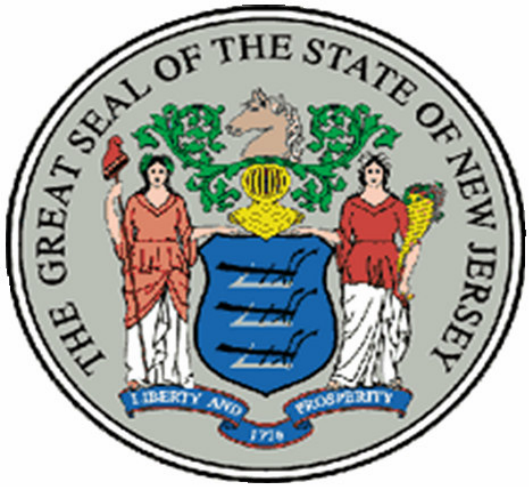
New Jersey



Child Fatality and Near Fatality Review Board
Annual Report

June 30, 2007

Table of Contents

	Page
Child Fatality and Near Fatality Board Membership	**3-4**
Introduction	**5**
Organization	**6**
Child Fatality and Near Fatality Review Process	**7**
Accomplishments	**7**
Death Classification	**8**
Trends	**9**
Cause of Death	**9**
Manner of Death	**9**
Race and Gender	**10**
Age at Time of Fatality or Near Fatality	**11**
DYFS History	**11**
Perpetrator	**12**
Perpetrator Relationship to Child	**12**
Manners of Death	**13**
Homicides	**13**
Non Accidental Blunt Force Trauma as Cause of Death in Homicides	**14**
Accidental	**14**
Natural/Sudden Infant Death Syndrome as Cause of Death	**15**
Race of Sudden Infant Death Victims	**16**
Suicide	**17**
Cause of Death in Suicide Cases	**17**
Age of Suicide Victims	**17**
Gender and Race of Suicide Victims	**18**
Mental Health and Substance Use of Suicide Victims	**18**
Caregiver Social Risk Factors	**18**
Recommendations	**19**
Parents and Caregivers	**19**
Medical Examiner System	**19**
Child Protective System	**19**
Inter-Systemic Issues	**20**

New Jersey Child Fatality & Near Fatality Review Board Members

Anthony V. D'Urso, Psy. D., Chair……..Supervising Psychologist, Audrey Hepburn Children's House
Ernest G. Leva, F.A.A.P., Vice-Chair……..University of Medical and Dentistry of New Robert Wood Johnson Medical School
Sean F. Dalton, Esq., Prosecutor……...Gloucester County Prosecutor's Office
Allen P. Blasucci, Psy. D., Clinical Director……..New Brunswick Counseling Center
James A. Louis, Esq., Deputy Public Defender……..Office of the Law Guardian
Arburta Jones, MPA, Director of Central Operations…….Department of Children and Families Commissioner's Designee
Christine Mozes, MSW, Deputy Director……Division of Youth and Family Services Director's Designee
Elizabeth Ferraro, RN…….Department of Health & Senior Services Commissioner's Designee
Robert Morgan, M.D……...Medical Director, Division of Youth and Family Services
E. Susan Hodgson, M.D., Child Advocate……...Office of the Child Advocate
Thomas Blumenfeld, M.D……Northern Regional Medical Examiner's Office State Medical Examiner Designee
Jessica M. Steinglass, Esq……..Office of the Attorney General Attorney General's Designee
Lt. Thomas Macauley…….....State Police Designee
Victor Weedn, M.D., Acting State Medical Examiner……...State Medical Examiner's Office
Jonathan Sabin, Executive Director……...NJ Task Force on Child Abuse and Neglect

Southern Regional Community-Based Review Team Members

Marita Lind, M.D., Chair……....NJ Cares Institute Southern Regional Diagnostic & Treatment Center
Gregory Smith, Esq., Vice-Chair……..Camden County Prosecutor's Office
Capt. John Angermeier……..Burlington County Prosecutor's Office
Janet Fayter, Esq…….Office of the Law Guardian
Wanda E. Wesley……...DYFS Quality Assurance
Aleema Abdur-Rahman…….……DYFS Case Practice Specialist
Gerald Feigin, M.D…….Camden, Gloucester, Salem County Medical Examiner
Barbara May, RN, DSN……...Southern NJ Perinatal Cooperative, Inc.

Northern Regional Community Based Review Team Members

Paulette Diah, M.D., Chair……..Audrey Hepburn Children's House Northern Regional Diagnostic & Treatment Center
Ruth Borgen, M.D., Vice-Chair……...Hackensack University Medical Center
Albert Sanz, M.D……...St. Joseph's Hospital
Cathy Fantuzzi, Esq……....Bergen County Prosecutor's Office
James Santulli, Esq…….Bergen County Prosecutor's Office
Sgt. Honey Spirito……..Hudson County Prosecutor's Office
Mary Ann Clayton, M.D……Bergen County Medical Examiner's Office

Kim Drayton……..DYFS Casework Supervisor
Sharon Psota……..DYFS Case Practice Specialist
Guadalupe Casillas, Esq……..Office of the Law Guardian
Stephen Percy, M.D., MBA……..Hackensack University Medical Center
Liliana Pinete, M.D., MPH……..Maternal & Child Health Consortium

Metropolitan Regional Community-Based Review Team Members

Patricia Morgan-Glenn, M.D., Chair……..Newark Beth Israel Medical Center
Metropolitan Regional Diagnostic & Treatment Center
Peggy Foster, Vice-Chair……Metropolitan Regional Diagnostic & Treatment Center
Christine Monahan, Esq……..Office of the Law Guardian
William Ciardi, MSW……....DYFS Casework Supervisor
Madeline DelRios……..DYFS Casework Supervisor
Raksha Garajawala, M.D……DYFS Pediatric Consultant
Barbara Wood, Ph.D……Wynona's House
Lt. Karen Freels……...Wynona's House
Marie Hogarty, RNC, MSN…….Gateway Northwest Maternal & Child Health Network
Thomas Blumenfeld, M.D……Northern Regional Medical Examiner's Office
John Esmerado, Esq……...Union County Child Advocacy Center

