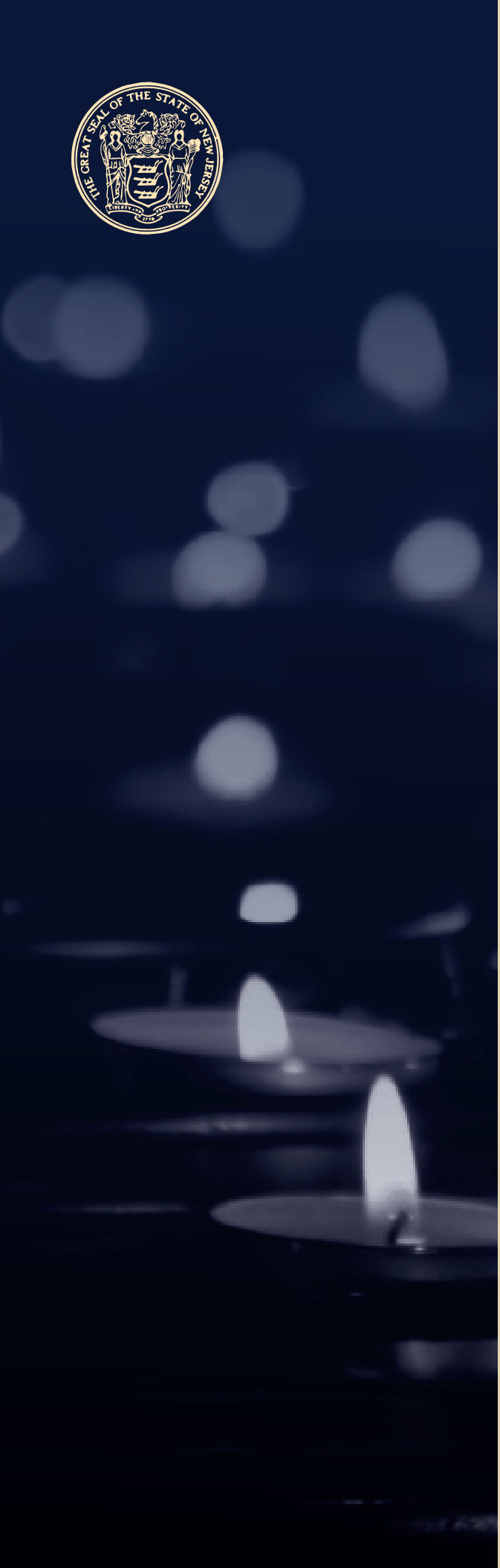

CHILD FATALITY & NEAR FATALITY REVIEW BOARD

2019 ANNUAL REPORT

NEW JERSEY

ISSUED 2021

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The **New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA),** adopted on July 31, 1997, established the statewide **Child Fatality and Near Fatality Review Board (CFNFRB, N.J.S.A. 9:6-8.88)**. The purpose of the CFNFRB is to ensure a comprehensive case review of child fatalities and near fatalities in order to identify and determine their cause, their relationship to governmental support systems, and methods of prevention. Pursuant to **N.J.S.A. 9:6-8.91**, the CFNFRB established local community-based teams to assist in the review of child fatalities in New Jersey.

These community-based teams are comprised of human services professionals from nonprofit and state organizations, as well as physicians, prosecutors, law enforcement officers, pathologists, social workers, child advocates, and educators. There are three community-based teams to represent different regions of the state; two statewide subcommittees that address specific types of fatalities, Sudden Unexplained Infant Deaths (SUID) and Suicide; and a sixth team comprised of the State Board, which reviews fatalities/near fatalities of children involved with the New Jersey Division of Child Protection and Permanency (CP&P) either at the time of the incident or within 12 months prior to the incident.

The State Board invites CP&P staff, including front-line workers, to our monthly meetings to gather more information about the case, and to fully understand CP&P's involvement and their experience working with the family. We always begin the review by asking CP&P staff for their views on what could have been done to prevent the fatality/near fatality. We explain that the Board is not looking to cast blame, but instead is looking for ways to improve the responses of New Jersey's systems to prevent such incidents from happening to other children. We look for challenges or barriers to CP&P doing their work and whether current protocols and procedures should be modified or if new resources are needed. We also ask about challenges erected by other systems in which the family was involved. These systems touch upon a variety of disciplinary fields, including physical health, mental health, substance use, law enforcement and education.

Our goal is to learn from the caseworkers and the materials provided, identify ways to make improvements to the systems, and then suggest recommendations to those systems to address any barriers or challenges that exist. We look for patterns, emerging trends, or problems that repeat over time. This report includes our recommendations from cases in which children died or nearly died in 2017. We hope these recommendations will be considered by the entities to whom we made them so that we can successfully prevent similar, future tragedies.

Sincerely,

Kathryn McCans, M.D., F.A.A.P.

Chairwoman

Selecting and Reviewing Cases

The 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, Law Enforcement, and upon request, the Department of Health. 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.

All relevant documentation is posted in a secure online library approximately two (2) weeks before a scheduled meeting for members to review in preparation for discussion.

Some of the possible actions following each case review include: 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.

Based on NJ case law, cases are reviewable when the cause of death is any of the following:

- Undetermined
- Substance abuse[1] may have been a contributing factor
- Homicide due to child abuse or neglect
- Child abuse or neglect may have been a contributing factor
- Malnutrition, dehydration, 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
- Children whose families were under the supervision of the Division of Child Protection and Permanency (CP&P) at the time of the fatal or near fatal incident or within twelve (12) months immediately preceding the fatal or near fatal incident.
- Drowning
- Motor vehicle accidents in which the child:
    - Had a positive toxicology screen
    - 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)

[1] *includes substance use*

Members

The type of case and its geographical location determines which team will review the case. There is a total of six teams: State CFNFR Board, Northern Community-Based Team, Central Community-Based Team, Southern Community-Based Team, Suicide Subcommittee (SSC) and the Sudden Unexpected Infant Death Subcommittee (SUID).

The State Board reviews only those cases that meet criteria in which CP&P was involved at the time of the fatality/near fatality or within the last twelve months; the Teams review all other cases. The SUID Subcommittee reviews all deaths in children under one year old whose cause/manner was SUID, Sudden Infant Death Syndrome (SIDS), undetermined, and any others that were sleep-related. The Suicide Subcommittee reviews all deaths with the manner certified as a suicide.

The State CFNFR Board Members:

- **Chair: Kathryn McCans, M.D., F.A.A.P.**, St. Christopher's Hospital for Children
- **Shereef Elnahal, Commissioner**, Department of Health, Designee: **Lakota Kruse, M.D., M.P.H.**
- **Christine Norbut Beyer, MSW, Commissioner,** Department of Children and Families
- **Sean F. Dalton, Esq.,** Prosecutor, Gloucester County
- **Andrew L. Falzon, M.D.**, Chief State Medical Examiner
- **Col. Rick Fuentes, Superintendent,** New Jersey State Police, Designee: **LT. Thomas Wieczerak**
- **Daniel Yale,** New Jersey Task Force on Child Abuse and Neglect
- **Gubir S. Grewal, Attorney General,** Office of the Attorney General, Division of Law, Designee: **Lea DeGuilo, Esq.**
- **Lillian Brennan, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Carmen Diaz-Petti Assistant Commissioner,** Division of Child Protection and Permanency,
- Department of Children and Families Designee: **Nancy Carre´-Lee**
- **Jennifer Pax, J.D., LCSW, Ph.D.,** Social Work
- **Elayne Weitz**, **PsyD,** Psychologist

STAFF: Lisa Kay Hartmann, State Coordinator, Amanda Craig, and Lauren Woods NJ DCF Liaisons to CFNFRB

2019 CFNFRB Report written by Melissa Weisel

Members Cont.

Northern Regional Community-Based Team

(Counties: Bergen ,Hudson, Morris, Passaic, Sussex, Warren, Essex)

- **Chair: Paulett Diah, M.D.**, Hackensack Meridian Health
- **Frederick DiCarlo, M.D.,** Bergen County Medical Examiner's Office
- **Maria Ojeda,** Division of Child Protection and Permanency
- **Yvonne Decicco, Esq.,** Office of the Public Defender, Office of Law Guardian
- **Sandra Parente,** Division of Child Protection and Permanency
- **LT. Javier Toro,** Hudson County Prosecutor's Office
- **Kelly Sandler**, Morris County Prosecutor's Office
- **Karen Eigen, M.D.,** Hackensack Meridian Health
- **Amber Rabines,** Partnership of Maternal Child Health of Northern NJ

Central Regional Community-Based Team

(Counties: Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset, Union)

- **Chair: Dr. Gladibel Medina, M.D.**, Dorothy B. Hersh Child Protection Center
- **Patricia Soffer, Esq.,** Office of the Public Defender, Office of Law Guardian
- **Carol Ann Giardelli,** Director, Safe Kids New Jersey – Central Jersey Family Health Consortium
- **Det. Matthew Norton,** Mercer County Prosecutor's Office
- **Laura Badilla,** Division of Child Protection and Permanency
- **Lauren Thoma, M.D.,** Middlesex Regional Medical Examiner's Office
- **Helen Varvi, M.Ed.,** Wellspring Center for Prevention
- **Laura Johnson, MSW,** Rutgers School of Social Work

Suicide Subcommitee

- **Andrew L. Falzon, M.D.,** State Medical Examiner
- **Jessica Houghton,** Children's System of Care
- **Michelle Scott, PhD, MSW,** Monmouth University
- **Maureen Brogan, LPC, DRCC,** Traumatic Loss Coalition
- **Marisol Garces, MSW,** Division of Child Protection and Permanency
- **Jennie Blakney, MA. ED.,** Department of Health
- **Det. Sgt. Michael A. Sperry,** Burlington County Prosecutor's Office
- **Iris Moore,** Division of Child Protection and Permanency
- **Michele Safrin,** Office of Adolescent Services
- **Susan Paredes**, Assistant Principal Metuchen High School
- **Diane Calello, M.D.,** NJ Poison Information and Education System, Rutgers

Members Cont.

