

NEW JERSEY  
CHILD FATALITY  
& NEAR FATALITY  
REVIEW BOARD

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2008 ANNUAL REPORT  
Issued August 24, 2009



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# Summary of Findings

- ▶ 181 fatalities and six near fatalities were reviewed.
- ▶ 6 children ranging in age from birth to 11 months were near fatally injured.
- ▶ 36% of the children reviewed died by natural manner, followed by accidents (24%), homicides (15%), undetermined (13%) and suicides (9%).
- ▶ Twice as many male than female (123 male and 64 female) children died and comprised 66% and 33% of the total number of cases reviewed, respectively.
- ▶ The birth to 11 month age group had the largest percentage of deaths among children 17 years of age and younger.
- ▶ African American infants accounted for 52% of Sudden Unexplained Infant Deaths (SUID). White infants accounted for 33% of SUID deaths.
- ▶ The most childhood deaths occurred in Essex County (38) followed by Monmouth (17), Ocean (17) and Camden (14) Counties.
- ▶ The leading causes of death in children were Sudden Unexplained Infant Death and Asphyxia which represented 79% of natural deaths and 43% of accidental deaths, respectively.

## Child Fatality and Near Fatality Review Board

### INTRODUCTION

The death of a child is a tragic loss to families, friends and communities. Fatalities and near fatalities of children stir within us strong emotions and reactions as we struggle to understand the facts and information leading up to the event. In some cases, we may never know why a child dies or have answers to our many questions. In other cases, the reasons for the death are complex and are the result of many factors. While we cannot change the circumstances surrounding the death or near fatality of a child, what we can do is learn from these tragedies and take advantage of every opportunity to prevent them in the future.

This report details the findings and recommendations of the State of New Jersey, Child Fatality, Near Fatality Review Board (CFNFRB), in keeping with the provisions of the Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA), N.J.S.A. 9:6-8.88. The information presented encompasses the results of the Board's review of 2008 child<sup>1</sup> fatalities and near fatalities that occurred in New Jersey primarily in calendar year 2007<sup>2</sup> and summarizes the CFNFRB's findings and recommendations for inter-systemic improvements to prevent future losses.

Reviewing the circumstances surrounding cases of child fatalities and near fatalities is a critically important task for state and local professionals working in an array of fields, including child welfare,

<sup>1</sup> "Child" is defined as any person under the age of 18.

<sup>2</sup> In addition to 2007 cases, the CFNFRB reviewed 1 case that occurred in 2005, 12 from 2006 and 4 from 2008.



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law enforcement, health, judicial, medical examiner, mental health, education and substance abuse. Recognizing that deaths and near fatalities of children and youth are a sentinel event, a comprehensive review by the community allows for a better understanding and identification of potential risk factors to surviving siblings and other children. In essence, the Board functions as a catalyst for needed change.

These reviews also allow a multidisciplinary team of professionals to comprehensively examine child deaths and near fatalities. Doing so allows for a determination as to why children die so that action and follow up recommendations can be implemented to prevent future deaths, develop needed service resources and improve the safety and well being of children overall. Some of these possible actions include policy and practice changes in particular fields, strengthened interagency collaboration, the need for staff training, public outreach and education or changes to state law. Lessons learned from these tragedies lead to stronger prevention efforts that keep children safe, healthy and protected.

In keeping with its State mandate, the New Jersey CFNFRB reviews cases of child fatalities and near-fatalities to examine for barriers and weaknesses in various State systems that protect and support the health and welfare of our precious children. These systems primarily involve the medical community, law enforcement, medical examiner, judicial, mental health, substance abuse, child protective service, and social service systems. The CFNFRB does not review all fatalities and near fatalities, but those which come to their attention involving abuse, neglect, violence, or appear preventable. The Board's views are influenced by this selection.

It should be recognized that each of these cases involves personal tragedy and often many failures—but not necessarily systemic failures. Although the CFNFRB inquires into the particulars and specifics of each case reviewed, it is not the task of the CFNFRB to micromanage various governmental agencies or actors, but rather to recognize repeated failures and make recommendations that lead to systemic improvement and needed change.

In conducting its review, the CFNFRB is permitted under state and federal law to examine all available records pertaining to the child victim, including those from law enforcement, health, mental health, treatment providers, child protection and education. Additionally, at its discretion, the Board interviews child protection staff or other key stakeholders involved in each fatality. The circumstances of each case are discussed fully using the expertise of the Board's membership and other resources as needed.