Central Regional Community-Based Review Team Members

Linda Shaw, M.D., Co-Chair……The Dorothy B. Hersh Child Protection Center
Central Regional Diagnostic & Treatment Center
Susan Hodgson, M.D., Co-Chair……..The Dorothy B. Hersh Child Protection Center
Central Regional Diagnostic & Treatment Center
Evan Stark, D.S.W……UMDNJ School of Public Health
Frederick DiCarlo, M.D……Middlesex County Medical Examiner's Office
Robin Scheiner, Esq……....Mercer County Prosecutor's Office
Karen Ortman……..Mercer County Prosecutor's Office
Gail Howell……DYFS Casework Supervisor
Caryl Scherer…….DYFS Asst. Regional Administrator
John M. Doran, Esq…….Office of the Law Guardian
Margaret Rose Agostino, RNC…….Central NJ Maternal & Child Health Consortium
Linda Esposito, RN, MPH, Ph.D……..SIDS Center of New Jersey, UMDNJ-RWJMS

Office of Evaluation, Support and Special Investigations

Michele Safrin, MSW……..CCAPTA Coordinator
Donna Rook, MSW……CCAPTA Liaison
Mark Sheerin, MSW……..…….CCAPTA Liaison

NEW JERSEY CHILD FATALITY AND NEAR FATALITY REVIEW BOARD/ CITIZEN REVIEW PANEL
2006 ANNUAL REPORT

Introduction

This is the eighth annual report of the Child Fatality and Near Fatality Review Board/Citizen Review Panel (CFNFRB) and its four regional teams established under N.J.S.A. 9:6-8.83, the Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA). Although the CFNFRB is placed administratively in the Department of Children and Families (DCF) and supported by DCF staff, it is statutorily independent of "any supervision or control by the Department" or any of the Department's other "boards or officers."

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 when deemed necessary. The scope of incidents that are subject to review includes child fatalities and near fatalities in the State of New Jersey as specified in N.J.S.A. 9:6-8.90. "Child" is defined as any person under the age of 18.

This report encompasses the review of child fatalities and near fatalities that occurred in New Jersey in 2005 (in addition to a number of fatalities and near fatalities that occurred during 2003 and 2004) and summarizes the CFNFRB's findings and recommendations for inter-systemic improvements to prevent future tragedies.

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 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; and
- Suicide.

The CFNFRB has also included the review of Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Deaths (SUID).

In addition, the CCAPTA mandates the CFNFRB to identify children whose family was under the Division of Youth and Family Services (DYFS) supervision at the time of the fatal or near fatal incident or who had been under DYFS supervision within 12 months immediately preceding the fatal

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

The CFNFRB is also mandated to review Near Fatalities. Near Fatality is defined as a serious or critical condition (certified by a physician) in which a child suffers a permanent neurological or physical impairment; a life-threatening injury or a condition that creates a probability of death within the foreseeable future.

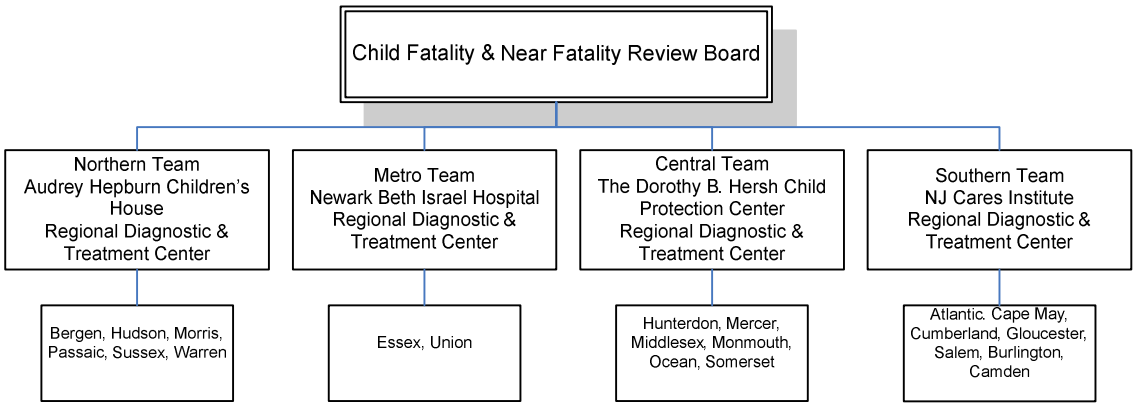
The Board and regional teams do not review all fatalities and near fatalities. Excluded are those cases due to medical causes that are not associated with medical neglect; motor vehicle accidents in which drugs, or neglect are not contributing factors; and homicides committed by individuals other than a caregiver (unless the family was under DYFS supervision at the time of death or received DYFS intervention during the year preceding the fatality or near fatality).

Organization

A central and guiding principle of the CFNFRB's establishment of local teams, as permitted in N.J.S.A. 9:6-8.91(a) was to enable local communities to learn from each child fatality and to assume ownership of developing prevention initiatives and strategies at the local and regional level.

The teams are geographically based in the Northern, Central, Metropolitan and Southern parts of the state and are chaired by a physician from the corresponding Regional Diagnostic and Treatment Center. Each regional team consists of a minimum of six core members: physician, law enforcement, public health advocate, prosecutor representative, medical examiner, and a DYFS case work supervisor. There are additional members on each team representing various disciplines.

The CFNFRB reviews fatalities and near fatalities that occurred in families while DYFS was either assessing for services or providing services. Identified cases with prior DYFS involvement or cases where the family was unknown to the child protective services system are reviewed by one of the four local teams.

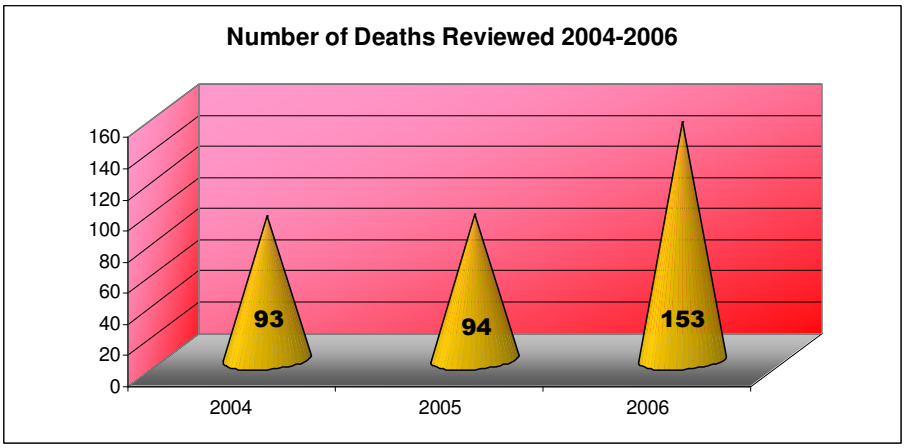


Child Fatality and Near Fatality Review Process

The review process begins with the DCF CCAPTA liaisons identifying cases to be reviewed utilizing data from both the Office of the State Medical Examiner (OSME) and the DCF. Information regarding each child is gathered from the relevant offices in DCF, county medical examiner's offices, schools, primary physicians and specialists, police, prosecutors, mental health providers, and the Bureau of Vital Statistics. The information relevant to the review process is copied and distributed to the Board or Team members two weeks prior to the scheduled review so that members have an opportunity to read and prepare for the discussion. During the review, a written record is prepared summarizing the circumstances surrounding the fatality or near fatality, systemic and case handling issues, comments, and recommendations to strengthen case practice and enhance the child protective services system. The CFNFRB or local team members are actively involved in follow-up activity identified during the review process, i.e., gathering additional information, drafting letters to community partners/ service providers, or calling service providers in the community to discuss systemic issues and methods to improve service delivery.