Southern Regional Community-Based Team

(Counties: Atlantic, Burlington, Camden, , Cape May, Cumberland, Gloucester, Salem)

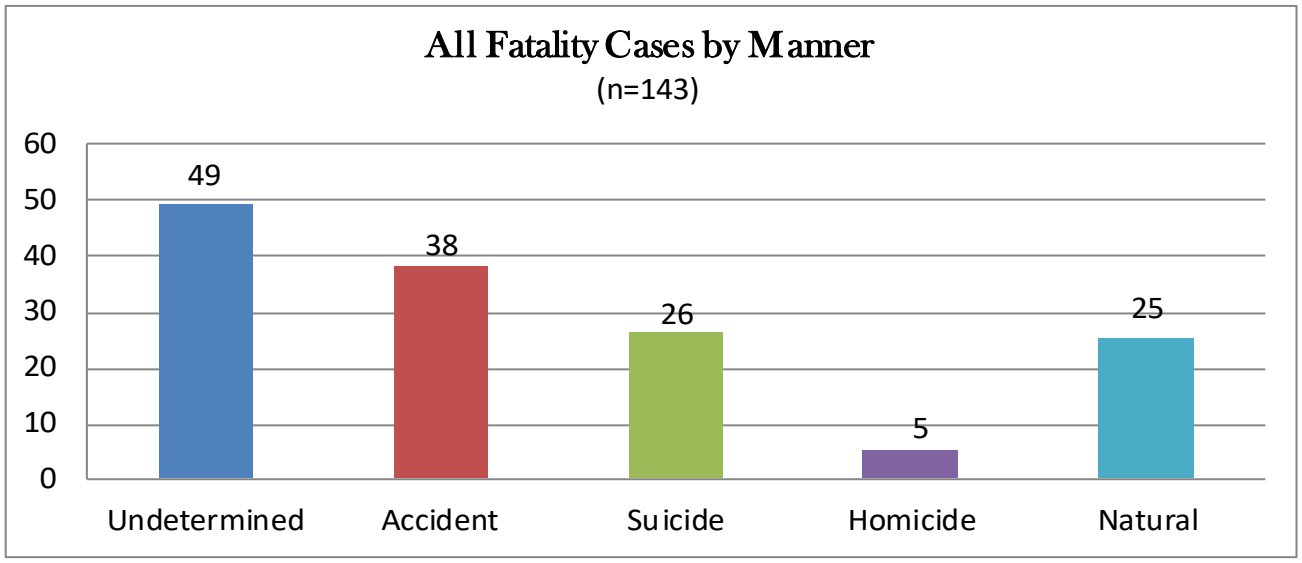
- **Chair: Laura Brennan, M.D.**, Rowan University, School of Osteopathic Medicine
- **Mary Alison Albright, Esq.,** Camden County Prosecutor's Office (Retired)
- **Nanette Briggs, Esq.,** Office of the Public Defender, Office of Law Guardian
- **Ian Hood, M.D.,** Burlington County Medical Examiner's Office
- **Lt. James Kirschner**, Atlantic County Prosecutor's Office
- **Barbara May, R.N., M.P.H.,** Southern NJ Perinatal Cooperative, Inc.
- I**ris Moore,** Division of Child Protection and Permanency
- **Det. Frank Sabella,** Cumberland County Prosecutor's Office
- **Christine Shah, Esq.,** Camden County Prosecutor's Office
- **Det. Sgt. Michael A. Sperry,** Burlington County Prosecutor's Office
- **Jacqueline Forss,** Department of Child Protection and Permanency
- **Sara Plummer, Ph.D., MSW**, School of Social Work, Rutgers
- **John Flammer, Esq.,** Atlantic County Prosecutor's Office

Sudden Unexpected Infant Death Subcommittee

- **Lillian Brennan, Esq.,** Office of the Public Defender, Office of Law Guardian
- **Susan Fiorilla**, Division of Child Protection and Permanency
- **Lakota Kruse, M.D., M.P.H.,** Department of Health
- **Det. Matt Norton**, Mercer County Prosecutor's Office
- **Alissa Sandler,** The SIDS Center of New Jersey
- **Matthew Maguire**, EMS Medical Direction Coordinator Cooper Health
- **Lenore Scott,** Early Childhood Services, Family and Community Partnerships

Statewide

The Fatality and Executive Review Unit of the Department of Children and Families was notified of 311 child fatalities/near fatalities in New Jersey for the 2017 calendar year. Of those 311 cases, 154 met the criteria for review. Of those 154 cases reviewed, 11 were near fatalities.



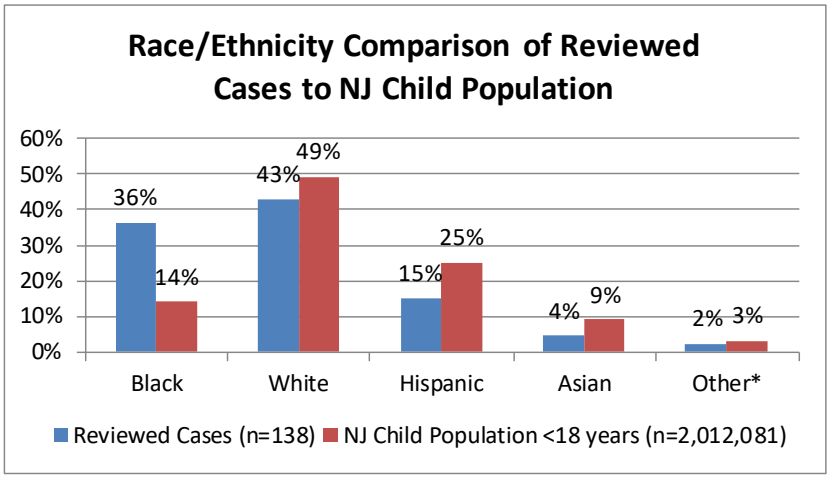
Source: Data collected from 2017 Reviews

The leading cause of death in each manner of death is as follows:

- 80% (39) of the Undetermined cases were sudden unexpected infant death (SUID)/Sleep-Related, followed by three cases of hanging, two undetermined , one acute anoxic encephalopathy of unknown etiology, and one acute methadone toxicity.
- 29% (11) of the Accident cases were due to asphyxia, 24% (9) of the deaths were due to drowning, 16% (6) were related to drugs, and 13% (5) were due to blunt force or multiple injuries. Only 5% (2) of the Accident cases were SUID/Sleep-Related . Other causes included one choking, one aspiration, and one smoke inhalation.
- 62% (16) of the Suicide cases were caused by hanging, followed by four gun shot wounds, three drug-related, two from blunt trauma, and one case from drowning.
- 80% (4) of the Homicide cases were caused by blunt force trauma and the other 20% (1) was from gun shot wound.
- 96% (24) of the Natural cases were SUID/Sleep-Related followed by one death from diabetic ketoacidosis. [2]
- 45% (65) of all reviewed cases were related to SUID and/or the sleeping environment.

[2] *Some medical examiners rule the SUIDs natural while some rule them undetermined*

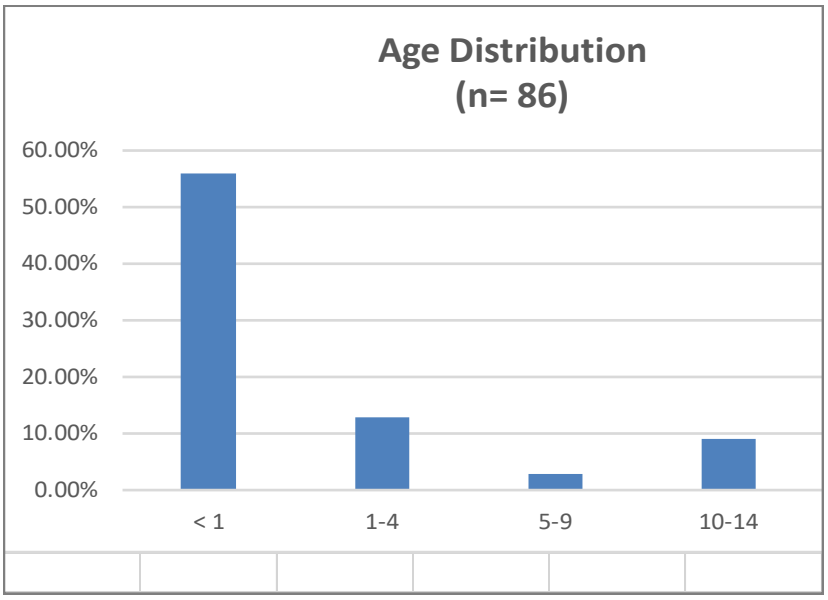
Statewide Cont.

