%) of the 113 deaths reviewed by the CFNFRB had a manner of death of undetermined. Of these 16 (61.5%) were infants whose deaths were listed as one of the following: Undetermined, Undetermined with Co-sleeping⁴, SUID⁵, and SUID with Co-sleeping.

Four (15.4%) were classified as having a cause of death of Smoke Inhalation. This was a case of four siblings who perished in a house fire. The undetermined manner is due to the house fire's uncertain etiology: it is not known if the fire was accidental or the result of arson.

Four (15.4%) were classified as having a cause of death of Hanging, Asphyxiation, Cervical Compression or Blunt Trauma of Head. Three of the cases were of teenagers found hanging but without suicide notes or prior history of suicidality. The fourth was of a teenager who walked into oncoming traffic after drinking alcohol. The undetermined manner of these cases is due to uncertainty as to whether the deaths were intentional (suicide) or the result of experimentation with altered states of consciousness, be it via oxygen deprivation or alcohol intoxication, gone awry (accidental).

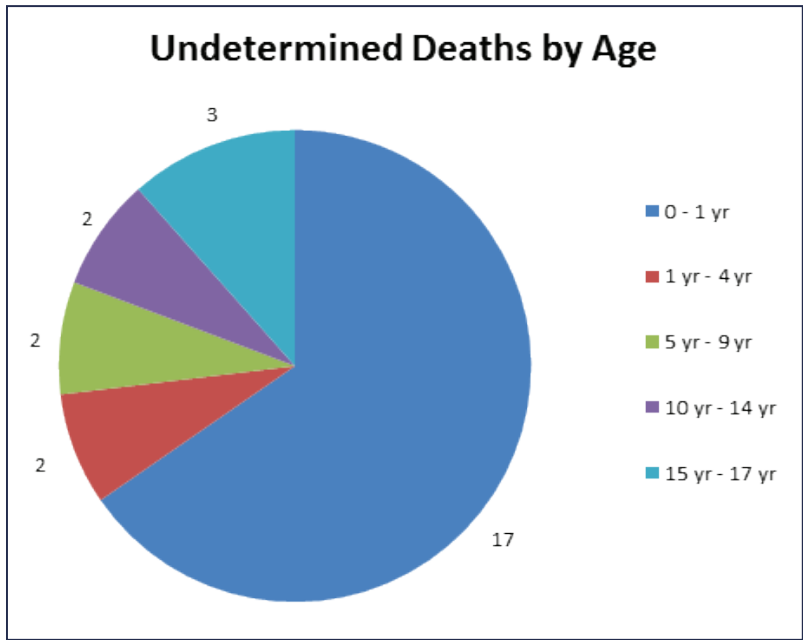
One (3.8%) was classified as having a cause of death of "Complications following attempted Percutaneous Gastrostomy Placement for Nutritional Support Required for the Treatment of Multiple Medical Conditions – Possible Syndrome." This one-year-old child died while in surgery, which was needed in part due to suffering an impact trauma to the head, possibly related to a fall while in the care of a 14-year-old sibling.

One (3.8%) was classified as having a cause of death of "Complications of Influenza A Infection; other condition: Face Down Sleeping Position." The undetermined manner of this eight-month-old's death is due to the presence of both natural (the infection) and accidental (the sleep position) factors.



⁴ Co-sleeping and Over-lay are considered to be synonymous for our analysis.

⁵ There is no uniformity among New Jersey's Medical Examiner's with regards to how they describe Sudden Unexpected Infant Death (SUID). Some use Unexplained instead of Unexpected, some invert Infant and Death, and some include contributory causes.

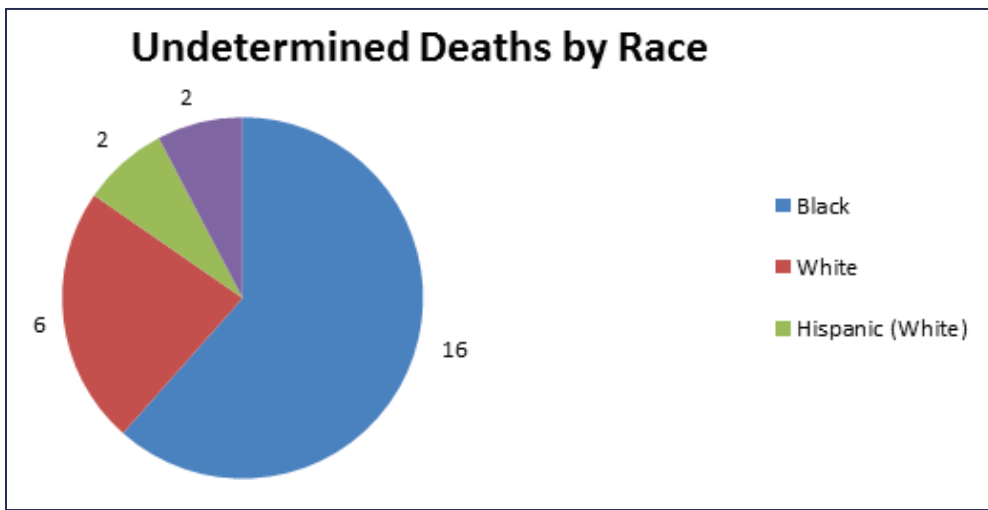


Age

Of the 26 cases reviewed with an undetermined manner of death, 17 (65.4%) of the children were less than one year old. Between the ages of one and four, five and nine, and ten and fourteen, two (7.7%) children, per age group had an undetermined manner of death. Between 15 and 17 years old, three (11.5%) of the children had an undetermined manner of death.

Race

Undetermined deaths reviewed by race give the following percentages: non-Hispanic black: 16 (61.5%); Hispanic white: two (7.7%); non-Hispanic white: six (23.1%); multiracial (black/white): 12 (7.7%).

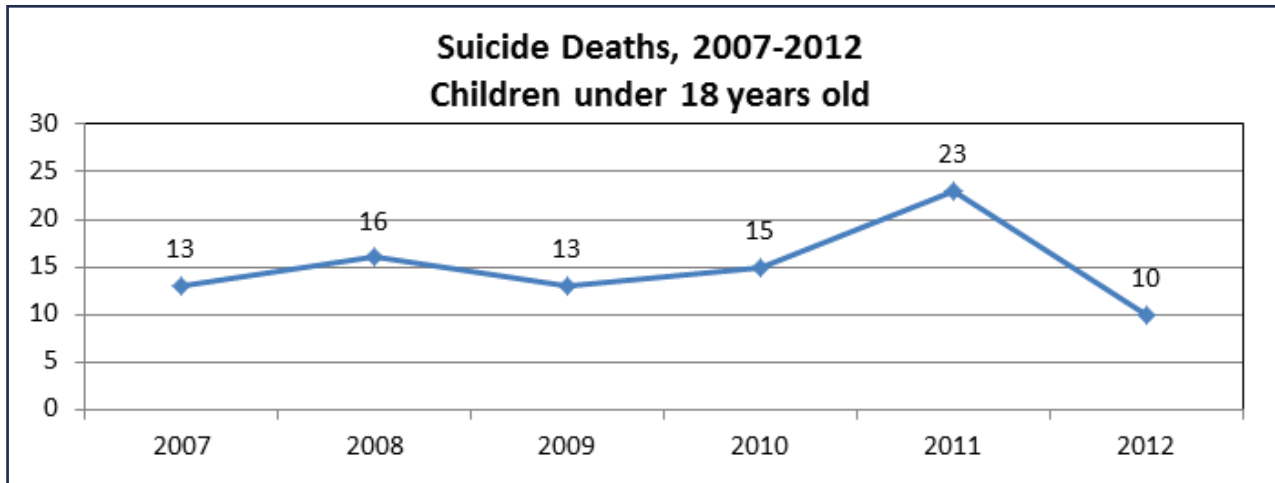


Gender

Of the 26 child deaths reviewed with an undetermined manner of death, ten (38.5%) were female and 16 (61.5%) were male, showing once again that male children are at higher risk than female children.

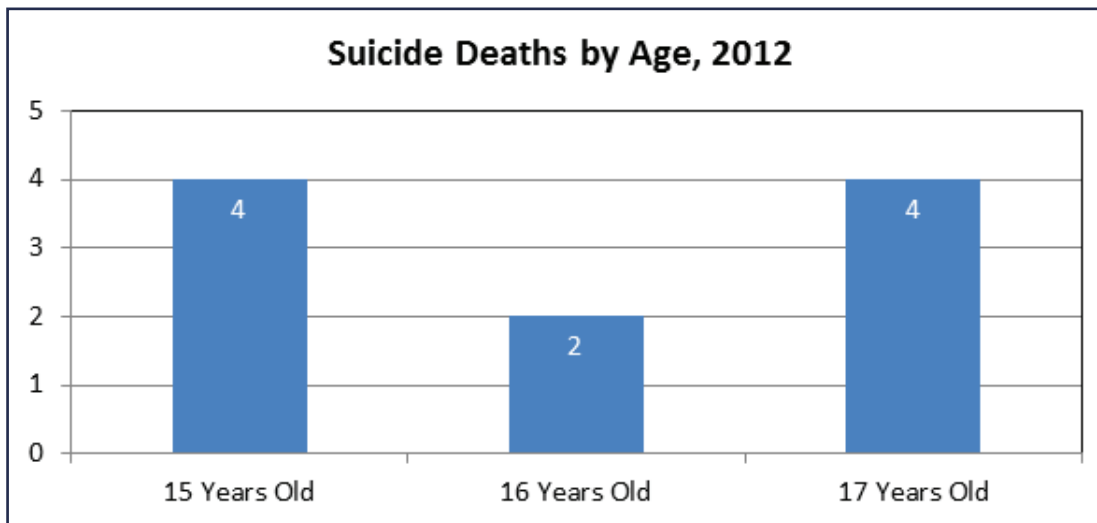
SUICIDE DEATHS

In 2012, there were ten fatalities by suicide for children under 18 years old. This is a decrease of 57% from 2011. It also represents a six-year low. Per statute, the CFNFRB and its regional teams reviewed all of these fatalities. Note: there were three hanging fatalities where the manner of death was certified as undetermined. They are not accounted for in this section due to their manner of death classification.