Accomplishments

- Initiated education for the regional teams regarding child fatality related issues. The first educational topic scheduled for implementation was domestic violence. The Board implemented a process in which the Board will receive training first, and then the same training will be provided to each Regional Team.
- The CFNFRB, Department of Human Services (DHS) Commissioner and Attorney General met to discuss challenges in reviewing homicide cases due to Prosecutor, Medical Examiner or police information not always being readily obtainable because of possible criminal proceedings. The meeting resulted in a decision to release documentation to the CFNFRB once an indictment has been returned by the grand jury.
- The data collection method has greatly improved during the past year with the collaboration with the National Center for Child Death Review.
- The CFNFRB increased its number of reviews by 61% in 2006. It has been the CFNFRB's practice to review fatalities and near fatalities from the preceding calendar year. During calendar year 2006, the CFNFRB reviewed 153 incidents (140 fatalities and 13 near fatalities) that met established criteria and occurred primarily in 2005. The 153 cases also included two incidents that occurred in 2003, forty five incidents that occurred in 2004, and three cases that occurred in 2006. The significant increase in reviews is attributed to the assignment of additional DCF staff to the CFNFRB.



Death Classification

Data on child fatalities in New Jersey due to all causes can be obtained from the New Jersey Department of Health and Senior Services, Center for Health Statistics on the internet at www.state.nj.us/health/chs. The medical examiner completing the autopsy is the physician who determines the **cause** and **manner** of death. The following definitions are nationally recognized by medical examiners and health professionals, and are provided to assure consistent interpretation of data presented in the tables that follow:

Cause of Death: The underlying disease (condition), injury, or combination of both that leads to a physiological derangement in the body that results in the death of the individual. Causes of death include but are not limited to: asphyxia, blunt force trauma, sharp force trauma, drowning, overlay, poisoning, burns, SIDS, SUIDS, hyperthermia, medical causes, and undetermined.

Manner of Death: A medical nosological classification system based on the circumstances that resulted in death. This classification system includes only the following five categories:

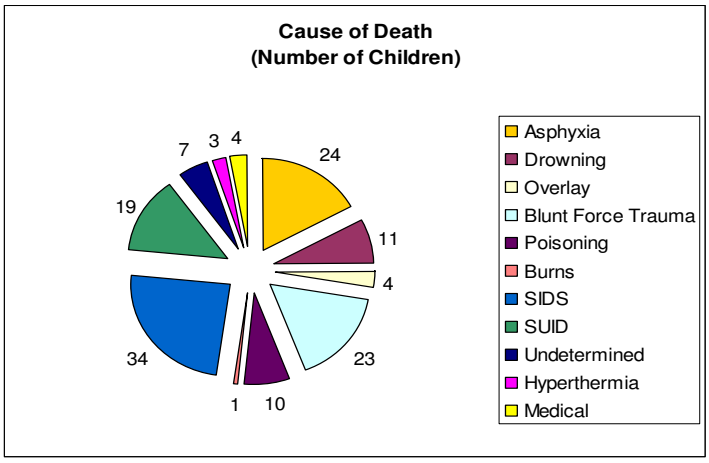
- **Natural –** A death resulting from a natural disease process, without the significant influence of any type of injury, drug toxicity, or other significant environmental or other non-natural factor.
- **Undetermined –** A death in which there is insufficient information about the circumstances surrounding the death to make a ruling, or in some instances, when the cause of death is unknown.
- **Accidental –** A non-natural (violent or traumatic) death resulting from an event occurring by chance or unknown causes, with a lack of intention; an unintended and usually sudden, unexpected and unforeseen occurrence. The designation commonly reflects a number of physical injuries, toxic events, or environmental conditions.
- **Suicide** – A death resulting from the deliberate taking of one's own life voluntarily. Placing one's self in reckless disregard of harm and resulting in a death may be ruled suicide.
- **Homicide** – Death due to another person's actions.

The term homicide may be used by both the criminal justice system and medical examiner system, however in determining responsibility and punishment the terms are not always applied the same. A shooting death may be considered a homicide by the medical examiner and vital statistics, but an accident by the police and the neighbors. Also, the courts may come to a different conclusion than by a medical examiner at the time the medical examiner certified the death.

Trends

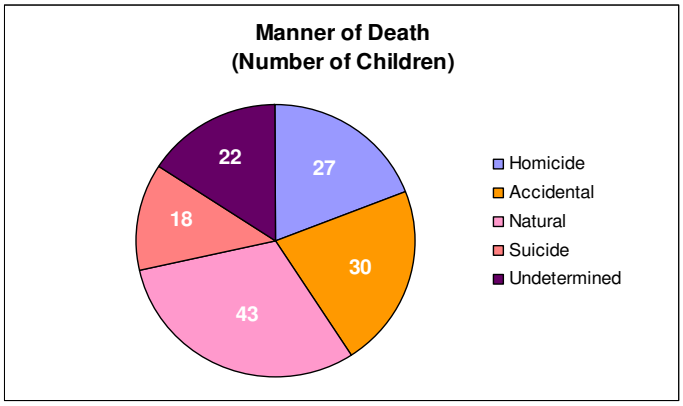
Cause of Death

A **cause of death** can be applied to various **manner of death** categories. For example, asphyxia could be due to a hanging, thus the manner would be suicide. In overlay asphyxiation (or suffocation); the manner may be attributed to an accident. If the act was purposeful, the asphyxiation or suffocation would be certified as a homicide. In the same respect, blunt force trauma may be a result of an accident or the result of a homicide. The most frequent cause of death identified on the cases reviewed was SIDS followed by asphyxia, blunt force trauma, SUIDS (Sudden Unexplained Infant Death), overlay, drowning and poisoning. There were fewer than 10 fatalities each in the undetermined, hyperthermia, medically related causes, and burn categories.