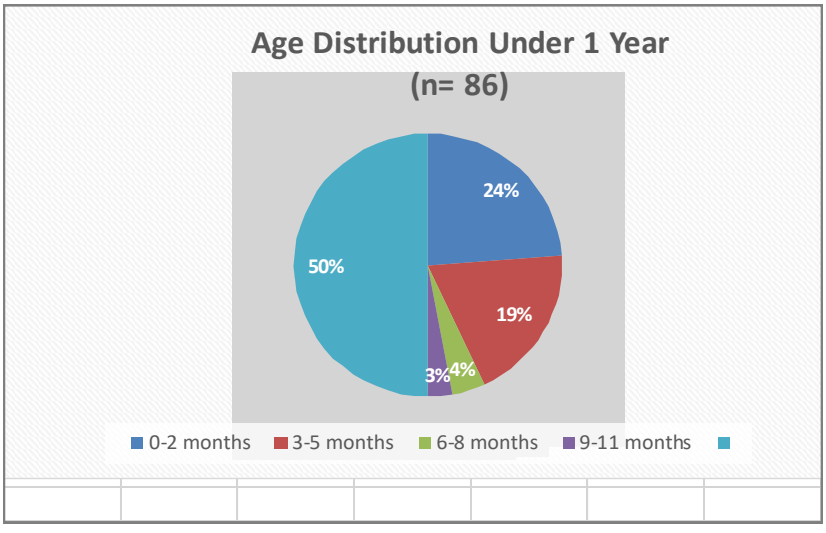


Gender Distribution

64% Male

36% Female



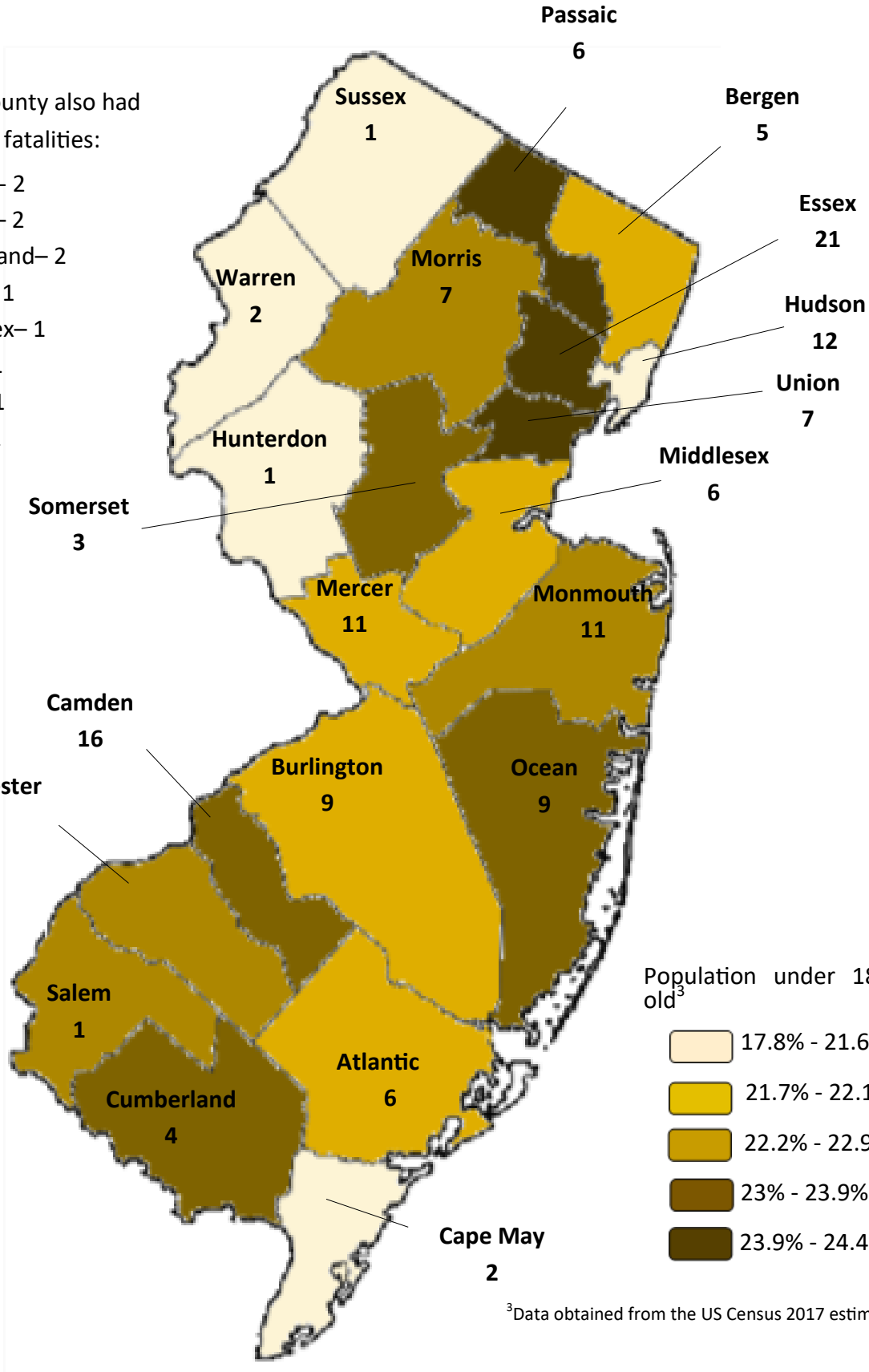


NJ Child Population data obtained from US Census, Population Division 2017 estimates

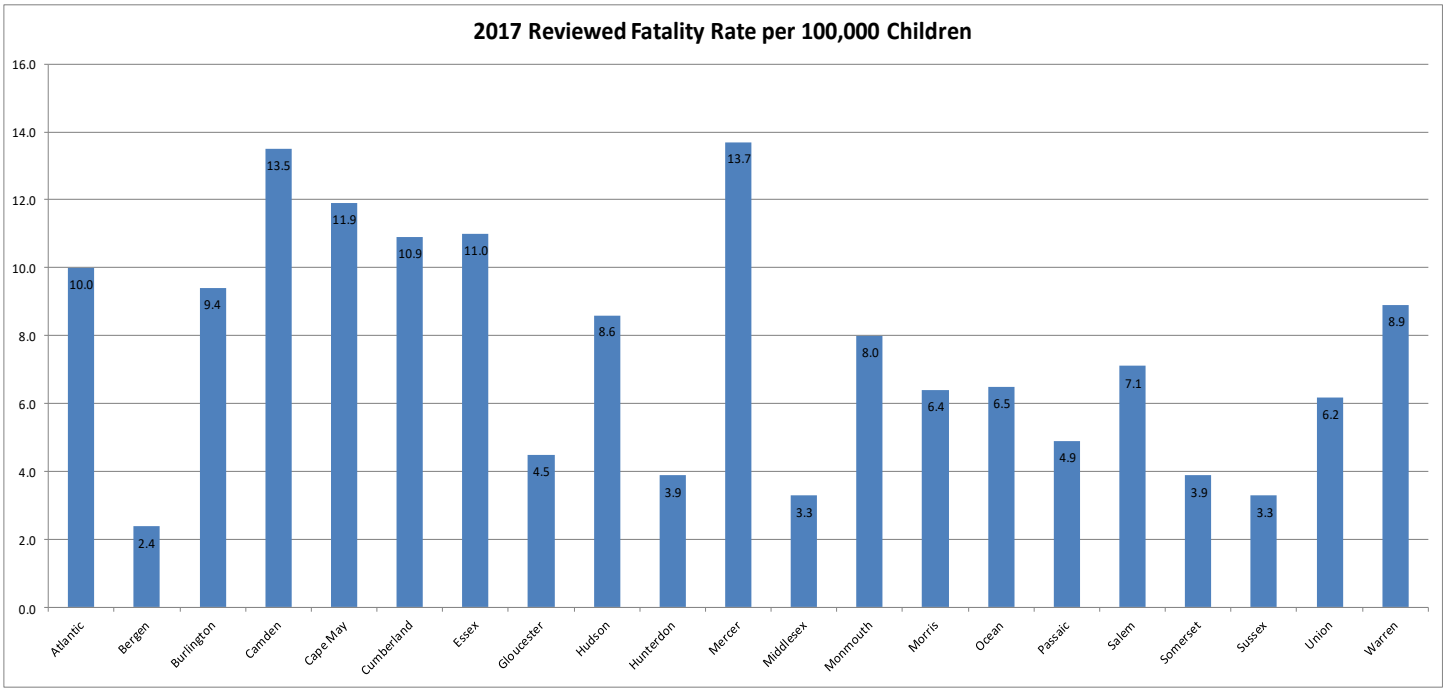
Reviewed 2017 Fatalities by County of Incident