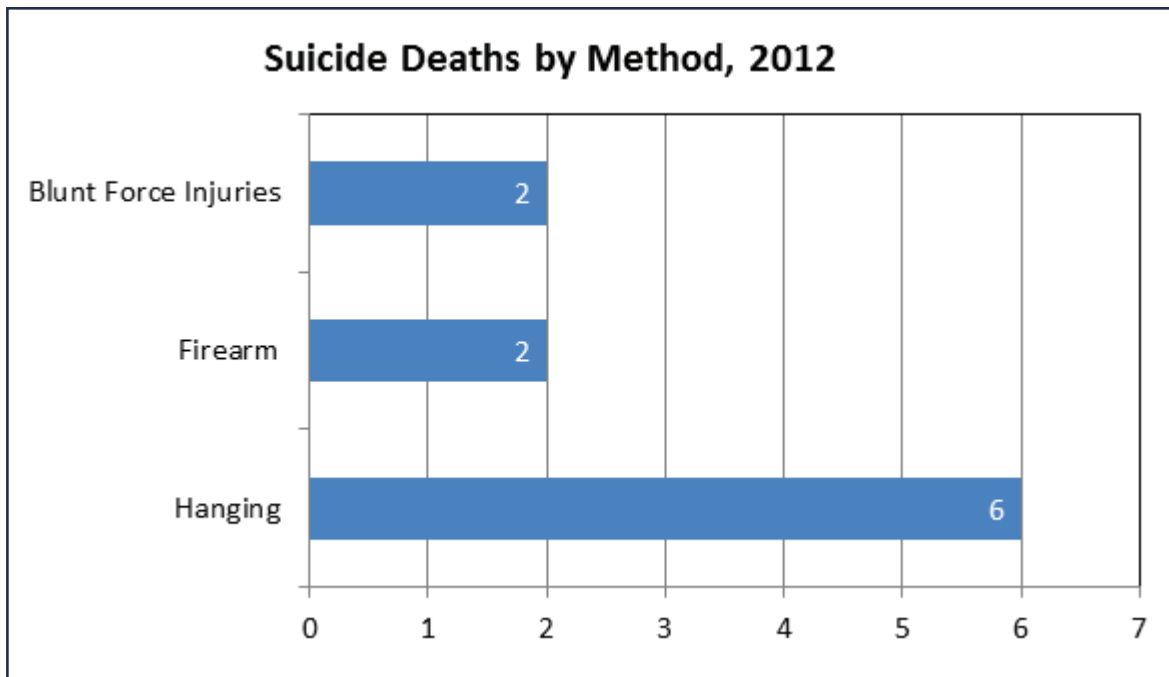
Suicides by Age, Race and Gender

All of the children who committed suicide were between the ages of 15 and 17 years old. Of these fatalities, all of the children were white males.



Suicides by Method

In six (60%) of the suicide cases, the child hanged himself in his own home. The children used ropes, belts and an audio/video cord. In two (20%) of the cases, the child utilized a firearm. In both cases, the firearms belonged to family members. A handgun was used in one case while a rifle was used in another. The recently



purchased rifle was stored in an unsecured room. It was unknown if the children had experience with firing a weapon and/or were familiar with gun safety practices. In two (20%) of the cases, the child was killed by blunt force trauma; one child ran into traffic and was hit by a motor vehicle, the other child was hit by an oncoming train.

Adolescent Risk Factors

The two highest known risk factors for these ten suicides were: family conflict (60%) and relationship conflict (60%). Five (50%) children experienced four or more risk factors in combination. Five children experienced three or less of these risk factors in combination. It should be noted that in many cases, these risk factors are not known or documented in any investigation.

School Problems: Half of the victims displayed problems in school, including attendance, disciplinary, and/or academic concerns. One child was suspected of being bullied. Two children were classified by a child study team.

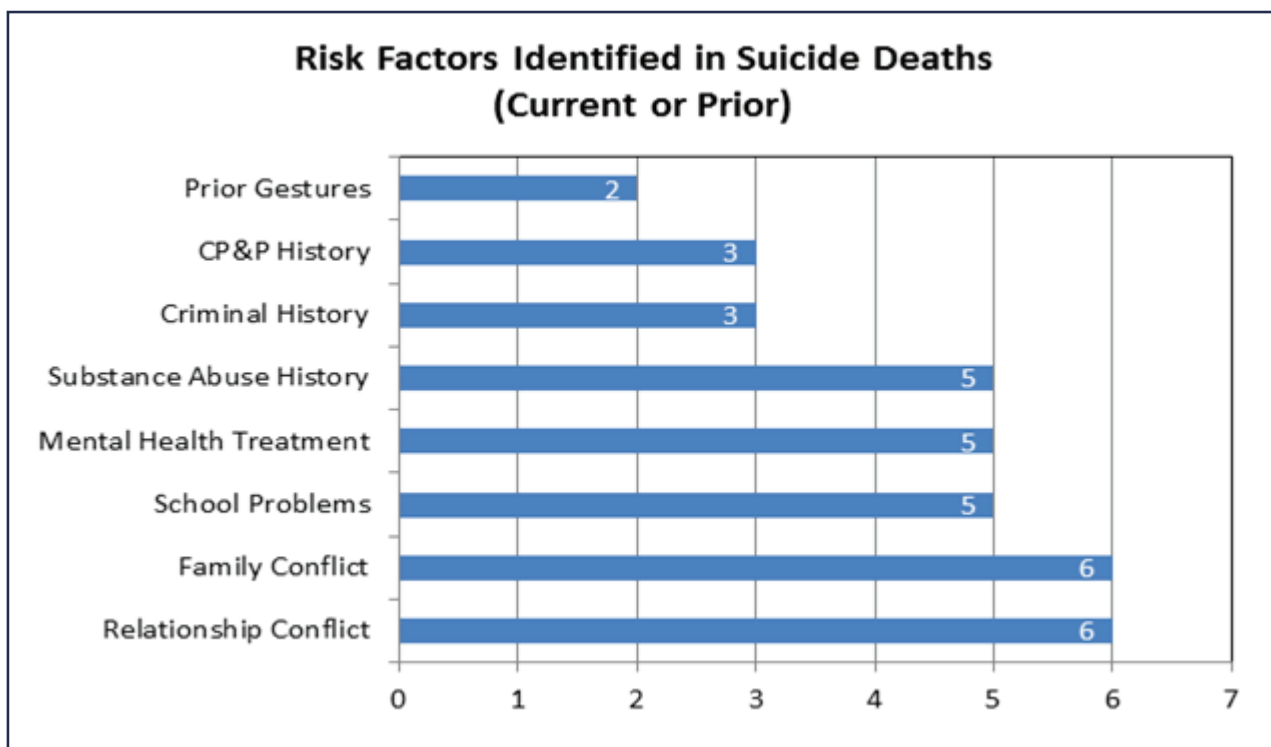
Family/Relationships: In six (60%) of the cases family problems were noted prior to the suicide. These problems include severe conflict with and amongst family members as well as family members being absent from the home. In six (60%) of the cases relationship troubles with a boyfriend or girlfriend were noted. Three of the victims left handwritten suicide notes behind; an additional victim notified another child he was speaking with on the phone of his suicide plan.

Mental health: In five (50%) of the suicide deaths the victims had a current or past history of mental health diagnoses and treatment. Two (20%) of the victims were engaged in treatment at the time of their death. Two (20%) of the victims made prior suicidal gestures or threats. One previously made verbal threats and the other previously made a physical gesture. Seven (70%) of the victims were not known to the CP&P previously. Three (30%) had a past history with CP&P. Two children were involved with CP&P over a year from the time of their fatality; one was involved within one year from the time of his fatality. One of the three

formerly CP&P-involved children was the victim of child abuse or neglect. Only two (20%) of the victims were previously involved with the Children’s System of Care (CSOC). Both children’s cases were closed over a year from the time of their death. Eight (80%) of the victims were not involved with CSOC.

Substance Abuse: In five (50%) of the suicide fatalities, past or current drug or alcohol use was noted. Substances include marijuana, Oxycodone and cocaine. Five (50%) of the cases had positive post mortem toxicology reports to include marijuana, Oxycodone and alcohol.

Juvenile Criminal History: Three (30%) of the victims of suicide had involvement with the juvenile justice system for charges including possession and/or distribution of drugs, destruction of property, and assault. One victim was on probation at the time of his death.