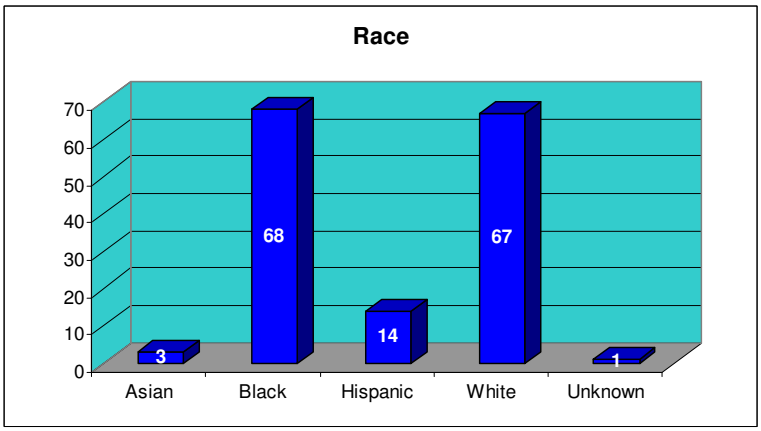
Manner of Death

In one third of the cases reviewed, 31% (43), the **manner of death** was natural due to Sudden Infant Death Syndrome and Sudden Unexplained Infant Death. The second largest category was accidental, 21% (30), consisted of 9 asphyxia (2 overlay, 3 soft bedding, 3 suffocation in the trunk of a car, and 1 accidental hanging). Homicide cases represented 20% (27), undetermined cases 16% (22), and suicide cases 13% (18).

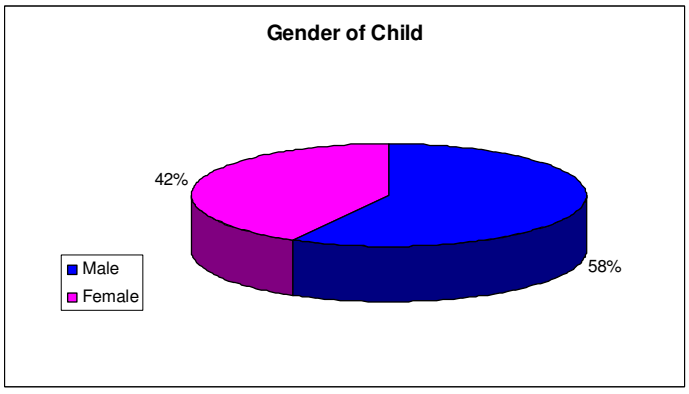


Race and Gender

There is an over-representation of child fatalities among African American children when compared to the NJ child population by race. Child fatality and near fatality victims identified by race were African-Americans 44% (68), followed by Caucasians 43% (67), Hispanics 9.1% (14), Asian 1.9% (3). One child's body was decomposed and unidentifiable. In 2005, the NJ child population consisted of 16% African American, 57% Caucasian, 18% Hispanic, 7% Asian, and 2% other races (U.S. Census Bureau).



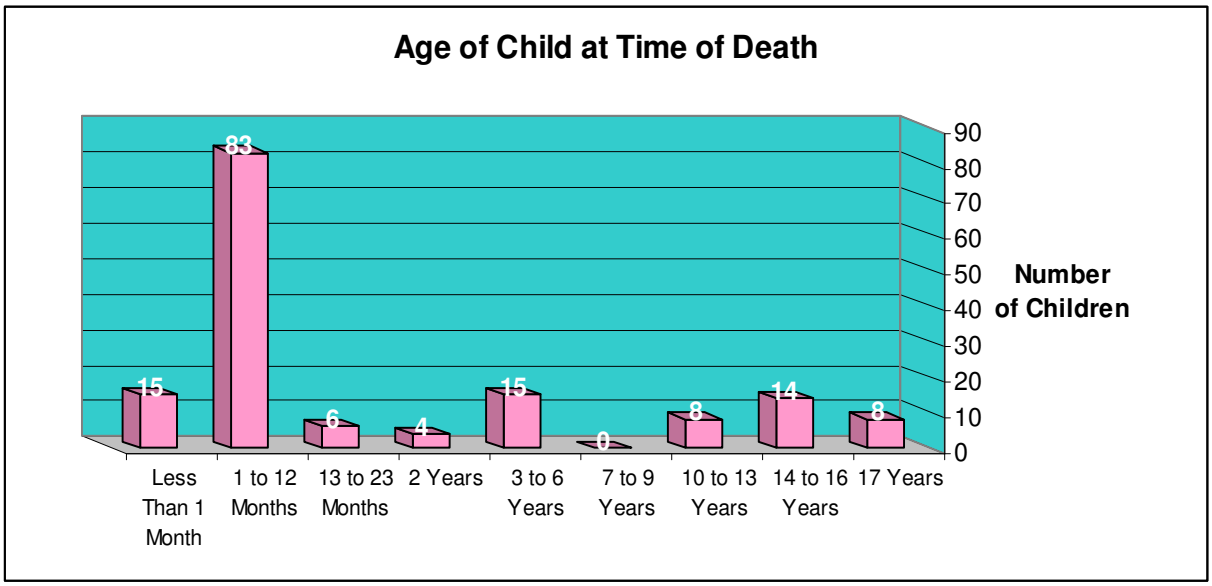
The results of all fatalities and near fatalities reviewed, in all categories, revealed that 89 fatalities were male and 64 fatalities were female.



Age at Time of Fatality or Near Fatality

Nationally, during Federal fiscal year (FFY) 2005, 76.6% of child fatality (due to maltreatment) victims were younger than 4 years. The youngest children experienced the highest rates of fatalities and infant boys younger than 1 year died more frequently due to child maltreatment. In general, fatality rates for both boys and girls decreased as the children get older (U. S. Children's Bureau).

Similarly, the CFNFRB data revealed that children between 1 month and 12 months of age appeared to be the most vulnerable (35 natural, 19 undetermined, 11 homicides, 8 accidental, 10 near fatalities). Of the 10 **near fatalities** within this age group, nine are substantiated abuse/neglect cases.



DYFS History

- In 54 of the 153 cases reviewed in 2006, the families of the victim were known to DYFS (this excludes those parents that had DYFS involvement as children).
- Of the 54 cases known to DYFS, 31 were open at the time of the fatality or near fatality:
  - 13 cases were open for child welfare services
  - 18 were open for child protection services.
- Of the 23 cases with previous DYFS history:
  - 8 were closed within 12 months of the fatality or near fatality.
  - 15 were closed longer than 12 months preceding the fatality or near fatality.
- DYFS substantiated abuse or neglect in 47 or the 153 that caused the fatality or near fatality:
  - 37 of the substantiations were for fatalities, 11 were for near fatalities.
  - 26 of the fatality substantiations were homicides.
  - 8 of the fatality substantiations were accidents (lack of supervision).
  - 3 of the fatality substantiations were for natural deaths (medical neglect and lack of supervision).