The following county also had reviewable near fatalities:

- Atlantic - 2
- Camden– 2
- Cumberland– 2
- Mercer– 1
- Middlesex– 1
- Morris- 1
- Ocean– 1
- Union– 1



[3]Data obtained from the US Census 2017 estimates

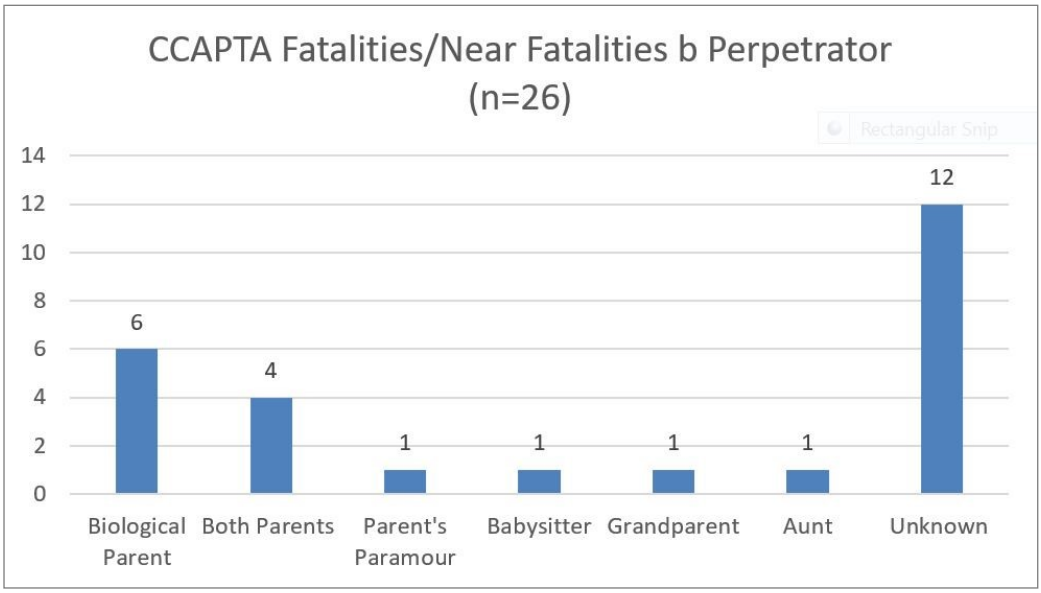


County	Accident	Homicide	Natural	Suicide	Undetermined	County Fatalities	% of NJ Fatalities	< 18 years old	Fatality Rate per 100,000 Children
Atlantic	4	0	1	0	1	6	4%	59,722	10.0
Bergen	1	0	0	2	2	5	4%	202,016	2.4
Burlington	4	0	5	0	0	9	9%	96,220	9.4
Camden	8	2	3	0	3	16	9%	118,140	13.5
Cape May	1	0	0	0	1	2	6%	16,865	11.9
Cumberland	1	0	1	1	1	4	5%	36,820	10.9
Essex	2	1	4	4	10	21	12%	191.160	11
Gloucester	1	0	0	1	1	3	4%	66,156	4.5
Hudson	3	0	1	1	7	12	5%	138,879	8.6
Hunterdon	0	0	0	1	0	1	1%	25,864	3.9
Mercer	4	0	0	2	5	11	2%	80,409	13.7
Middlesex	1	0	1	2	2	6	4%	183,576	3.3
Monmouth	4	0	1	2	4	11	5%	137,851	8
Morris	0	0	2	4	1	7	3%	109,554	6.4
Ocean	1	1	3	2	2	9	4%	139,158	6.5
Passaic	1	0	1	1	3	6	6%	123,172	4.9
Salem	1	0	0	0	0	1	2%	14,082	7.1
Somerset	0	0	1	0	2	3	4%	76,144	3.9
Sussex	0	0	0	1	0	1	1%	30,194	3.3
Union	0	1	1	2	3	7	7%	131,444	6.2
Warren	1	0	0	0	1	2	3%	22,395	8.9
State Total	38	25	5	26	49	143	100%	2,181,821	6.6

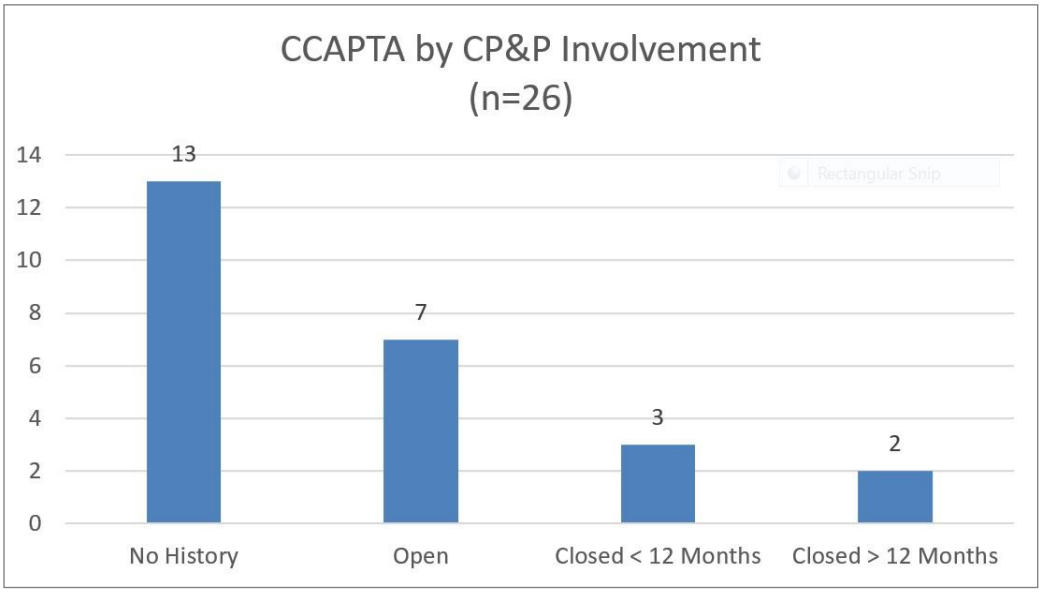
[4]*Data obtained from the US Census 2017 estimates*

Comprehensive Child Abuse Prevention & Treatment Act

The CFNFRB serves as one of the citizen review panels established by the Comprehensive Child Abuse Prevention and Treatment Act of 1997 (CCAPTA). A case is considered a 'CCAPTA' when a child fatality or near fatality is the result of child abuse or neglect; whether or not the family was involved with CP&P at the time of the incident.



Of the 26 incidents that constitute the 2017 CCAPTA cases, 38% (10) of those children were involved with CP&P at the time of the incident or had been involved with CP&P within the last twelve months.

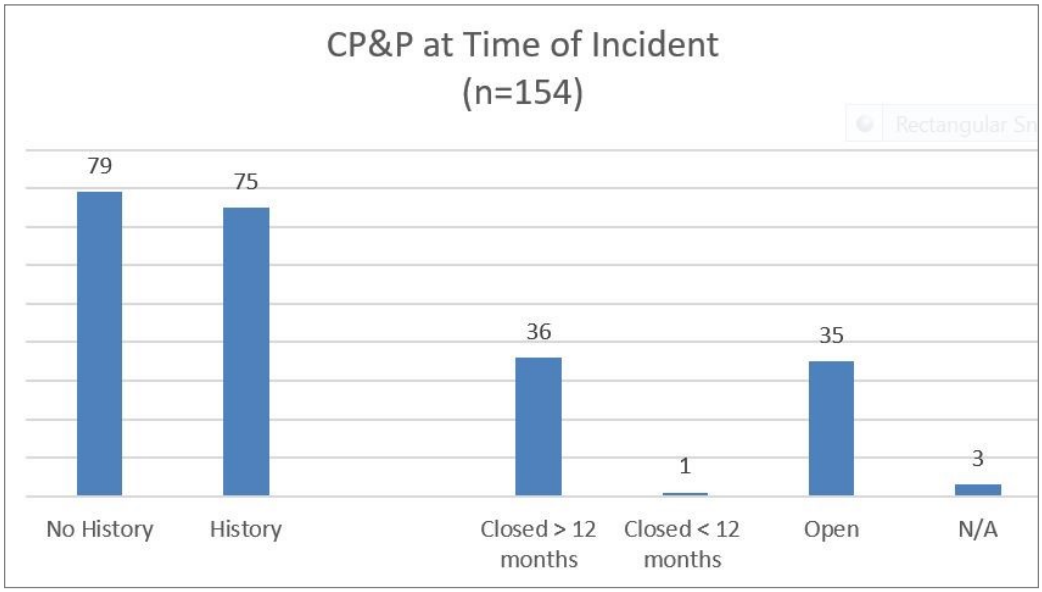


Division of Child Protection and Permanency (CP&P)

Child Protection and Permanency (CP&P) is New Jersey's child protection and child welfare agency within the New Jersey Department of Children and Families. Its mission is to ensure the safety, permanency, and well-being of children and support 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 reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the CP&P Local Office who investigates.