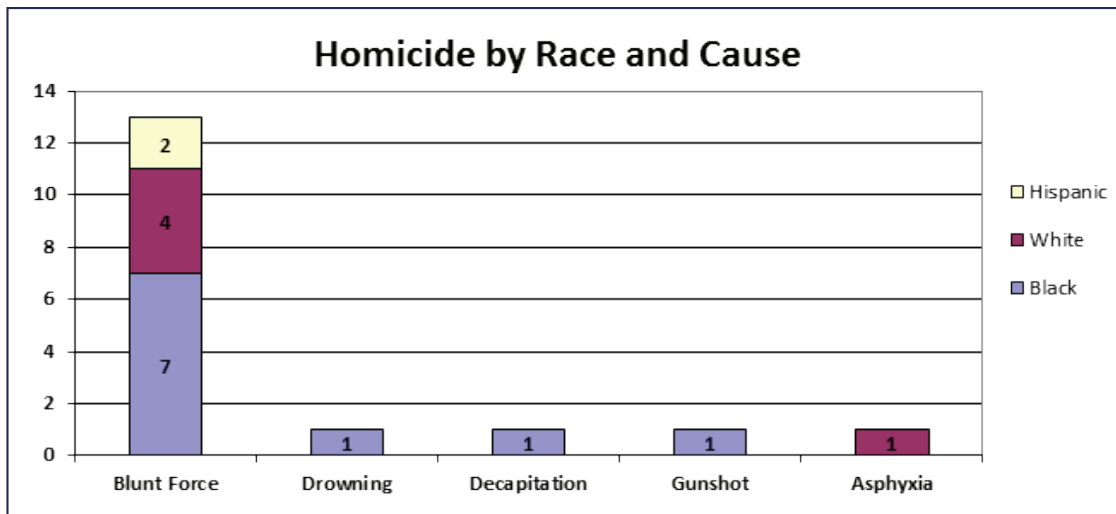


HOMICIDE DEATHS

The CFNFRB reviewed 16 homicides that occurred in 2012. Ten victims suffered various fatal blunt force trauma injuries, one victim died from asphyxia due to inhalation of products of combustion, one victim died from gunshot wounds, one victim drowned and one victim was decapitated.

Race of Homicide Victim

The majority, nine (56.3%), of the homicide victims were black. Five (31.3%) were white, and two (12.5%) were Hispanic.



Of the 16 homicides reviewed, CP&P had an active case with five of the families. Eleven cases were opened as a result of the child's homicide.

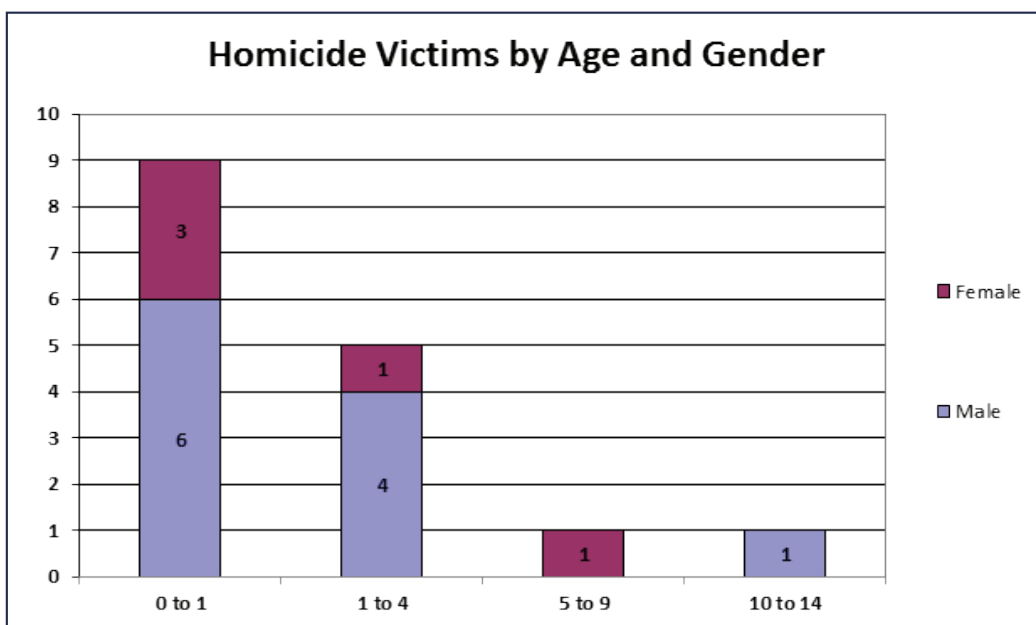
Fourteen (87.5%) homicides were ruled to be related to child abuse and neglect and designated as CCAPTA cases. One of the 16 homicide cases was that of a teenager shot by unknown assailant(s). The other case involved an out of state resident visiting New Jersey and it was unclear where the fatal injury occurred.

Age of Homicide Victim

Nine children under a year old were killed as a result of homicide. Five children ages one to four years old were killed. One child between the ages of five and nine and one child between the ages of ten and 14 were killed. No homicide victims between the ages of 15 and 17 were reviewed.

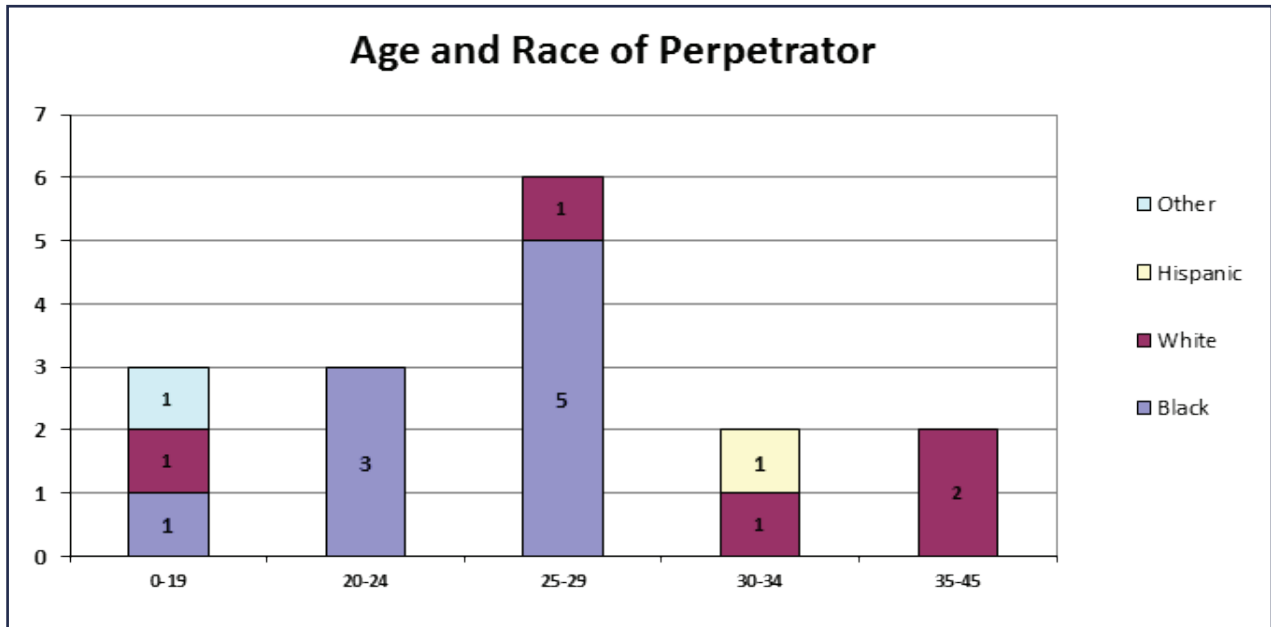
Gender of Homicide Victim

Of the 16 homicide fatalities reviewed, 11 (68.8%) of the victims were male and five (31.3%) of the victims were female.

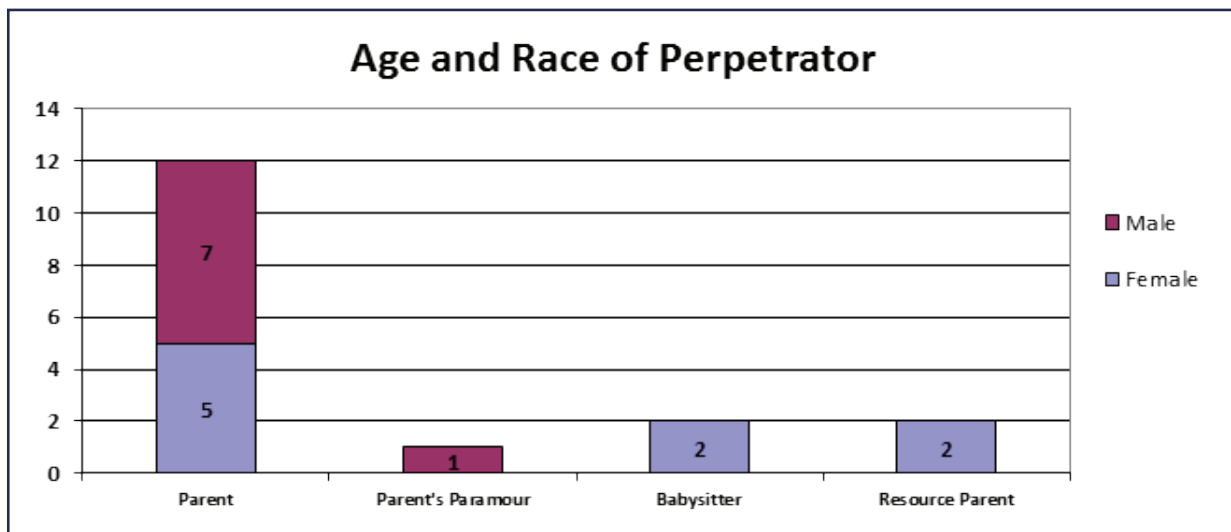


Risk Factors for Victims of Homicide

The majority of the perpetrators were between the ages of 25 and 29 years old. The youngest perpetrator was an 11 year old child with severe autism. Fifty-six percent of the perpetrators were black, 32% were white, 6% were Hispanic and 6% were classified as other race.