The information and recommendations made within the body of this report are the generalized findings of all cases reviewed by the state Board and the regional teams and are presented in accordance with what the law permits. The deliberations and conclusions of the Board and its regional teams, related to a specific case, are required to be kept confidential.

As stated, the principle objective of the CFNFRB is to provide impartial reviews 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 near fatalities and fatalities in the State of New Jersey as specified in N.J.S.A. 9:6-8.90.

Fatalities due to unusual circumstances are reviewed according to 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

CCAPTA also mandates the CFNFRB to identify children whose families were under the Division of Youth and Family Services (DYFS) supervision at the time of the fatal or near fatal incident or who had been under DYFS supervision within 12 months immediately preceding the fatal or near fatal incident.

In addition, N.J.A.C. 10:16-2.1 permits the CFNFRB to review the deaths of infants and children whose deaths were due to Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID). The CFNFRB is empowered to establish priorities and select cases from among these categories and to conduct a full review.

The CFNFRB has the following secondary objectives/tasks that guide them toward the prevention of child deaths:

- ① Identify factors that place children at risk of death by exploring conditions surrounding child deaths to determine preventability.**
- ② Improve local and state investigative procedures, specifically for unexplained/unexpected child deaths.**
- ③ Improve existing services and systems while identifying gaps in community and governmental services and points of intervention.**
- ④ Identify trends relevant to child deaths.**
- ⑤ Educate the public about the cause of child deaths while defining the public's role to prevent these tragic deaths.**
- ⑥ To construct recommendations that are data driven and aim to prevent future deaths of children.**

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 (see figure 1). 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.

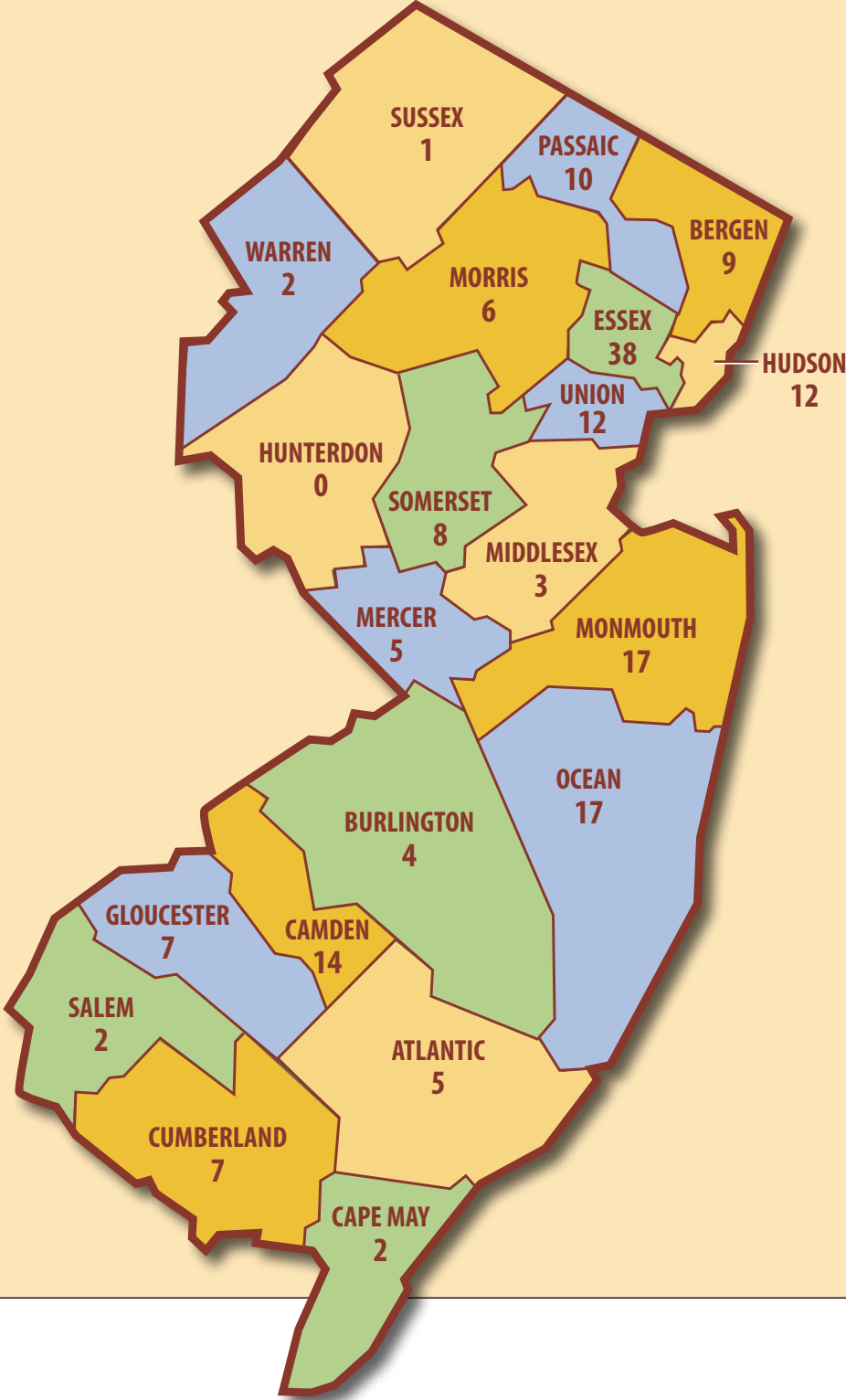
The CFNFRB reviews fatalities and near fatalities that occurred in families while DYFS was either investigating assessing for or providing services. Identified cases with prior DYFS involvement or cases where the family was unknown to the child protective services system are reviewed by one of the four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