State Central Registry (SCR):

1-877-652-2873/ 1-877-NJ-ABUSE



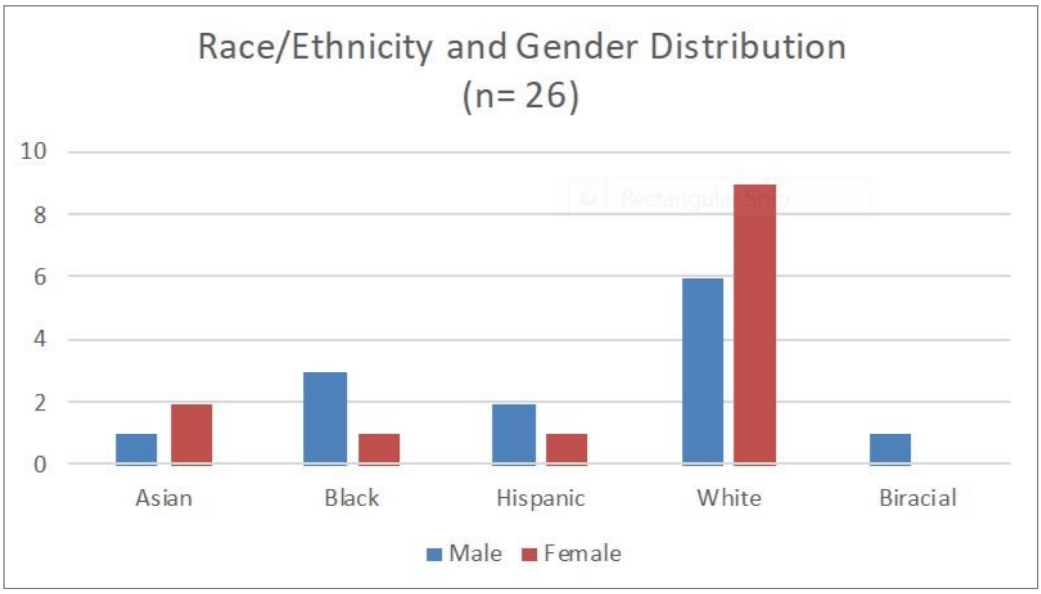
Source: Data collected through 2017 reviews

'History' includes all children who had ever been involved with CP&P regardless of timeframe.

CP&P investigates all reported allegations of child abuse and neglect. The mission is to ensure the safety, permanency, and well-being of children and to support families.

- 23% (35) of the cases reviewed were open with CP&P at the time of the incident.
- Of the 154 children reviewed, 49% (75) of them had, at some point in their life, been involved with CP&P.

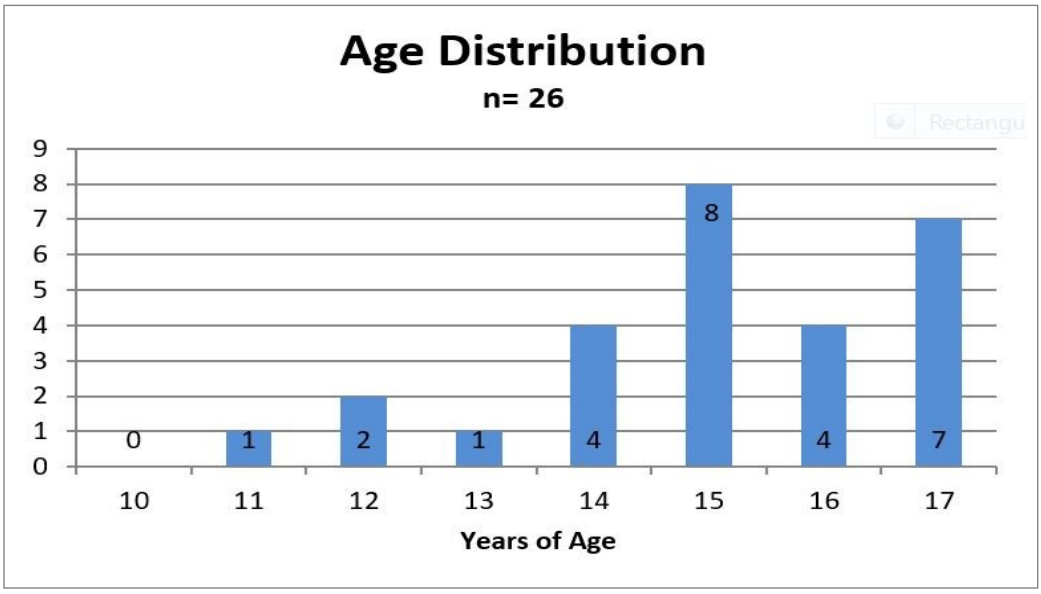
Suicide



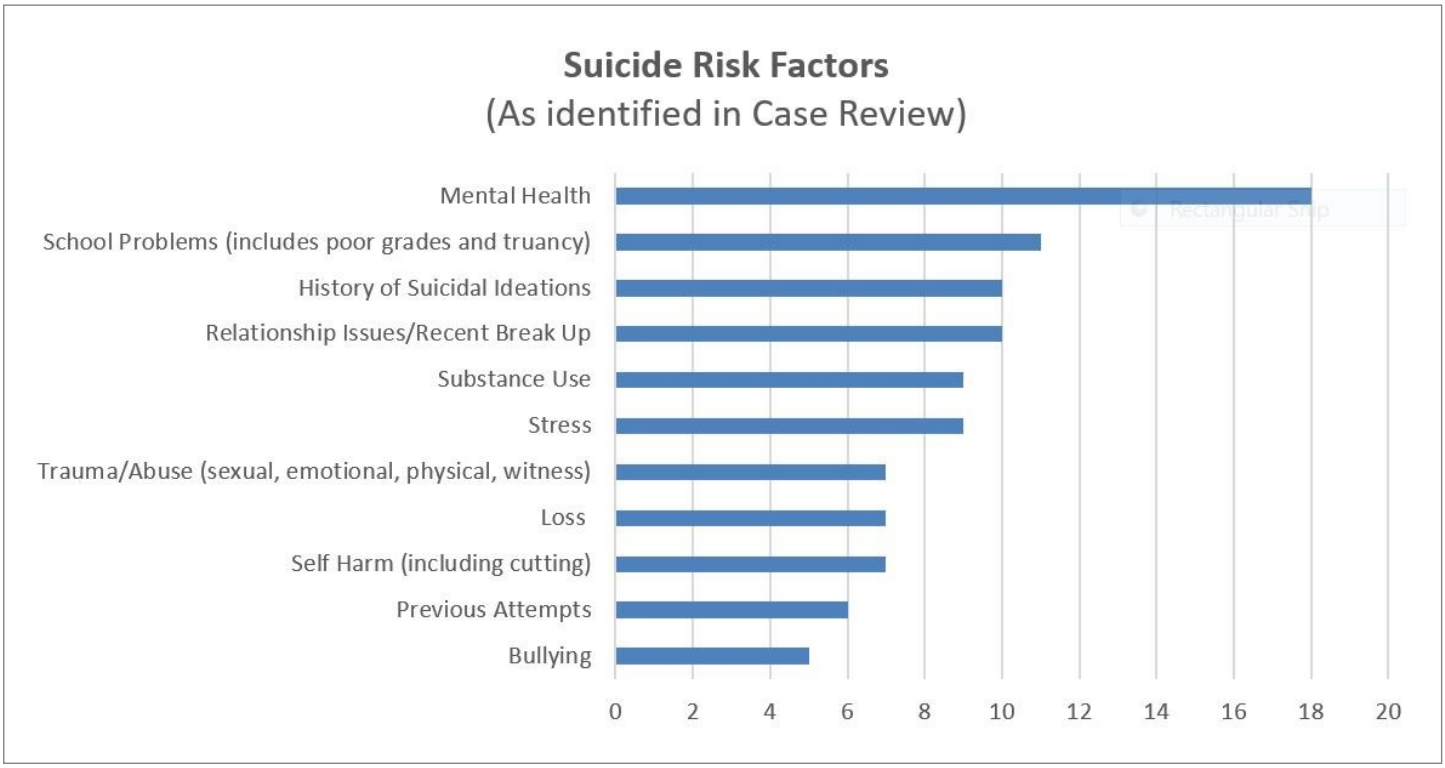
62% (16) of the suicides were completed by hanging.

8% (3) were completed by drug overdose.

The remaining methods (7) included use of a firearm, blunt force trauma and drowning.