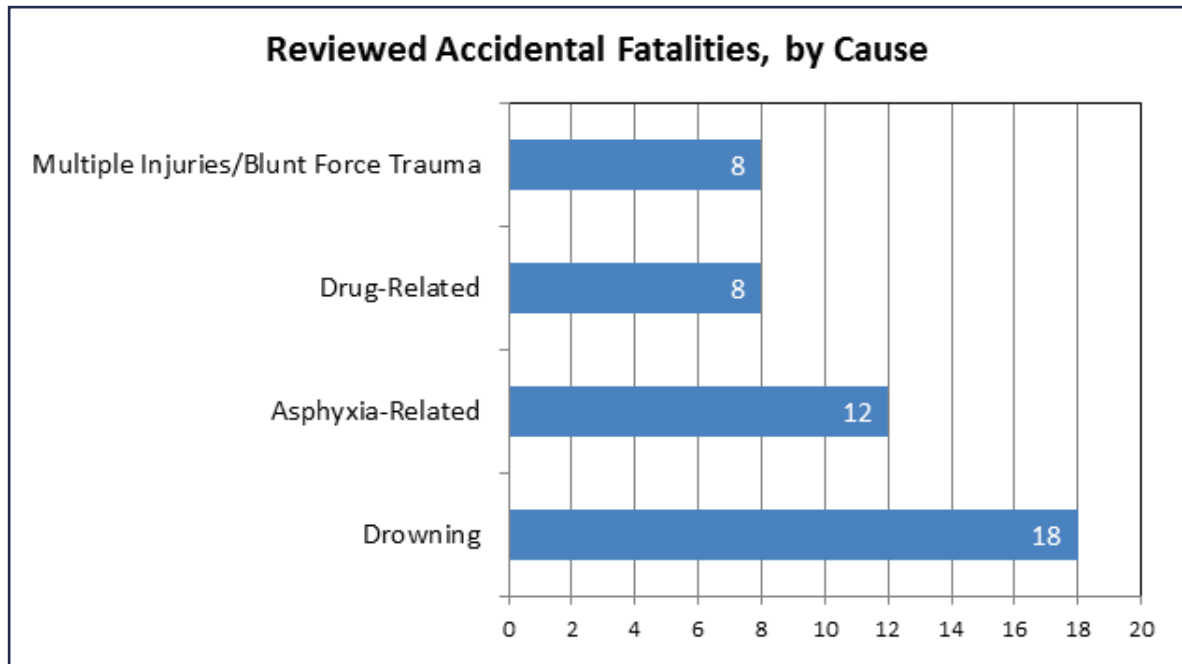
Two of the children were murdered by perpetrator(s) unknown; for the purposes of this analysis it will be assumed that there was one perpetrator for each child, however it is possible that one or both of these children were murdered by more than one person. Seventeen perpetrators were identified for the remaining 14 children, bringing the total number of perpetrators to 19.



The records available for review revealed that 32% of the perpetrators had a previous criminal history. Eleven percent had a history of domestic violence as the victim and 21% had a history of domestic violence as the perpetrator. Twenty-one percent had a history with CP&P as a child. For each case in which the perpetrator was known, the race of the perpetrator was the same as the victim, regardless of blood relation.

ACCIDENTAL FATALITIES

The CFNFRB reviewed 46 fatalities whose manner of death was certified as accident. The leading cause of accidental fatality was drowning, with 18 instances. There were 12 asphyxia related fatalities. Eight accidental fatalities were due to multiple injuries / blunt force trauma, and eight were drug related.



ASPHYXIA-RELATED

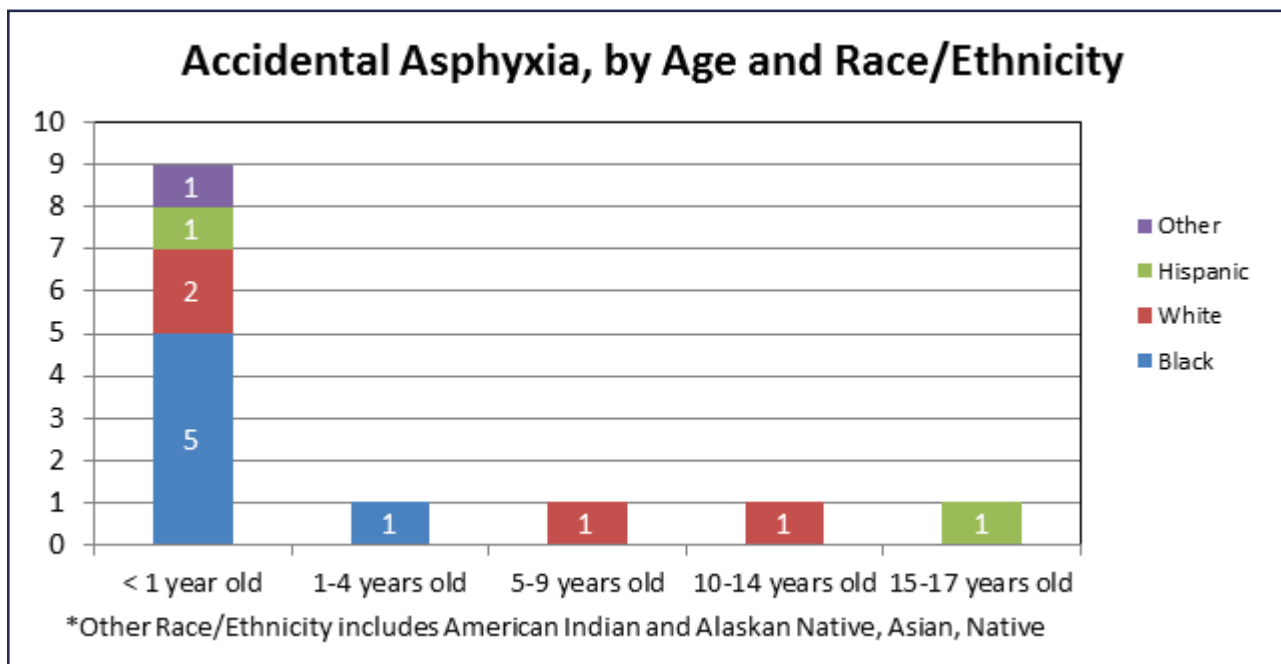
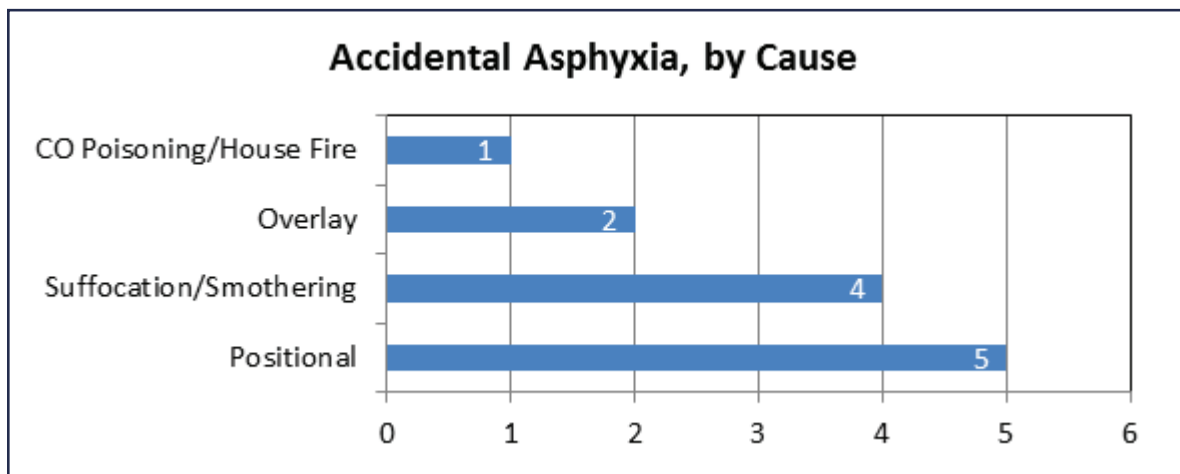
The CFNFRB reviewed 12 cases where children died as a result of accidental asphyxia. In five cases, the child's cause of death was positional asphyxia; in four cases, the case was suffocation and/or smothering; in two cases the cause was overlay; and in one case, the cause was carbon monoxide (CO) poisoning. In five of the nine (56%) cases where the child was under age four years old and died due to accidental asphyxia, co-sleeping was involved.