Figure 1

The CFNFRB and its four regional teams were 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.

# Child Deaths by County



# Natural and Undetermined Deaths

## INTRODUCTION

With the exception of sudden unexplained deaths, the CFNFRB reviews those natural deaths in which the child's family was receiving DYFS services or had received services within 12 months preceding the child's death. Under N.J.S.A 9:6-8.90, all undetermined causes of death are reviewed. In New Jersey, deaths are certified as Undetermined by medical examiners when there is insufficient evidence to express a cause and/or manner of death.

## OVERVIEW

Natural causes are the second leading cause of fatality for children over 1 year of age in the United States<sup>3</sup>. Natural causes contribute to nearly 20,000 deaths annually for children under one, excluding SIDS (National Center for Child Death Review) Medical conditions, infectious disease and disorders are the cause of many of these deaths. Risk factors include pre-term birth, low birth weight, congenital abnormalities, poverty, lack of medical care and hazardous living environments.

Some experts believe that undetermined deaths, particularly in children, have a high likelihood of being homicides and suicides that could not be proven otherwise by a medical examiner or law enforcement for a variety of reasons; including poor investigations, lack of training, lack of evidence, suspicious fatalities written off as sudden unexplained deaths.

## FINDINGS

In 2008, the CFNFRB reviewed 91 fatalities in which the manner of death was certified by medical examiners as Natural (68) or Undetermined (23). In 75% of these natural or undetermined deaths, the cause was attributed to sudden unexplained infant death. The remaining natural causes were related to either medical conditions or were unknown. Manners of death that could not be determined, had causes that included SUID, asphyxia, head trauma, poisoning and smoke inhalation.

Undetermined manners included :

- ▶ HEAD TRAUMA
- ▶ POISONING
- ▶ SMOKE INHALATION
- ▶ UNDETERMINED

# Sudden Unexplained Deaths

Sudden Unexplained Infant Death (SUID) is one of the leading causes of fatality among children from birth to one year old in the United States; causing nearly 4,500 deaths annually<sup>4</sup>. The highly researched disease is also a leading killer among New Jersey’s children. By definition, a SUID is the sudden and unexpected death of an infant in which the cause of death can not be specifically identified or categorized. A SUID may be associated with several conditions; including suffocation, poisoning, hyperthermia, hypothermia, Sudden Infant Death Syndrome (SIDS), metabolic disorders, which may be contributive to the death but not the definite cause. The most prevalent designation of a SUID is Sudden Infant Death Syndrome (SIDS), which comprises nearly half of all SUIDs<sup>5</sup>. SIDS is the sudden and unexpected death of an infant less than one year of age which remains unexplained after a thorough case investigation, including complete autopsy, death scene examination, and review of the infant and family medical history. The difference between a SUID and SIDS is that SIDS is a diagnosis of exclusion, meaning it is only diagnosed after all other possibilities are ruled out. In a SUID, there may be a possibility that something happened, but there may not be enough evidence to be certain. If a child over the age of 12 months dies unexpectedly, after a thorough case investigation, the death is defined as a Sudden Unexplained Death in Childhood (SUDC).