Suicidal Warning Signs: Talking about wanting to die ● Looking for a way to kill themselves •Feeling hopeless or having no reason to live● Talking about feeling trapped or in unbearable pain •Extreme mood swings; sudden changes in personality ● Talking about being a burden to others ● Increasing use of alcohol or drugs • Acting anxious or agitated; behaving recklessly • Sleeping too little or too much • Withdrawing or isolating themselves • Showing rage or talking about seeking revenge • Running away from home Sources: National Prevention Suicide Lifeline, National Alliance for Mental Illness



Other notable factors (4 cases each): Family Conflict, Sexuality or Gender Issues, Medications Accessible, Chronic Illness, Life Transitions

Teen Suicide Risk Factors:

A recent or serious loss • A psychiatric disorder, particularly a mood disorder like depression, or a trauma-and stress-related disorder • Prior suicide attempts increase risk for another suicide attempt • Alcohol and other substance use disorders, as well as getting into a lot of trouble, having disciplinary problems, engaging in a lot of high-risk behaviors • Struggling with sexual orientation in an environment that is not respectful or accepting of that orientation • A family history of suicide is something that can be really significant and concerning, as is a history of domestic violence, child abuse or neglect • Lack of social support • Bullying We know that being a victim of bullying is a risk factor, but there's also some evidence that kids who are bullies may be at increased risk for suicidal behavior • Access to lethal means, like firearms and pills • Stigma associated with asking for help • Barriers to accessing services • Cultural and religious beliefs that suicide is a noble way to resolve a personal dilemma

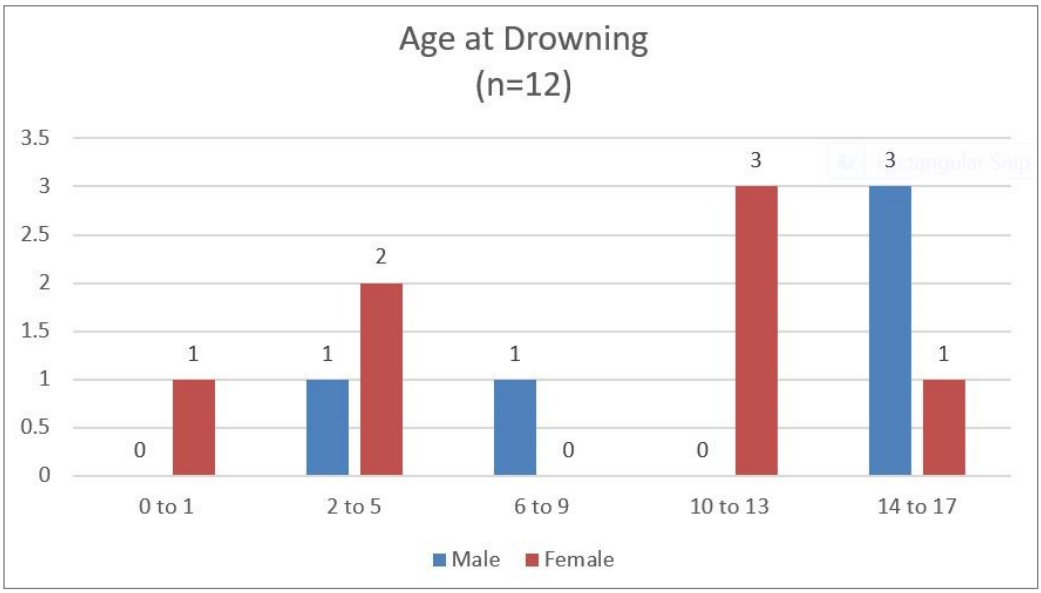
Source: Child Mind Institute

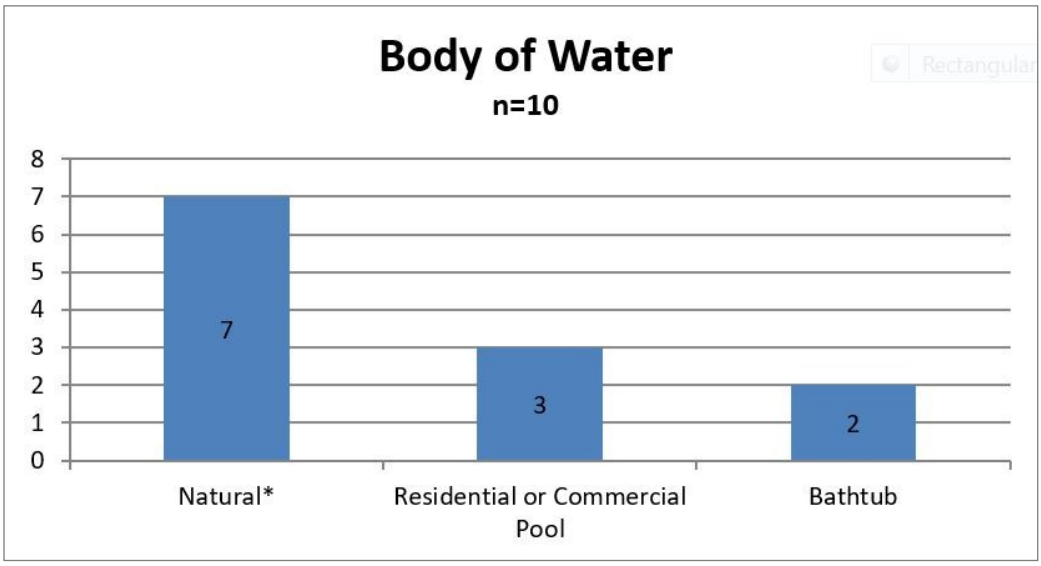
If in a crisis, youth between 10 and 24 years old can call or text 2nd Floor Youth Helpline at 888-222-2228 and visit their website www.2ndfloor.org
OR
People of any age can call the NJ Suicide Prevention Hope Line at 1-855-654-6735, text at njhopeline@ubhc.rutgers.edu, or visit their website ww.njhopeline.com

Additional resources include:

- PerformCare (provides linkage to various services for children):
  1-877-652-7624
  www.performcarenj.org
- Mobile Response and Crisis Screening:
  1-877-652-2764
- National Suicide Prevention Lifeline:
  1-800-273-TALK (8255)
  www.suicidepreventionlifeline.org

Drowning





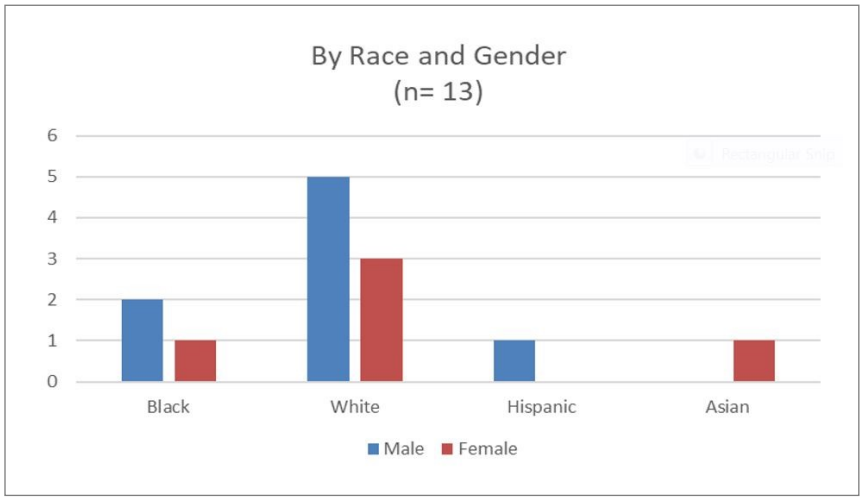
**Natural includes lake, river, and ocean*

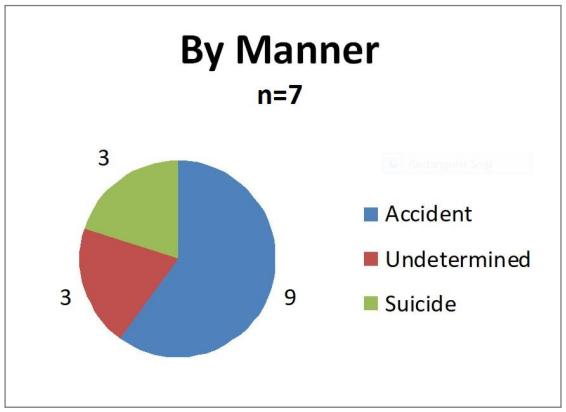
Pool Safety[5]:

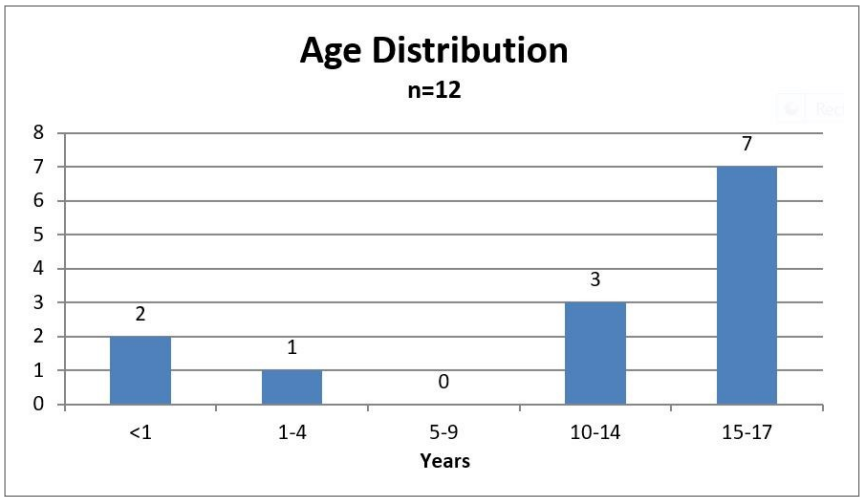
- Never leave children in or near water unattended; stay within an arm's length of small children in water to protect against rapid drowning.
- Warn children to never swim at a pool or beach alone or without a lifeguard.
- Train children to swim at an early age.
- Teach children that swimming in open water is far different than swimming in a pool.
- Be certain only qualified and undistracted adults are entrusted with supervising children in water.
- Always empty inflatable pools, buckets, pails, and bathtubs after each use.
- Personal flotation devices do not guarantee water safety.