Positional Asphyxia: A four-month-old, white female was placed to sleep on a couch on top of a pillow. She was found wedged between the sections of a sofa. A two-month-old, Hispanic male was placed to sleep and found on his stomach in his crib. The child was placed to sleep with a baby and an adult-sized blanket. A one-month-old, black female fell asleep in her mother's arms in bed. The mother also fell asleep and the child was found on the floor next to the bed. A six-month-old, black male went to sleep with his mother in a king-sized bed and the child was found between the bed and a wall. A 17-year-old, Hispanic male was found wedged between two large barrels in a warehouse; the child was paranoid and thought police were chasing him. The child also had a history with substance abuse and police involvement.

Suffocating/Smothering: A two-month-old, biracial female was placed to sleep on an ottoman. She was found wedged between the sofa and ottoman with a blanket wrapped around her which obstructed her mouth and nose. A four-year-old, black female was co-sleeping with her mother in a twin bed. A laundry basket was placed next to the bed in order to “catch” the child if she rolled. The child was found face-down in the basket. A three-month-old, black female was placed face-down to sleep on the floor on top of and covered with blankets. A 12-year-old, white male was building a two-to-three foot deep sand tunnel when it collapsed on him.

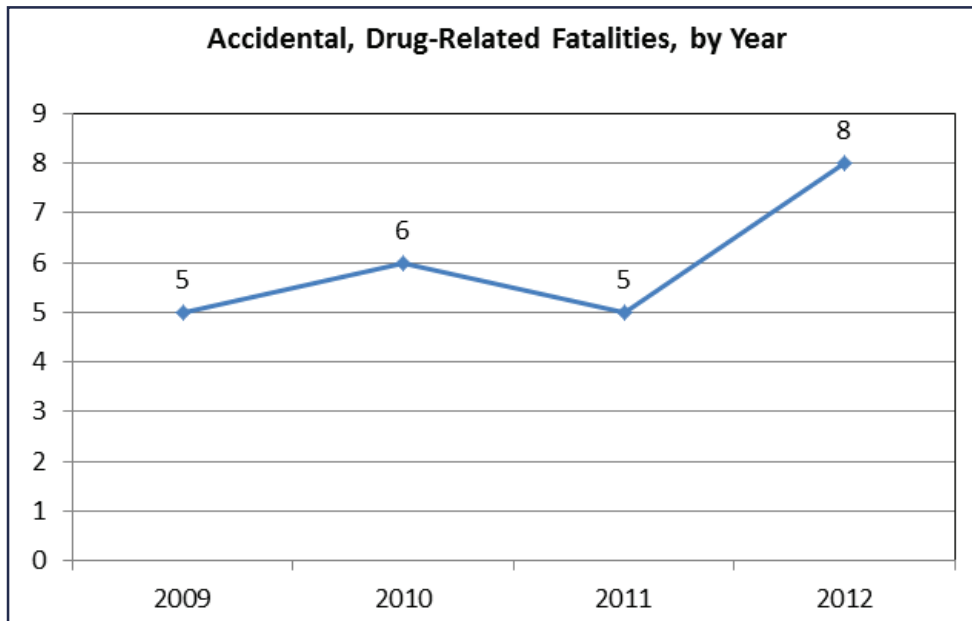
Overlay: A seven-week-old, black male slept in an adult bed with his mother and father. A one-year old, black male was found wedged between his two siblings. A total of four children were sleeping in one bed.

CO Poisoning: An eight-year-old, white female died due to a house fire. This was the family’s third house fire. The fire was believed to have started in the living room, and it was potentially due to the mother’s criminal activities.



DRUG RELATED

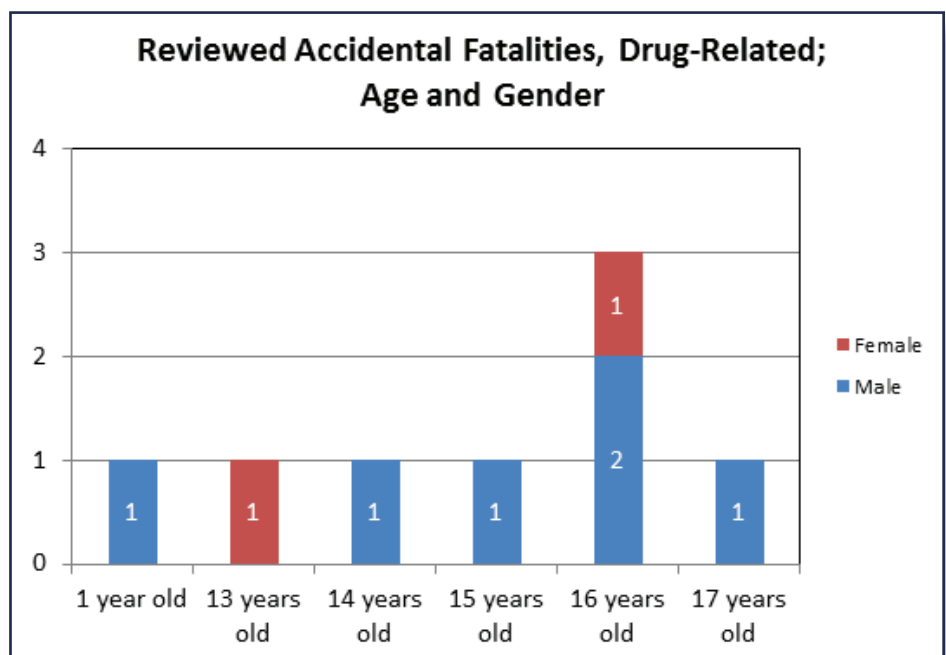
The CFNFRB or its regional teams reviewed eight cases where children died as a result of accidental drug-related fatalities. This is an increase of 60% from 2011.



In seven of the eight cases, the children died as a result of Heroin or prescription opioids intoxication. The opioids included Buprenorphine, Oxycodone, Fentanyl and Propoxyphene (which was banned by the FDA in 2010). In one case, a 15-year-old, Hispanic male died as a result of alcohol intoxication. One parent was substantiated for child neglect as her one-year-old, white male child died due to acute Fentanyl Intoxication.

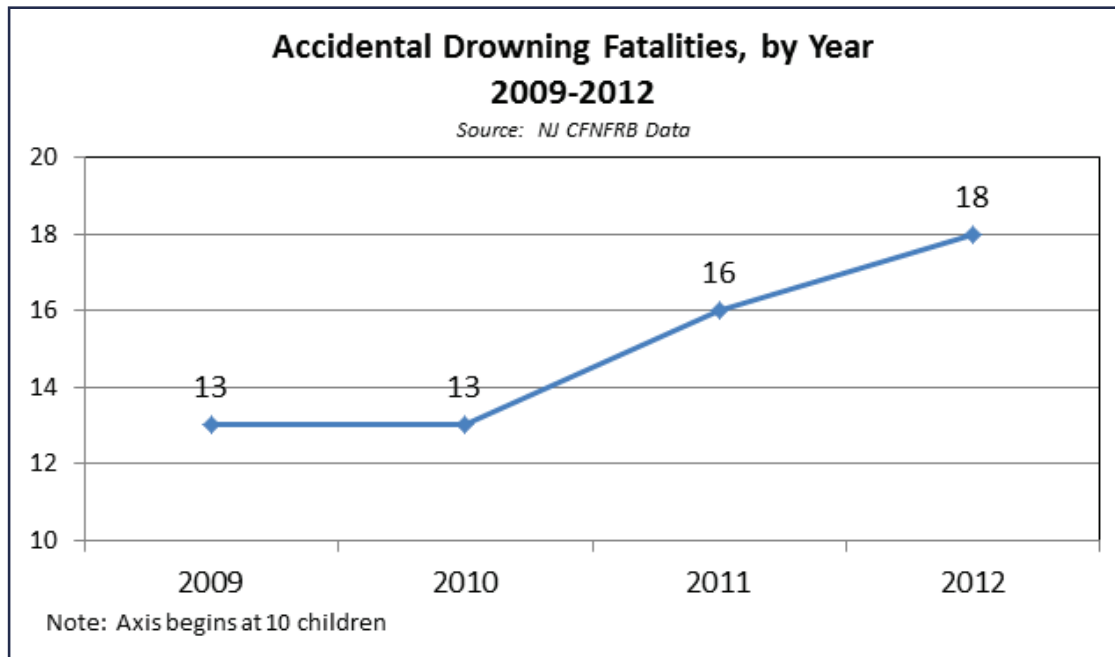
Six of the eight (75%) children had a substance abuse history including prescription medication, Heroin, Marijuana, and alcohol. Five of the eight (63%) children had mental health concerns including Bi-Polar Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, depression, self-mutilation, and Mood Disorder. One child had a previous overdose. Four of the eight (50%) children had police involvement and/or juvenile charges.

Four of the eight children were not known to CP&P. Two children had open cases with CP&P at the time of their fatalities. One child was involved with CP&P within 12 months of his death, and one child's case was opened due to his death.



DROWNING FATALITIES

The CFNFRB reviewed 19 drowning fatalities that occurred in 2012. Eighteen (95%) of the drowning fatalities were determined to be accidental in manner; the manner of death was homicide in one (5%) of the drowning fatalities. The number of accidental drowning fatalities has increased 38% since 2010.



Location of Accidental Drowning Fatalities

Eight (44%) of the accidental drowning fatalities occurred in a residential pool setting. Six of the eight pool fatalities occurred in an in-ground pool while two occurred in an above-ground pool. In three cases, the child drowned in a neighbor's pool; in two cases, the child drowned in the family's own pool; and in three cases, the child drowned in a friend or family's pool. In five instances, the child exited their own house and drowned in their own, family or neighbor's pool. In two cases, the child was at a friend's pool party where he drowned. In one case, the child and his sibling were left in or near a pool unsupervised. In this case, the child removed the life jacket she had been wearing.