Perpetrator

A prosecutor must have an identified perpetrator and evidence to support the criminal charge and overcome proof beyond a reasonable doubt in order to pursue criminal charges. By contrast, DYFS must have a preponderance of credible evidence to reach a finding of substantiated abuse or neglect. Therefore, a perpetrator may not be charged with a crime, but may be found substantiated for abuse or neglect by DYFS. The perpetrator totals are determined by a criminal charge or a DYFS finding that a caregiver was substantiated for abusing and/or neglecting a child. For instance, for a child death when the manner of death was accidental, the caregiver may not be criminally charged; however DYFS may have substantiated neglect against the caregiver for lack of supervision. In order for a caregiver to be charged with murder, the act must be purposeful and knowing.

According to these two definitions of perpetrator, 42 of the fatalities and near fatalities had at least one perpetrator. In seven cases no perpetrator was identified despite five of those cases involving two caregivers who were suspect and were never prosecuted or substantiated for abuse. For example, one case involved an infant who died from complications of injuries sustained after a disposable washcloth (baby wipe) was lodged in his throat. The victim's father's explanation that the injury (which ultimately resulted in death) was caused accidentally by the infant's 22 month old sibling was not plausible. The CFNFRB opined that a 22 month old would have been physically incapable of inserting the wipe as deep into the throat as it was located. The father was suspected of causing the injury as well as prior unreported physical abuse (the examination at the time of the near fatal injury revealed that the child had sustained rib fractures approximately 3-4 weeks prior).

Perpetrator by Relationship to Child

In 26 of the cases reviewed the substantiated perpetrator was either the child's mother or father acting alone. In 3 of the cases both parents were substantiated perpetrators of fatally or near fatally injuring their child.

PERPETRATOR RELATIONSHIP	NUMBER
Father	13
Mother (Includes One Stepmother)	13
Both Parents	3
Mother's Paramour	6
Other Relative (Grandfather, Sibling, Uncle, sibling, Step-mother	7
Unknown	7

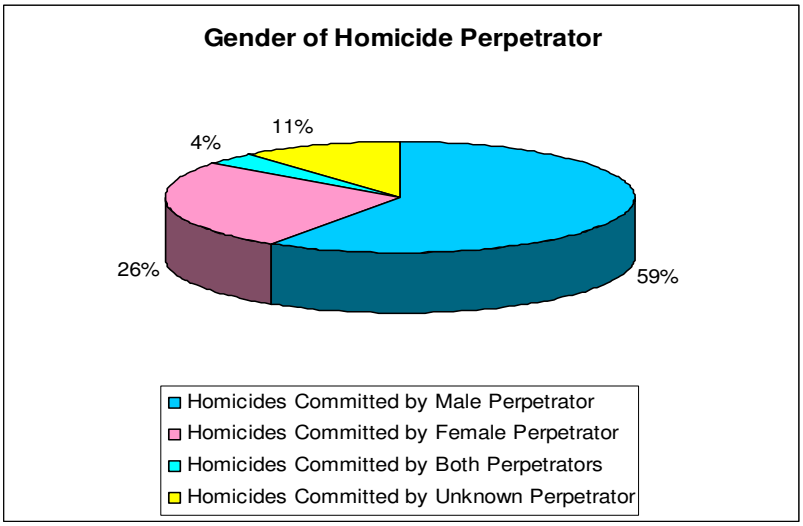
Manners of Death

Homicides

The force required to assault and control a child is low compared to a teenage or adult homicide, due to the high physiological vulnerability of children. Head trauma and asphyxiation are the most common causes of infant homicide, and the most commonly used weapons for inflicting these injuries are personal weapons, such as adult hands and feet (Journal of Family Violence).[1]

New Jersey's results are consistent with current literature indicating the majority of identified perpetrators are males[2]. A child homicide perpetrator is most likely the child's father or mother's partner until the child reaches 2 years of age. This review revealed that after 2 years of age, the rate of homicides declined by 40%.

- Of the 27 homicides 16 were perpetrated by males and 7 by females.
- Both parents were convicted of manslaughter in the death of their child in 1 case.
- The gender was unknown in 3 cases because no perpetrator was identified.



Non Accidental Blunt Force Trauma as a Cause of Death in Homicide Cases

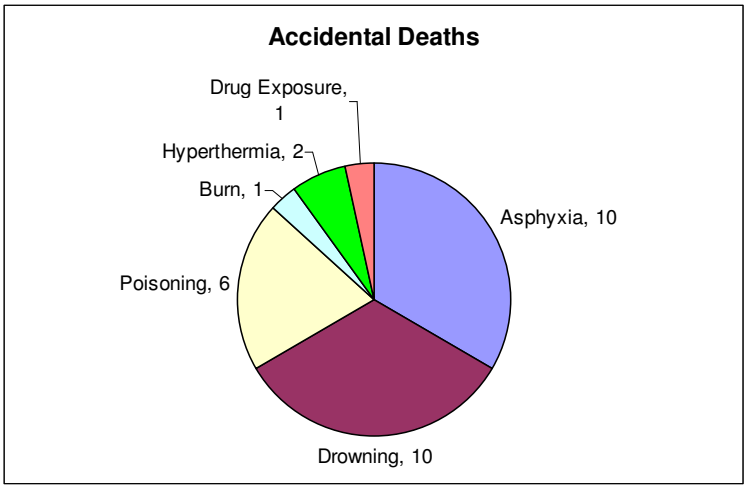
78% (21) of homicide deaths were caused by blunt force trauma injury from a blunt instrument or victim striking a blunt surface and resulted from a violent action that was preventable. Deaths due to non accidental intentional blunt force trauma are classified homicides by the medical examiner and often prosecuted.

- 12 blunt force trauma homicide victims were between the ages of 1 month and 2 years old,
- 4 blunt force trauma homicide victims were between 3 and 9 years of age
- 2 blunt force trauma homicide victims were between 10 and 13 years of age.
- 3 children were 14 years old.

Accidental

- 30 fatalities were accidental.
- 10 of the accidental fatalities resulted from drowning; 8 of them directly related to lack of supervision. Children were either left unsupervised in the bath rub, left by the poolside, and/or barriers to the bodies of water were left ajar.
- 10 accidental asphyxia fatalities consisted of one incident of 3 children playing in an abandoned car and becoming locked in the trunk, 1 child accidentally hanging herself with ribbon while playing, 3 incidents of overlay due to co-sleeping, and 3 incidents of asphyxiation in soft bedding.
- 6 cases of poisoning included 5 cases of carbon monoxide poisoning and 1 case of ingestion of a prescription drug.
- 2 cases of hyperthermia were due to young children being accidentally left in a car.
- 1 burn case was due to a developmentally disabled child being unsupervised and being scalded in the bathroom.
- 1 case was intrauterine drug exposure.