[5] *http://nj.gov/dcf/families/safety/water/*

Substance Use







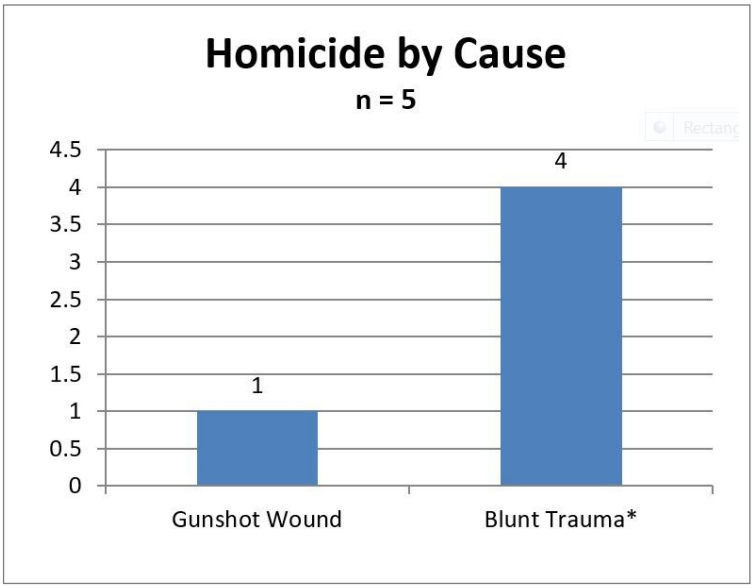
Call PerformCare at 877-652-7624 to access child behavioral healthcare and other services
OR
Call the NJ Mental Health Cares hotline at 866-202-4357 for referrals to services

Warning Signs: • Changes in mood • Academic/school problems • Changing friends and a reluctance to have parents/family get to know the new friends • A "nothing matters" attitude • Finding substances (drug or alcohol) in youth's belongings • Physical or mental changes (memory lapses, poor concentration, lack of coordination, slurred speech, etc.)

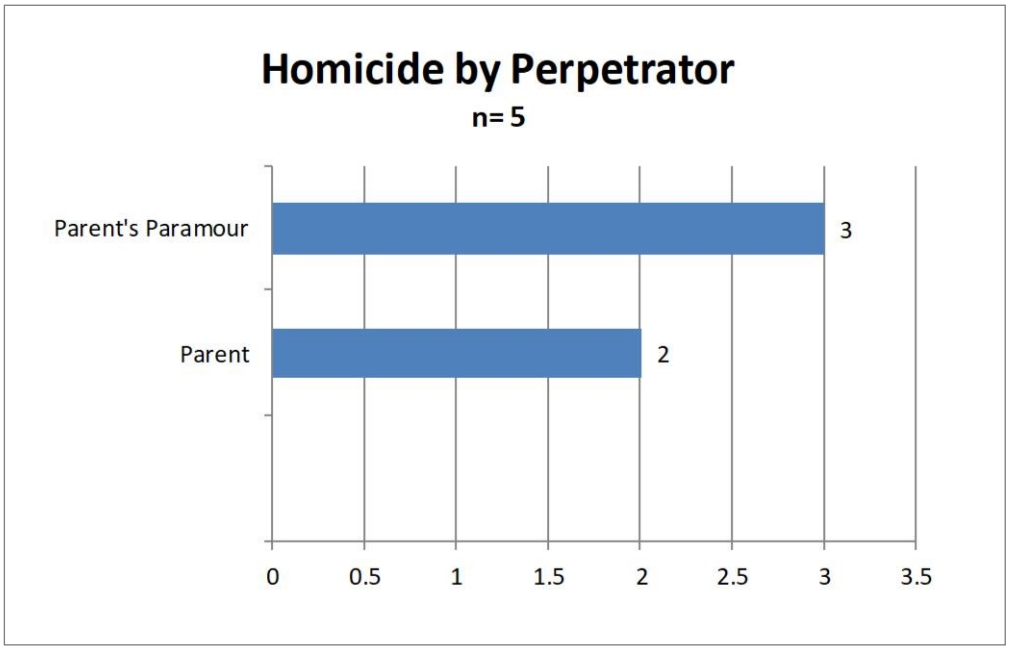
Warning signs indicate that there may be a problem —not that there definitely is a problem. Speak with the youth to get a better understanding of the situation and have the youth screened for substance use by a professional. If formal intervention is necessary, local substance abuse professionals should be contacted. If there is no clear evidence of substance use/abuse, consider working with your primary care physician or a mental health professional to address the child's behaviors and needs.

Source: http://youth.gov/youth-topics/substance-abuse/warning-signs-adolescent-substance-abuse

Homicide



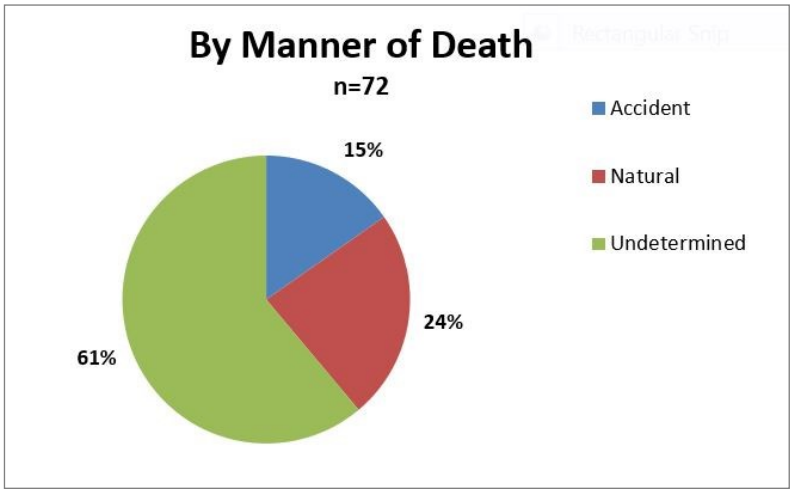
* Three of the homicide victims were male, and two were female.

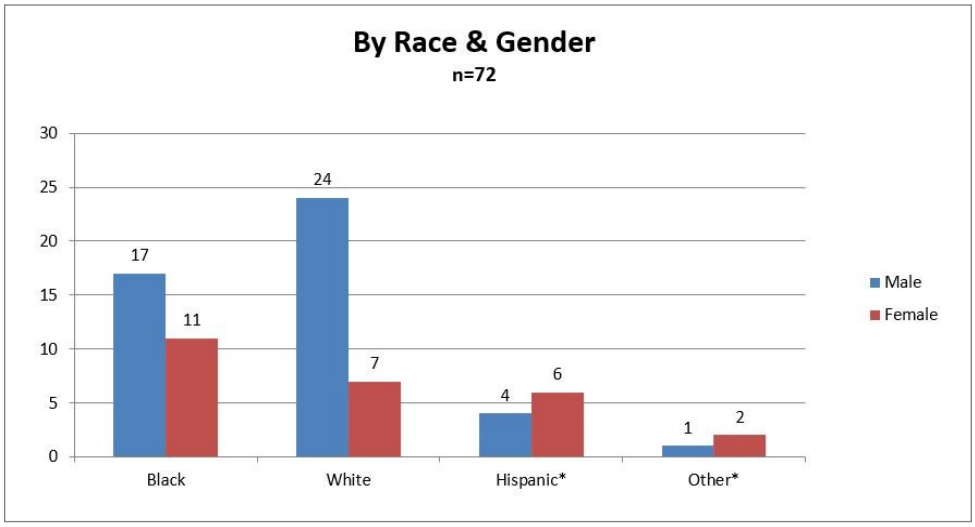


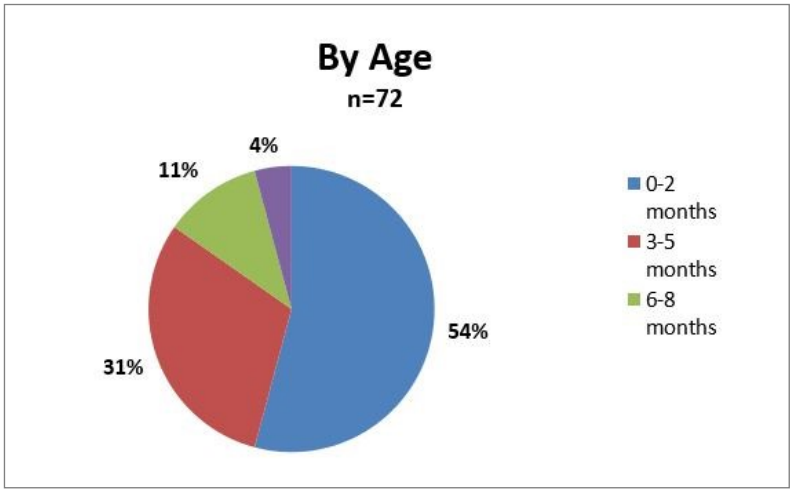
- The four children who died from blunt force trauma were between the ages of 7 years old and 6 months old.