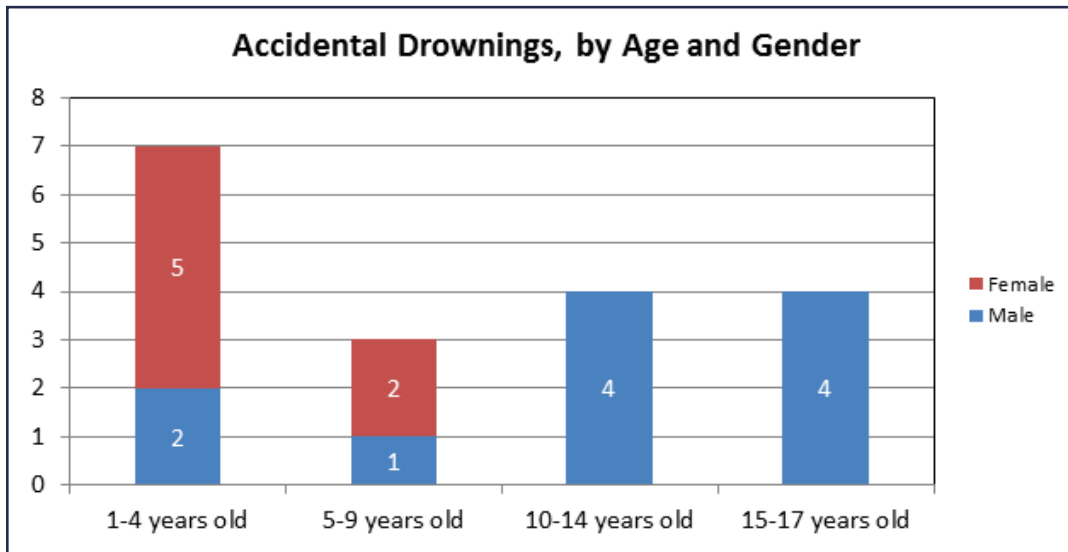
Seven (39%) of the drowning fatalities reviewed in New Jersey occurred in open water (i.e. lake, river, pond or ocean). Of these fatalities, four occurred in a river, two occurred in the ocean, and one occurred at a pond. Two children (a ten-year-old, Hispanic male, and an 11-year-old, black male) left their homes to play in a local park. They were found in the river. A 16-year-old, black male was tubing in the river when he drowned. He was not wearing a life jacket. A 16-year-old, Hispanic male along with a family member unsuccessfully attempted to swim across a large river opening. Two children (a ten-year-old, black male and a 17-year-old, Hispanic male) drowned in the ocean. Both were swimming when lifeguards were off duty. A four-year-old, white male drowned at a pond. He was there for a large gathering/outing.

Two (11%) of the accidental drowning fatalities occurred in a bathtub. In both instances, the two-year-old, black female and the seven-year-old, white female had a seizure while bathing.

In one of the drowning fatalities, a two-year-old, white female drowned in the family's septic tank. The child was playing outside her house with siblings.

Age, Gender and Race of Drowning Fatality Victims

With regards to the 18 reviewed accidental drowning fatalities, 11 (61%) of the victims were male. All of the children over the age of ten years old who drowned were male and non-white.



Reasons Why Children Drown

- Weak or no supervision
- Weak or no swimming ability
- Lack of life jacket or other floatation device use
- Broken or 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, unlocked/broken doors accessing pools)
- Weak or no Cardiopulmonary Resuscitation (CPR) skills
- Children with medical conditions and/or developmental delays

Supervision

Supervision plays an important role in the prevention of child drowning fatalities. Of the 18 reviewed accidental drowning fatalities occurring in 2012, four of the caregivers were substantiated for inadequate supervision by CP&P. In nine additional cases, the family was referred to CP&P with 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 (in person or on the telephone), leaving the child briefly alone in or near water in order to get something from another room or inside the home, leaving child in the care of another sibling or young relative and/or caring for other children. Large gatherings can also be problematic when supervision is assumed and/or miscommunicated.

BLUNT FORCE TRAUMA

The CFNFRB reviewed eight fatalities from 2012 in which the manner of death was accident, and the cause was blunt force trauma. Six (75%) cases involved motor vehicles; six (75%) cases involved substance abuse; four (50%) involved both motor vehicles and substance abuse. In the first case a one-year-old female was traveling unrestrained in a car driven by a relative who was intoxicated (alcohol). In the next, a five-year-old male was traveling in a car with his father who also passed away; his toxicology report indicated he had heroin in his system. In another case a 13-year-old was a passenger in a motor vehicle accident; his toxicology report indicated he had THC (marijuana) in his system and the car had been stolen. Another case involved a sixteen-year-old male who put his head through an emergency exit on the roof of the bus; he was struck by an overpass; his toxicology report indicated he had ethanol (alcohol) in his system. The final motor vehicle related case was that of a seven-year-old female who ran out into traffic and was struck and killed. The final substance abuse related death was that of a sixteen-year-old male who, while intoxicated (alcohol), fell off a cliff.

Of the remaining two cases, the first was a one-year-old female who pulled a cathode ray tube television onto her head. The second was a three-year-old female who died from complications of blunt head trauma. This child reportedly fell from playground equipment, striking both her chin, which was severely lacerated, and her head. Her parents did not seek medical attention for the child who passed two days later. The medical examiner discovered additional injuries which were never fully explained.

CHILD PROTECTION AND PERMANENCY (CP&P)

“The Division of Child Protection and Permanency, CP&P, is New Jersey's child protection and child welfare agency within the Department of Children and Families (DCF). Its mission: In partnership with New Jersey's communities, DCF will ensure the safety, well-being, and success of New Jersey's children and families.

CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment.

The Child Abuse Hotline (State Central Registry) receives all reports of child abuse and neglect 24 hours a day, seven days a week. Reports requiring a field response are forwarded to the CP&P Local Office (LO) who investigates.”⁶

“The State Central Registry (SCR) is a 24 hour, 365 day a year, state-of-the-art call center. SCR receives approximately 15,000 phone calls each month.”⁷ Many of these phone call referrals are forwarded to one of the 47 CP&P Local Offices for investigation of child abuse and/or neglect or assessment of child welfare needs.

“The Institutional Abuse Investigation Unit (IAIU) is a child protective service unit that investigates allegations of child abuse and neglect in out-of-home settings such as foster homes, residential centers, schools, detention centers, etc. IAIU consists of a Central Administrative Office and four Regional Investigative Offices.”⁸

As of December 2012, 52,398 children were receiving services from CP&P.⁹ The Child Fatality and Near Fatality Review Board (CFNFRB) and its regional teams identified and reviewed a total of 113 fatalities and 4 near fatalities which occurred in 2012.

In twenty-nine (25%) 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 fifteen (13%) of the families within the 12 months preceding the fatality or near fatality. Ten (8%) of the families had a history with CP&P greater than 12 months prior to the child's fatality or near fatality. In thirty-four (29%) of the cases reviewed, CP&P responded to a call on or after the date of the child's injury or death.

Twenty-nine (25%) 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 or were reported, but did not rise to the level of a child protection services (CPS) investigation or a child welfare service (CWS) assessment.

In 2012 the CFNFRB found a higher incidence of fatality/near fatality with open CP&P cases in Middlesex and Essex Counties, each with six (20%) of the 29 open cases with a fatality/near fatality, than in any other county.