SUID, SIDS and SUDC are certified as Natural or Undetermined manners of deaths depending on the circumstances or risk factors surrounding the death. Sudden unexplained deaths accounted for 75% of Natural and Undetermined deaths reviewed by the CFNFRB.

Much like in 2007, sudden unexplained deaths among infants and children accounted for 39% of all fatalities reviewed by the CFNFRB in 2008. As figure 2 shows, of the 70 total sudden unexplained death cases reviewed in 2008, 47 (67%) were SIDS (less than one year of age), 20 were SUIDS and 3 were SUDC (older than 12 months).

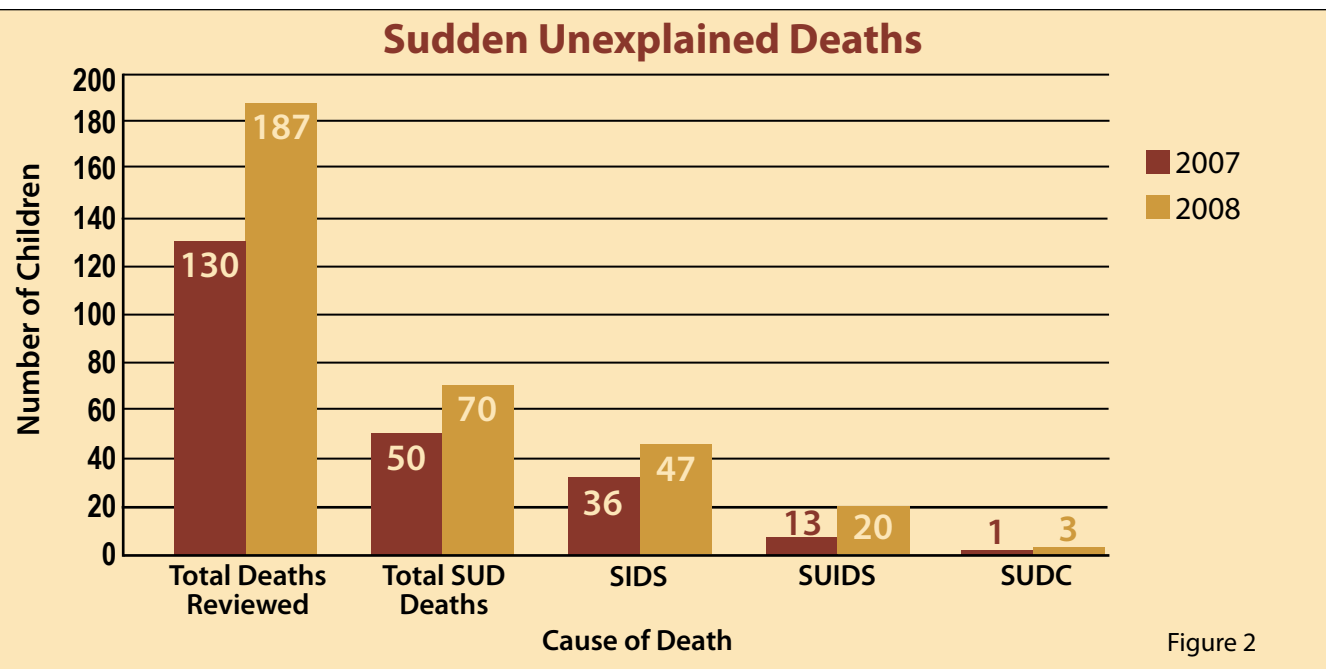


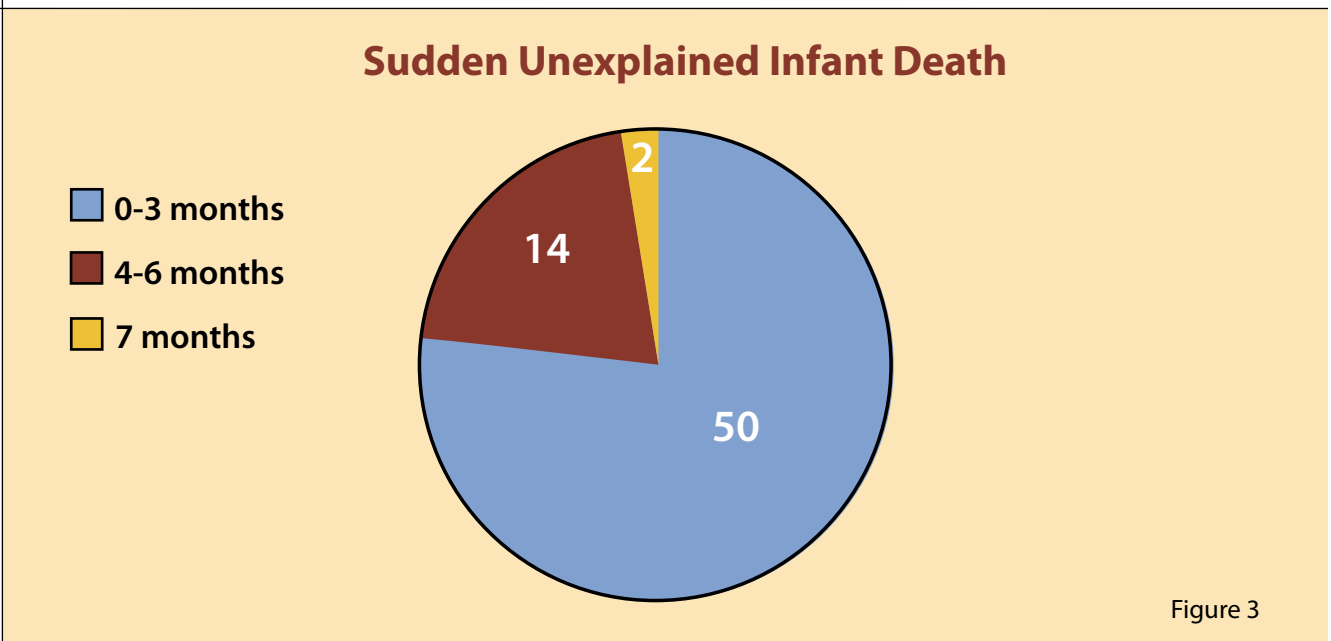
Figure 2

4 Center for Disease Control and Prevention, Sudden Infant Death Syndrome and Sudden Unexplained Infant Death: Home <http://www.cdc.gov/SIDS/index.htm>

5 IBID

### DEMOGRAPHICS (AGE, RACE AND LOCATION)

According to the National Institute for Child Health and Human Development, most SIDS deaths occur when infants are between 2 months and 4 months of age<sup>6</sup>. Similarly, New Jersey's CFNFRB reviews revealed that newborns up to 3 months old accounted for 71% of all sudden unexplained infant deaths. While 4-6 month olds totaled 21%. The data revealed that after six months of age, the risk of infants dying of a sudden unexplained death decreased significantly as only two child deaths occurred at 7 months and none between the ages of 8 and 11 months (see figure 3).



<sup>6</sup> National Institute for Child Health and Human Development, Sudden Infant Death Syndrome (SIDS)  
[http://www.nichd.nih.gov/health/topics/Sudden\\_Infant\\_Death\\_Syndrome.cfm](http://www.nichd.nih.gov/health/topics/Sudden_Infant_Death_Syndrome.cfm)