DYFS substantiated neglect in 4 of the accidental drowning cases, 1 overlay case, 1 accidental hanging, 1 child who was left unsupervised in a car, and 1 poisoning case.



Natural

Each year in the United States, Approximately 4,500 infants die suddenly of no immediate obvious cause. Half of these **Sudden Unexplained Infant Deaths (SUIDS)** are attributed to **Sudden Infant Death (SIDS),** the leading cause of **SUID** and of all deaths among infants aged one to 12 months (Centers for Disease Control and Prevention).

The State of New Jersey Autopsy Protocol for Sudden Death in Infancy and Childhood defines **Sudden Infant Death Syndrome (SIDS)** as the sudden death of an infant (twelve months or younger) which is unexpected and remains unexplained after a thorough case investigation, including

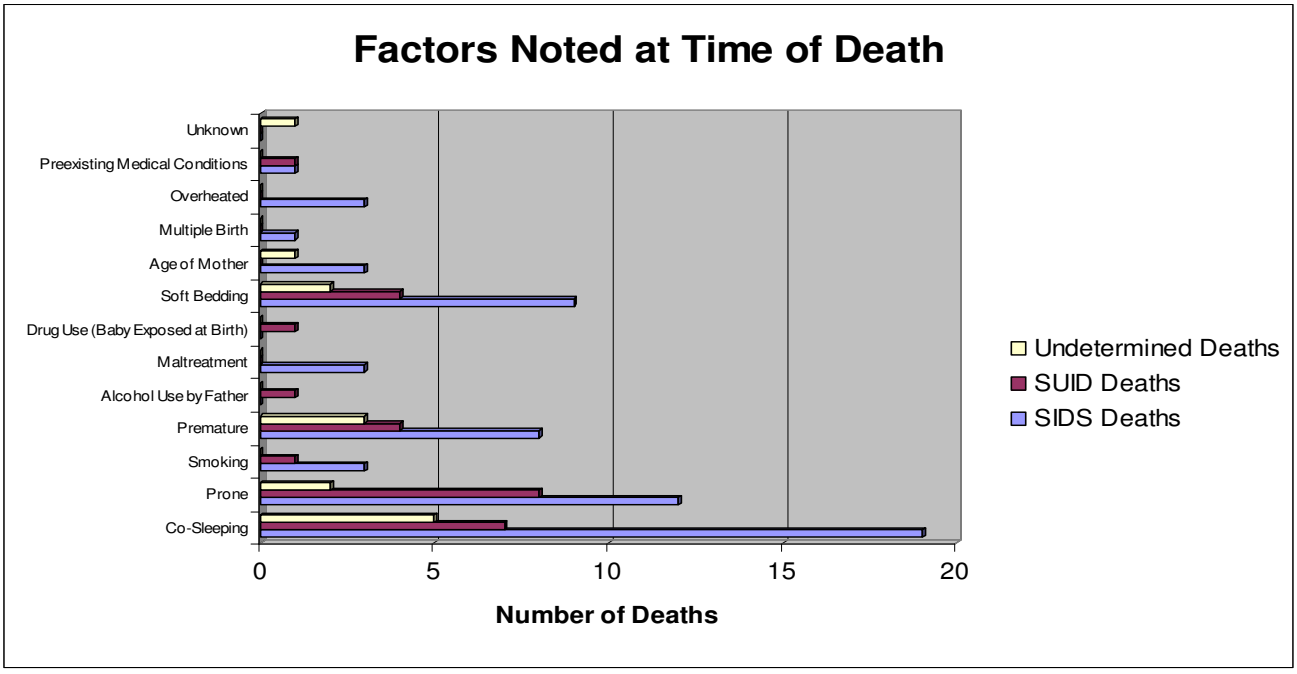
performance of a complete autopsy, examination of the death scene and review of the clinical history[3]". Typically, **SIDS** is identified when an infant is put down to sleep at night and is found dead in the morning.

Thirty four (34) fatalities reviewed in 2006 were attributed to SIDS as the cause of death. Although SIDS is defined as the manner of death occurring naturally, the manner of death in the SIDS cases was not consistent among the medical examiners. In seven SIDS cases, medical examiners certified both the cause and manner of death as undetermined.

Although no one can guarantee prevention of SIDS, as families have adopted risk reducing behaviors, the incidence of SIDS has been cut in half in the families employing risk reduction strategies (SIDS Center of New Jersey)[4]. Research indicates that SIDS has been linked etiologically to prone sleep position, sleeping on a soft surface, maternal smoking during pregnancy or smoking in the household after the birth, overheating, late or no prenatal care, prematurity, low birth weight and male gender[5]. Other risk factors include mothers who are younger than 20 years old at the time of their first pregnancy[6]. Other factors in the SIDS, SUID, and undetermined cases were noted by the CFNFRB/teams. These included pre-existing medical conditions of the infant; the infant was a multiple birth or drug exposed at birth, alcohol use by a parent and co-sleeping. For the purpose of this report, co-sleeping is defined as the act of an adult or another person sharing the same surface (bed mattress, couch, air mattress, etc.) with an infant during sleep.

In all but 9 of 60 SIDS, SUID, and undetermined (cause) fatalities had at least one factor.

- In 50% (30 of 60) of SIDS, SUID, and undetermined fatalities co-sleeping was noted.
- 35% (21) of the infants were noted to be in the prone sleeping position when found.
- 27% (16) of the infants were born premature.
- 22% (13) infants were noted to be sleeping in soft bedding.



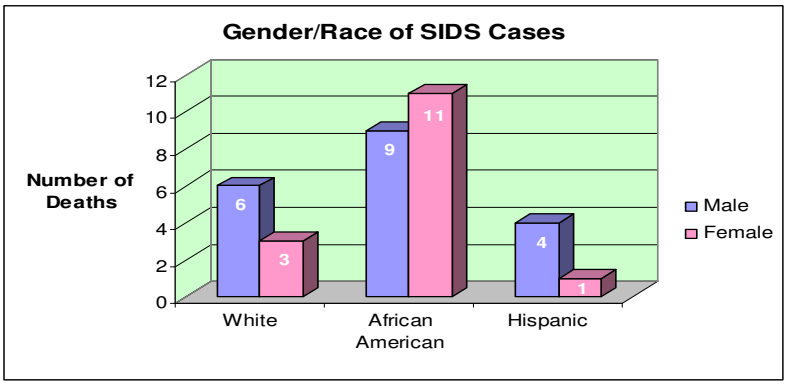
Race of SIDS Fatalities

While infant mortality rates overall are declining in New Jersey and within all racial/ethnic groups, African American have significantly higher infant mortality rates than other groups. The infant mortality rate among African American remains nearly three times the rate among whites.