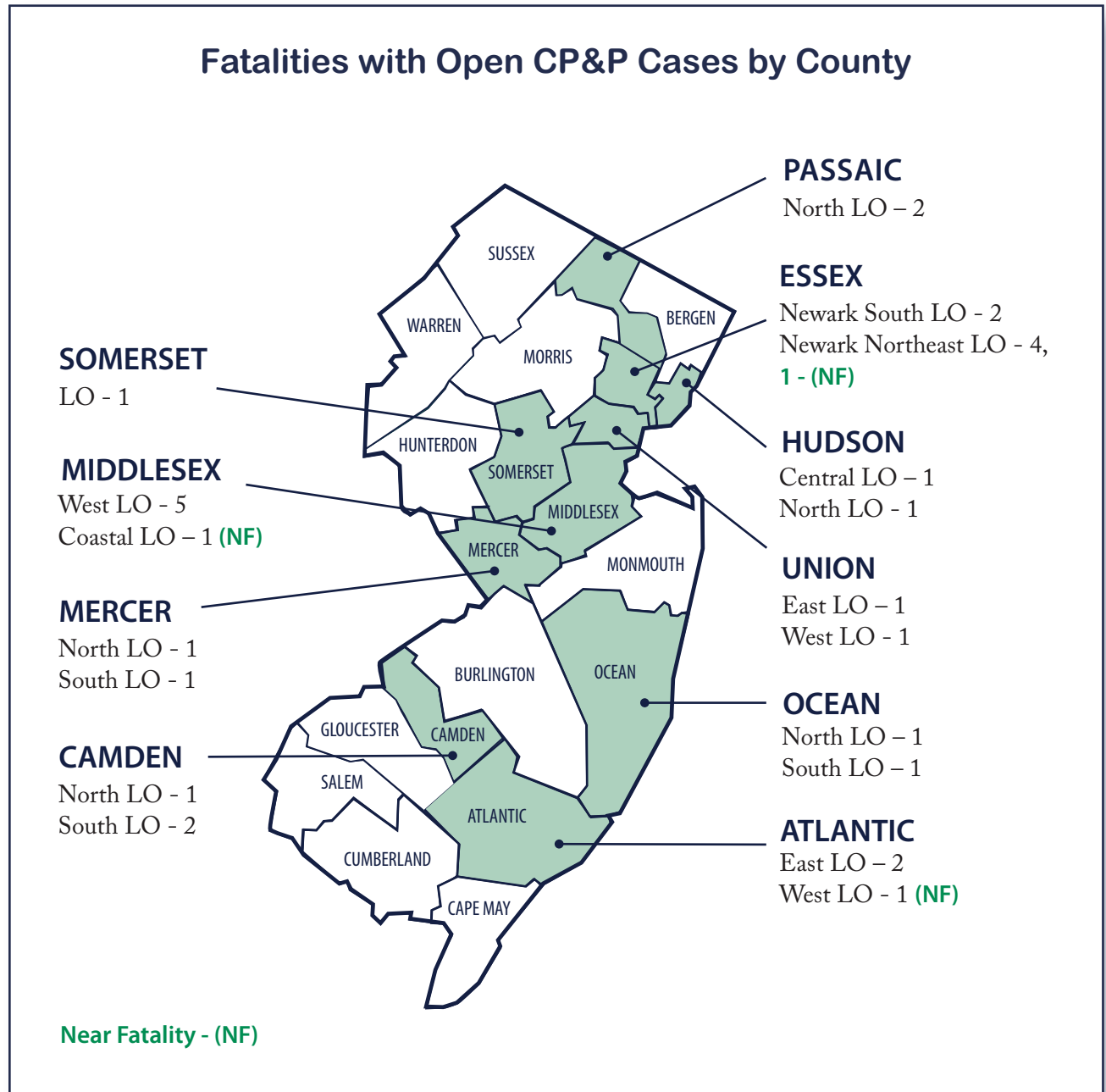
⁶ Department of Children and Families. 2013. State of New Jersey. <http://www.state.nj.us/dcf/about/divisions/dcpp/>

⁷ Department of Children and Families. Annual Agency Performance Report. New Jersey, 2011. Page 8. http://www.state.nj.us/dcf/documents/about/AnnualAgencyReport2011_110911.pdf

⁸ Department of Children and Families. 2013. State of New Jersey. <http://www.nj.gov/dcf/about/divisions/iaiu/>

⁹ Department of Children and Families Website. New Jersey, 2014. <http://nj.gov/dcf/childdata/dcppdemo/AllSupervisedChildren-in-and-out-home.pdf>

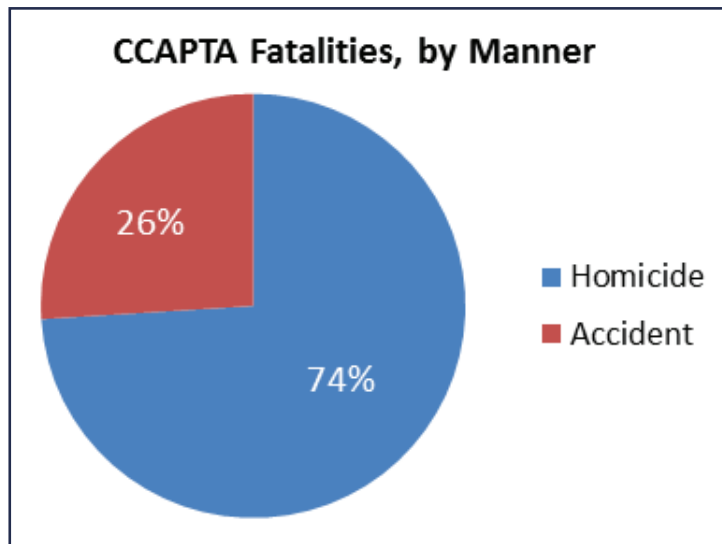
CASES OPEN WITH CP&P AT TIME OF DEATH



DRUG RELATED

CCAPTA Fatalities by Manner

Of the 19 CCAPTA fatalities reviewed, homicide was determined to be the leading manner of death with fourteen (74%) incidents, followed by accident with five (26%) incidents.



CCAPTA Fatalities by Cause

Inflicted injuries, including blunt impact injuries, multiple injuries, decapitation and severe non-accidental head trauma, were the leading cause of death for the CCAPTA fatalities reviewed with 12 (63%) cases total. The manner of death in all twelve of these cases was homicide.

There were four (21%) CCAPTA fatalities involving a child who drowned. Three were accidents and one was a homicide.

In one (5%) case, a child died as a result of Acute Fentanyl Intoxication. The child was one year old and the fatality was deemed an accident. In one (5%) case, a child died due to Positional Asphyxia. The child's death was deemed an accident. In one (5%) case, a child died due to Asphyxia due to Inhalation of Products of Combustion. The child and mother died in a house fire and the child's death was deemed a homicide.

Of the 19 CCAPTA fatalities, the family was unknown to CP&P in 14 cases. CP&P became involved due to the child's death in all 14 cases. The family was open with CP&P at the time of the child's death in four cases. In one case, the family was involved with CP&P previously, but the family was not currently involved at the time of the child's death.

CCAPTA Near Fatal Incidents

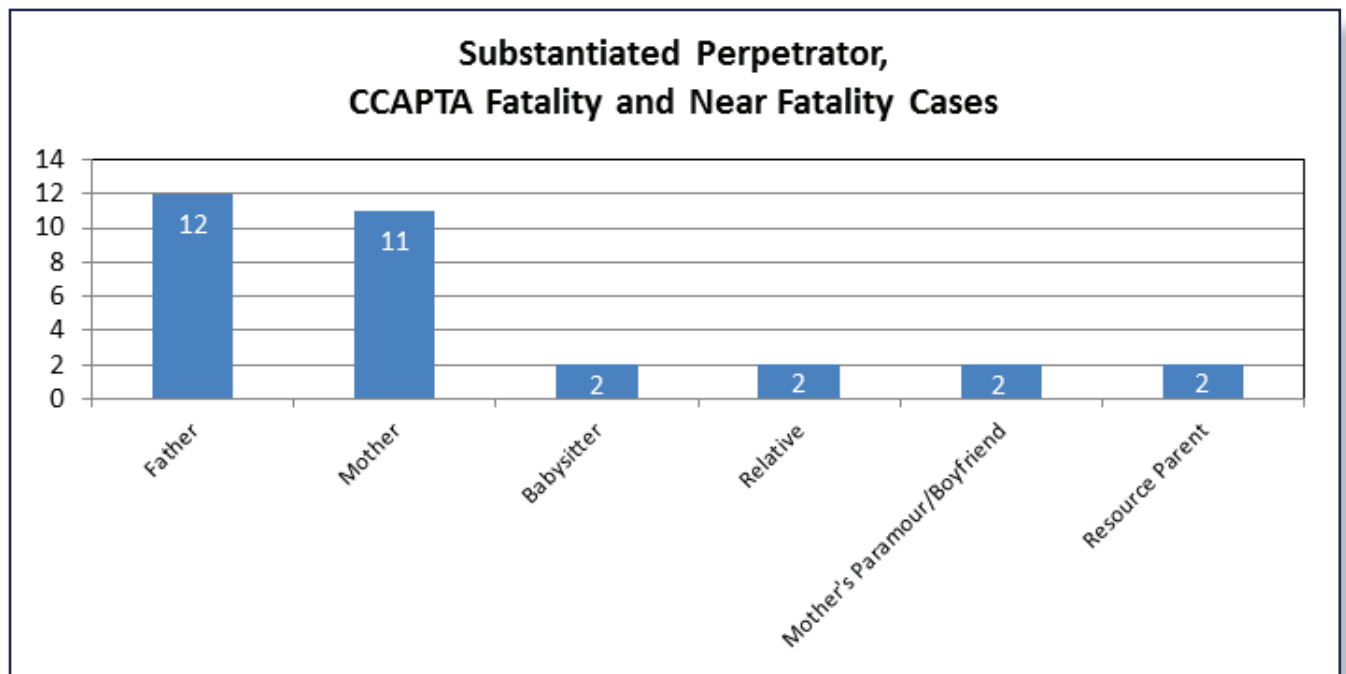
The CFNFRB and its regional teams reviewed four near fatalities which occurred in 2012. All of the cases were designated as CCAPTA cases and all four were substantiated for either abuse and/or neglect. All of the four children were subjected to bone fractures, head injuries, and/or other internal/external injuries. All of the children were under the age of seven months at the time of their injuries.

In three of the cases, the family's case was open with CP&P at the time of the child's injuries. In one case, the family was not previously known to CP&P, but the family became involved due to the child's injuries.

CCAPTA Substantiated Perpetrators

For the 19 CCAPTA fatality cases, there were a total of 25 substantiated perpetrators. The child's father was substantiated in nine cases; the mother was also substantiated in nine cases. The child's babysitter was substantiated in two cases. In one case, the child's maternal grandmother and maternal aunt were substantiated for neglect. In one case, the mother's boyfriend was substantiated for physical abuse. In one case, the child's two resource parents were substantiated for physical abuse and neglect.