Sudden Unexpected and Sleep Related

Children Under 12 Months Old





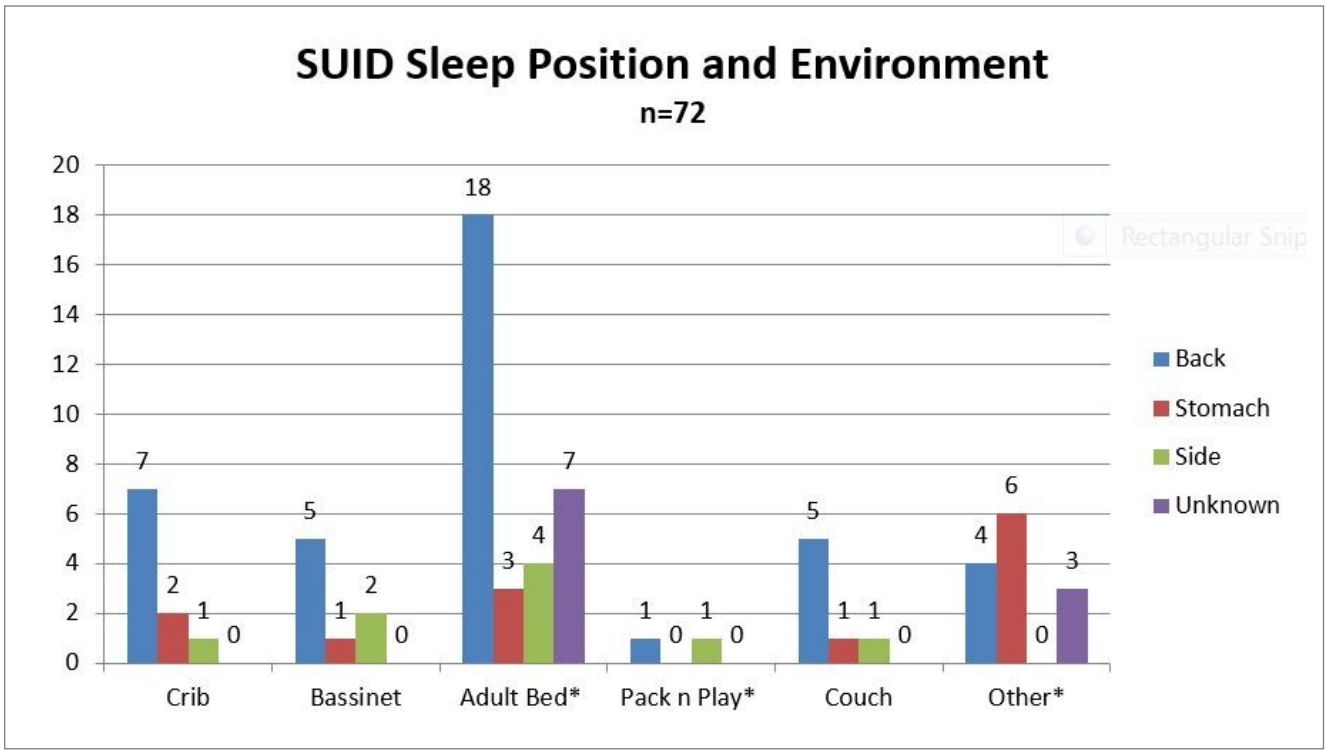


According to the CDC, Sudden unexpected infant death (SUID) is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before investigation.

**Includes Black & White Hispanic;*
***Includes two Asian & one Bi-racial (Black/White)*

Sudden Unexpected and Sleep Related Cont.

Sleep-related infant deaths are those where the sleep environment was likely to have contributed to the death, including those ruled SIDS, SUID, suffocation, and other causes.



* *Adult bed includes toddler bed and 2 twin, beds, Pack n Play includes one playpen, Other includes 7 parents' arms or chest, 1 floor, 2 mattresses, 1 swing, 1 carriage and 1 unknown*

40% (29) of the children were sharing a sleep surface with another person. 10% (7) cases it is unknown if they were sharing sleep surfaces.

99% (71) of the fatalities reviewed by the SUID Subcommittee were related to sleep and/or the sleep environment.

Guidelines for Safe Sleep[6]:

- Back is Best: Place baby on the back to sleep in a crib free from objects (i.e. toys, stuffed animals, and blankets)
- Place baby on a firm sleep surface
- Place baby in the same room with you but not the same bed
- Limit baby's exposure to smoke (cigarette, cigar, illegal substances)
- Consider breastfeeding
- Bring baby to the pediatrician for all well-visits
- Practice supervised, awake 'tummy time'
- Avoid overheating
- Avoid products such as wedges, positioners, and bumpers

[6]*www.healthychildren.org*

Recommendations

To Department of Children and Families

Poison and prevention information should be provided to families with toddlers and preschool age children in the home. This should include information on safe storage of medication when there are small children in the home.

The Board supports the continuation of public outreach campaigns regarding pool and water safety.

To Department of Law and Public Safety, Office of the Attorney General:

Law Enforcement should develop a standard in New Jersey that meets national best practices that would be expected to be applied to all investigations including suicide investigations throughout the State. This should include prosecutor response on all suicide investigations, in person interviews of all family and friends involved with the victim, and consistent investigation of the victim's social media accounts.

The Department of Child Protection and Permanency (DCPP) should be provided with thorough law enforcement investigations, as opposed to solely incident reports to assist DCPP with their investigations and review processes.

To the Department of Health, Office of the Chief State Medical Examiner:

It is recommended that the State Medical Examiner's Office utilize suicide specific forms to assist during the investigation to create uniformity in suicide investigations and capture pertinent information.

It is recommended that the Medical Examiner's Office perform toxicology tests on all cases involving suicide.

It is recommended that while investigative and gross anatomic findings are incomplete the death certificate should be signed out as pending in order to collect all other data to determine manner and cause, especially in cases of potential sudden unexplained infant death.

It is recommended that all Medical Examiner offices use the most up to date, electronic Sudden Unexplained Infant Death Investigation (SUIDI) reporting form as recommended by the CDC.

To New Jersey Division of Consumer Affairs:

Unguarded bodies of water pose a particular risk to children; therefore, certified lifeguards should be present during all open hours at hotel pools. In addition, all children should have proper adult supervision when around unguarded bodies of water. Finally, all children, who cannot swim, should wear coast guard approved life jackets.

The Department of Child Protection and Permanency workers should have access to the prescription monitoring database to assist in their investigation and ongoing service management of parents with substance use issues.

Recommendations Cont.

The New Jersey State Police:

The Board supports efforts to educate and provide information to families, with children of all ages including infants, toddlers and school age children, in proper passenger restraint and car seat safety.

Department of Education:

The Board supports efforts to educate and provide information to families, with children of all ages including infants, toddlers and school age children, in proper passenger restraint and car seat safety.

The Board supports recent initiatives undertaken by the Department of Education including social media and ad campaigns highlighting risks of suicide.

Department of Children and Families, Office of Licensing:

The Board recommends that day care facilities provide families with car seat safety education and training on how to properly install and use car seats for children of all ages including infant, toddler and school age.

Department of Motor Vehicle:

The Board recommends that at the time of routine car inspections at Motor Vehicle public education regarding car seat safety should be provided including public service announcements and brochures to families with children of all ages that require car seat restraint.

To Department of Children and Families and American Heart Association:

The Board recommends that when there is an initiative to train people in infant CPR, safe sleep information should be included. The Board would support collaboration between NJ DCF and the American Heart Association to implement the combined training.

Recommendations regarding Sudden Unexpected Infant Death (SUID)

The Board recognizes and supports campaigns highlighting the importance of infant safe sleep as outlined by the American Academy of Pediatrics in the prevention of sudden unexpected infant deaths.

The Board supports thorough investigations of SUID which includes completion of the SUIDI form, doll reenactments with scene photos, and witness interviews in order to have a complete narrative for the medical examiner determining case and manner. The Board recommends that all investigative staff be trained on national best practices of SUID investigation and the completion of the SUIDI reporting form.

The Board recognizes that social work consults completed during mother's delivery stay are especially beneficial in the review process. Typically, the social work consults are only contained in the mother's record although they pertain to both the mother and baby. The Board will begin to initiate requests for pertinent social work consult information from the maternal record to assist in review of Sudden Unexpected Infant Death (SUID).