The Sudden Infant Death Syndrome (SIDS) rate is 7.5 times higher for blacks than for whites (NJ Department of Health and Senior Services)[7].

The CFNFRB data revealed:

- 58% (20) of the 34 children whose cause of death was certified SIDS were African American, 26% (9) were Caucasian, and 15% (5) were Hispanic. In 2005 New Jersey's child population (1 month through 17 years) consisted of 58% white, 18% Hispanic, 15% African American, and 7% Asian and 2% other (U.S. Census Bureau).
- Of those 34 cases, 19 were male and 15 were female.

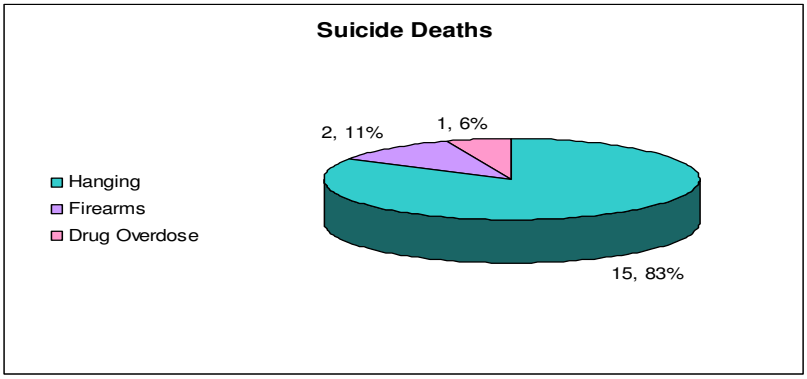


Suicide

The CFNFRB/teams reviewed eighteen cases of suicide; eight of the victims committed suicide in 2004 (there were 22 child suicides in 2004). The number of children who committed suicide in New Jersey decreased to ten in 2005.

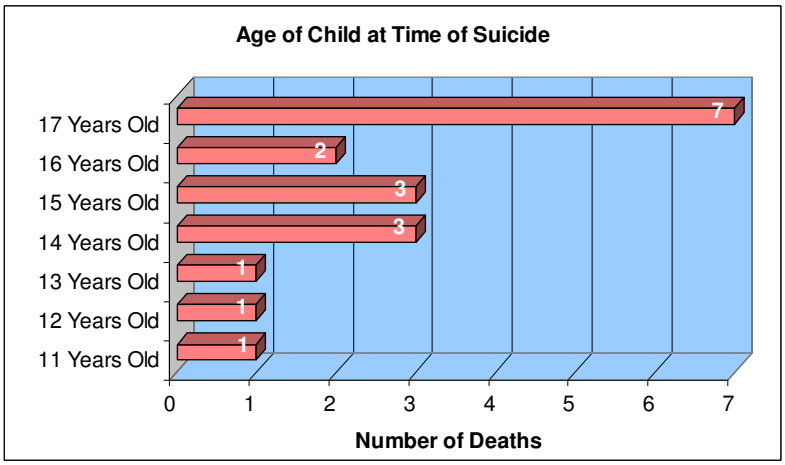
Cause of Death in Suicide Cases

- 15 of 18 children committed suicide by hanging.
- 2 children used firearms.
- 1 child overdosed on prescription medication.



Age of Suicide Victims

- The children who committed suicide ranged 11 years old to 17 years old.
- 3 were between ages 11 and 13.
- 6 between 14 to 15 years of age.
- 2 were 16 years old.
- 7 were 17 years old (see diagram below).



- 10 of the 18 children who committed suicide experienced school issues such as bullying (they were the victims), academic failure, or recently transferred to a new school. Some children may have also experienced more than one issue.
    - 5 of the 18 children experienced academic failure.
    - 4 of the 18 had recently transferred to a new school.
    - 4 of the 18 were behavioral problems (including truancy).
    - 1 child was a victim of bullying prior death.
- 16 of the 18 children experienced at least one of the following: physical and/or sexual abuse as a victim; arguments with parents; separation/divorce, family history of suicide, domestic violence, lack of parental supervision, and custody disputes between parents.

Gender and Race of Suicide Victims

- 16 of the 18 were males, 12 were Caucasian, 3 were African American, and 1 was Hispanic.
- 2 were Caucasian females.

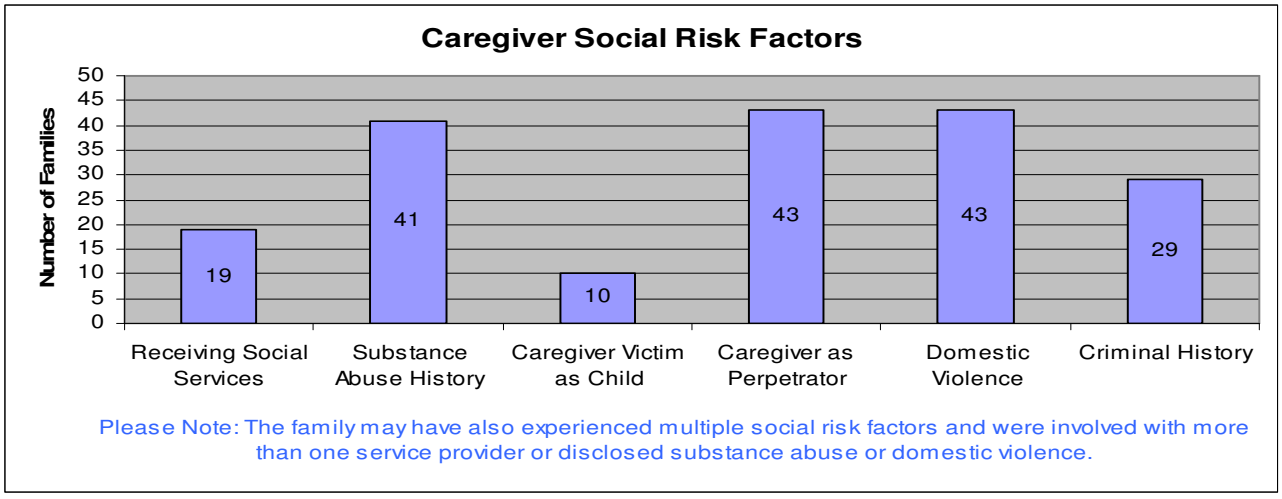
Mental Health and Substance Use of Suicide Victims

- Half (9) of the children were receiving mental health services at the time of their death.
- 8 of the 9 children who were receiving mental health services reported drug/alcohol use.