For the four near fatality CCAPTA cases, there were six substantiated perpetrators. The child's father was a substantiated perpetrator of the abuse and/or neglect in three cases; the mother was a substantiated perpetrator in two cases, and the mother's paramour was a substantiated perpetrator in one case.



RECOMMENDATIONS

STATE MEDICAL EXAMINER

The Board has repeatedly identified the need for a permanent State Medical Examiner. Since the Board's inception, there have been at least eight acting State Medical Examiners. Without strong, centralized leadership, the disparate practices of New Jersey's medical examiners continues to put the children of the state at risk by reducing the potential to thoroughly and consistently investigate child deaths. The disparate practices also significantly impact the State of New Jersey's ability to collect data, the use of which might help prevent child fatalities. The New Jersey legislature has once again proposed legislation to address this issue and the Task Force on Child Abuse and Neglect has recently elected to take up this issue; the Board commends both and hopes to support them in this endeavor.

RISK ASSESSMENT

The Board has identified the need for an enhanced risk assessment of children and families involved with the Department of Children and Families. This need has resulted in the formulation of the following recommendations:

- **To the Department of Children and Families:**

1. CP&P must develop a strategy to consistently implement its risk assessment and reassessment process statewide. It is the board's understanding that the department has convened a task force and is in the process of reviewing recommendations and implementation strategies. It would be expected that by next year the department will have made substantial progress in this area.
2. CP&P should continue to evaluate its guidelines to forensic psychologists regarding the evaluations they produce to assure best practices

- **To the Division of Consumer Affairs:**

1. NJ Board of Psychological Examiners should initiate a best practice standard within the area of child abuse and maltreatment, requiring a continuing education component.
2. The NJ Board of Medical Examiners should require pediatricians, family practitioners, emergency department doctors, and any physician who routinely provides medical care to children complete continuing medical education (CME) on child abuse and neglect.

NEW JERSEY HOSPITALS

All child deaths must be referred to the medical examiner to determine cause and manner of death. It is not appropriate for a hospital to make a determination of cause or manner of death even in an unofficial capacity. It is the medical examiner's responsibility to determine whether an autopsy needs to be completed:

THE DEPARTMENT OF EDUCATION

The Department of Education should review their curriculum regarding intergenerational substance abuse and its effect on the family, including child maltreatment and death, within the context of health education.

PREVENTION

Prevention tips for the following types of fatalities:

- Abusive Head Trauma
- Sudden Unexpected Infant Death
- Drowning
- Suicide

Thank you to the National Center on Shaken Baby Syndrome, the American Academy of Pediatrics, Safe Kids Worldwide, and the National Association of School Psychologists.

ABUSIVE HEAD TRAUMA (SHAKEN BABY SYNDROME) PREVENTION

The Period of **PURPLE** Crying

Starting at about two weeks of age, some babies begin crying more and may be hard to soothe. As a result, parents may feel guilty and angry if they are not able to console them. The Period of Purple Crying explains that if the baby is not ill and parents have tried everything they can think of to soothe the baby, it is okay if they cannot stop their baby from crying. This is true even if the crying lasts for hours. Not being able to soothe an infant does not make mom and dad bad parents. Some babies are just going to cry. It will end, and life will return to normal.

The letters in **PURPLE** stand for the common parts of non-stop crying in infants:

- P** - peak pattern (crying peaks around two months, then decreases)
- U** - unpredictable (crying for long periods can come and go for no reason)
- R** - resistant to soothing (the baby may keep crying for long periods)
- P** - pain-like look on face
- L** - long bouts of crying (crying can go on for hours)
- E** - evening crying (baby cries more in the afternoon and evening)

How to Cope

Even if you know that non-stop infant crying is **not your fault**, crying can still be hard to cope with. The keys to getting through it are trying different things and having a plan.

Try Different Things - Basic Soothing Tips for a Fussy Baby

- **Feed Your Baby** - The main reason babies cry is because they are hungry. A full tummy may be just what baby is looking for. Keep in mind that even adults sometimes get hungry before the next mealtime. So even if it has not been that long since your baby was fed, hunger may still be the cause of the crying.
- **Check Your Baby's Temperature** - She may be fussing because she is not feeling well. Use a clean digital thermometer under the arm. If she is less than three-months-old and her temperature is above 100.4° F or if you think she is sick, call the doctor.
- **Hold Your Baby** - This may be on your lap, in a sling, or against your chest—whatever is most comfortable for you and baby. Always remember to support your baby's head.
- **Cuddle, coo, read, and sing.** Your baby does not know if you cannot carry a tune—it is all music to his ears!
- **Rock baby** gently, walk around, dance slowly. Even if your baby doesn't stop crying, she will know you care and are there for her. A baby swing may work. Make sure you use one that rocks side to side and not front to back.
- **Check Your Baby's Diaper** - Check to see if your baby has a dirty diaper. Babies should have between eight and ten wet diapers each day. Your baby may be crying to let you know it is time for a change. Also watch for diaper rash, which can make baby fussy. Ask your doctor what to use to treat diaper rash.
- **Check Your Baby's Clothes** - Is something too tight? Is a tag rubbing baby's skin? Is baby too hot or too cool? Try taking off socks or putting on a little hat. Some babies feel better wrapped up securely in a light blanket.
- **Create "white noise"** - Some babies like the sound of the vacuum cleaner or dishwasher. A radio or TV playing in the background may work, too.
- **Take Baby for a Walk** - A change of scenery may help. It will probably help you to get out, too.

Have a Plan

- **Let Others Help You** - Take friends and family up on their offers to watch the baby for a while. Use this time to get some work done, run an errand, or even take a nap. Do not feel bad about leaving your baby with someone for a couple of hours. Moms and Dads need some time for themselves as well.
- **Join a Play or Support Group** - By getting together with others who have babies the same age, you can share stories and tips. Just seeing that you are not alone can be a big help. If you cannot get to a group, perhaps you can find one or two other parents in your neighborhood who would like to get together. Call First Call for Help 211 (just dial 211) to get information about local groups that meet your needs (twins, stay-at-home moms, newcomers, etc.).
- **Take a Break** - If nothing else works and you have no one to call on, put the baby in the cradle or crib and walk away. You need to take care of you before you can take care of the baby. Relax for a few minutes, calm down and regroup. Listen to some music, read, have a snack, do something else for a few minutes. A parent who is angry and upset may take it out on the baby. Remember, this is not your fault and it is not the baby's fault. It is just the way it is.
- **This stage will end!** - Your baby will learn to smile and laugh and play. If you can be as comforting as possible through this difficult time, your baby will also learn that you are there for her no matter what.

SUDDEN UNEXPECTED INFANT DEATH/SUDDEN INFANT DEATH SYNDROME PREVENTION:

American Academy of Pediatrics' recommendations on Safe Sleep

- Always place your baby on his or her back for every sleep time.
- Always use a firm sleep surface. Car seats and other sitting devices are not recommended for routine sleep.
- The baby should sleep in the same room as the parents, but not in the same bed (room-sharing without bed-sharing/co-sleeping).
- Keep soft objects or loose bedding out of the crib. This includes pillows, blankets, and bumper pads.
- Wedges and positioners should not be used.
- Pregnant woman should receive regular prenatal care.
- Don't smoke during pregnancy or after birth.
- Breastfeeding is recommended.
- Offer a pacifier at nap time and bedtime.
- Avoid covering the infant's head or overheating.
- Do not use home monitors or commercial devices marketed to reduce the risk of SIDS.
- Infants should receive all recommended vaccinations.
- Supervised, awake tummy time is recommended daily to facilitate development and minimize the occurrence of positional plagiocephaly (flat heads).

Source: www.AAP.org

SUICIDE PREVENTION: Risk Factors, Warning Signs and What to Do

Suicide Risk Factors - Certain characteristics are associated with increased suicide risk.

These include:

- Mental illness including depression, conduct disorders, and substance abuse.
- Family stress/dysfunction.
- Environmental risks, including presence of a firearm in the home.
- Situational crises (i.e., traumatic death of a loved one, physical or sexual abuse, family violence, etc.).

Suicide Warning Signs - Many suicidal youth demonstrate observable behaviors that signal their suicidal thinking. These include: Mental illness including depression, conduct disorders, and substance abuse.

- Suicidal threats in the form of direct and indirect statements.
- Suicide notes and plans.
- Prior suicidal behavior.
- Making final arrangements (e.g., making funeral arrangements, writing a will, giving away prized possessions).
- Preoccupation with death.
- Changes in behavior, appearance, thoughts and/or feelings.

What To Do - Youth who feel suicidal are not likely to seek help directly; however, parents, school personnel, and peers can recognize the warning signs and take immediate action to keep the youth safe. When a youth gives signs that they may be considering suicide, the following actions should be taken.

- Remain calm.
- Ask the youth directly if he or she is thinking about suicide.
- Focus on your concern for their wellbeing and avoid being accusatory.
- Listen.
- Reassure them that there is help and they will not feel like this forever.
- Do not judge.
- Provide constant supervision. Do not leave the youth alone.
- Remove means for self-harm.
- Get help: Peers should not agree to keep the suicidal thoughts a secret and instead should tell an adult, such as a parent, teacher, or school psychologist. Parents should seek help from school or community mental health resources as soon as possible. School staff should take the student to the designated school mental health professional or administrator.

Source: www.nasponline.org/resources/crisis_safety/suicideprevention.aspx