Caregiver Social Risk Factors

The data supports that when intervening with families, service providers must be mindful that a family who experiences multiple stressors may require greater attention. For the purposes of this report, social factors within the family are defined as either one or both caregivers having a history of using substances, engaging in criminal behavior, involved in violent relationship, receiving social services or having been victims of maltreatment as a child. Social and legal data was incomplete due to information being unavailable. In some situations, the family may have recently relocated to New Jersey and criminal and/or child protection information was not accessed from out of state jurisdictions. Issues such as domestic violence and substance abuse within the family were not always known as families may have been unwilling to disclose. Criminal records were also not consistently and readily available. The numbers in the chart below reflect documented information from DYFS, Department of Corrections, police, prosecutor, medical records, and medical examiner records. The social factors existed at one point in time during a family's life and are not mutually exclusive and frequently co-existed.

- 43 families had documented history of domestic violence.
- 41 families had documented history of substance abuse.
- 29 families had documented criminal history.
- 19 families were receiving community-based social services (other than DYFS).
- 43 families had documentation of a caregiver having been a perpetrator of child abuse.
- 10 caregivers were victims of child abuse before reaching adulthood.



Recommendations

Various themes were identified as a result of the reviews. The following recommendations are made in an effort to improve practice and prevent tragedies from occurring in the future.

Parents and Caregivers and Home Safety

- The CFNFRB recommends that the Department of Children and Families integrate Public Service Announcements (PSAs) promoting home safety and reinforcing the necessity for heightened supervision of children. Home safety topics should include safe sleep practices to prevent overlay deaths and reduce the risk of Sudden Infant Death Syndrome, recreational dangers such as drowning and the dangers of leaving children alone in parked vehicles or access to parked vehicles, fire safety, access to medications and weapons.

Medical Examiner System

- For the eighth consecutive year, the CFNFRB recommends that the New Jersey legislature amend N.J.S.A 52:17B-78 et seq. to empower the State Medical Examiner to create and enforce uniform forensic investigatory policies and procedures. The Board continues to observe inconsistent practices in county based medical examiner offices with no capacity for mandated remediation. Child pathologists and radiologists are not routinely retained by or hired as county medical examiners leading to a unique need for supervision. A previously sponsored bill integrating the concerns of the CFNFRB and Homeland Security in 2006 was not released from committee. In deference to the newly appointed State Medical Examiner (SME), the Board did not press last year's recommendation until review could occur by the SME. At this time, the Board is asking the legislature to critiquely review that bill and the reasons for its failure to be released from committee as, in our judgment, there is no substantive reason for delay. In the absence of legislative change, autopsy and investigative practices in infant and child death remain problematic.
- The CFNFRB leadership will meet with legislative leadership to discuss the sponsorship of a bill that will empower the State Medical Examiner to enforce current statutorily mandated statewide protocols developed by the mandated Sudden Child Death Autopsy Protocol Committee.
- The CFNFRB will monitor progress toward achieving the finalization and implementation of the Death Scene Investigation Protocol that will assist Medical Examiners in establishing the cause and manner of death of infants and children up to three years of age who die suddenly and unexpectedly; standardize the postmortem examination in all counties; assist in the comparison of SIDS and SUDC cases and support the efforts of related research.

Child Protection System

- The CFNFRB recommends that DCF incorporate relevant CFNFRB findings regarding risk assessment when evaluating the Structured Decision Making tool. The utilization of such findings may assist in any revisions that will enhance case managers' and supervisors' ability to assess risk of future harm to children.

- The CFNFRB recommends that DCF and CFNFRB develop a mechanism to share CFNFRB's case handling observations/findings with all DYFS frontline and supervisory personnel on a monthly basis. This information sharing shall include the analysis of sentinel events and and their appropriate investigative and case management standards. The intent of information sharing is to provide feedback so that personnel may learn from exemplary practices that mitigate risk.
- The CFNFRB recommends that DCF implement a comprehensive domestic violence protocol to assist DYFS case managers in recognizing and assessing domestic violence within families served by DYFS.

Inter-Systemic Issues

- The CFNFRB recommends the Department of Health and Senior Services consider including the NJ Task Force on Child Abuse and Neglect, Department of Children and Families (NJ Division of Prevention and Community Partnerships) and the New Jersey Hospitals Association in their 2007 Strategic Plan to Eliminate Health Disparities that includes the Black Infant Mortality Reduction (BIMR) Initiative (involving the Maternal and Child Health Consortia and Healthy Mothers/Healthy Babies and Healthy Start programs). The CFNFRB recommends a collaborative campaign providing education regarding the association between safe sleep practices and the reduction in Sudden Infant Death Syndrome targeting the African American community.
- The CFNFRB recommends that the NJ Task Force coordinate and host yearly training on child abuse and neglect to all county prosecutors' staff involved in child homicide investigations through its Multi-Disciplinary Team (MDT) initiative. It is a common occurrence that the child abuse MDT coordination of law enforcement, prosecution, child protective services and Regional Diagnostic and Treatment Centers (RDTCs) including medical and mental health services is infrequently utilized in the investigation of fatality and near fatality.
- The Board recommends that the Police Training Commission (PTC) revise their training curriculum to include mandatory yearly child abuse training to first responder police officers and all county prosecutors' investigators.
- The CFNFRB recommends that the newly appointed Attorney General convene an ad hoc committee with representatives from the Department of Children and Families (DCF) and the CFNFRB to review CFNFRB's role, responsibilities and recommendations to develop a plan for systemic change.

---

[1] *Smithey, M (1998). Journal of Family Violence, Vol 13, No.3*
[2] *Reading, R. (2006). Child: Care, Health & Development. Journal compilation. 32(2), 353-256.*
[3] *Willinger M., James LS, Catz C. Defining the sudden infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of child Health and Human Development. Pediatric Pathology. 1001:11:677-684.*
[4] *SIDS center of New Jersey http://www2.umdnj.edu/sidsweb/education/education.htm*
[5] *Hoffman HJ, Damus K, Hillman L, Krongrad E. Risk Factors for SIDS. Result of the National Institute of Child Health and Human Development SIDS cooperative epidemiological study. Ann NY Acad Sci. 1988; 533: 13-30.*
[6] *SIDS Center of New Jersey, www.scnj.org*
[7] *New Jersey Department of Health and Senior Services*
http://www.state.nj.us/health/omh/documents/healthdisparityplan07.pdf