# Sudden Unexplained Deaths in NJ

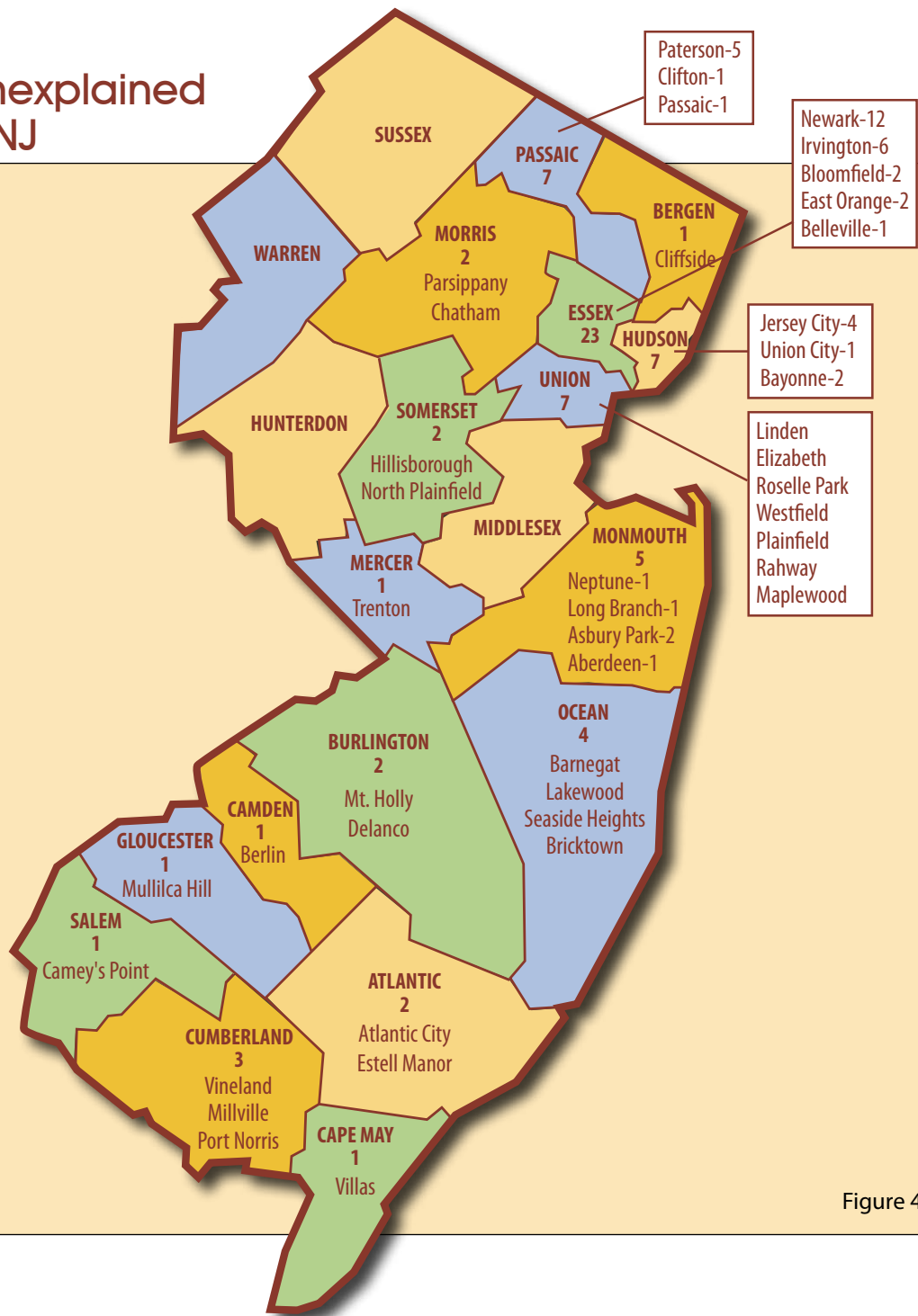


Figure 4

## LOCATION

CFNFRB data revealed that there was a heavy concentration of sudden unexplained deaths in the Northern Region of New Jersey. Essex County accounted for one-third (33%) of all sudden unexplained fatalities in the state, followed by Hudson, Passaic and Union Counties, accounting for 10% each. Of the 70 total sudden unexplained deaths that were reviewed, 44 or 63% occurred within those four counties (see figure 4). While the CFNFRB can not speak specifically to the reason for the increased presence of unexplained deaths in these areas, data from the U.S. Census Bureau revealed that in 2007, Hudson, Essex and Passaic Counties ranked #2, 3, and 4, respectively, in the number of children under the age of 18 who lived in poverty. Union County ranked #12<sup>7</sup>. Poverty may be associated with a number of risk factors in sudden unexplained death cases, including lack of access to resources, inadequate sleeping arrangements and lack of access to education.

7 United States Census Bureau <http://www.census.gov/cgi-bin/saippe/saippe/cgi>



## RACE and GENDER

African-American children, particularly males, between the ages of 0-3 months appear to be at the greatest risk of dying suddenly without explanation. African American children are disproportionately represented. Despite only accounting for 15% of the child population in NJ, African-American children account for 53% of all SUID, SIDS and SUDC. Caucasian non-Hispanic whites accounted for 31% of all sudden explained deaths and Hispanics accounted for 14%.

In the 0-3 months age group 62% (31) were males, and 38% (19) were females; in the 4-6 month age group 82% (14) were male and 18% (3) were female; two males age 7 months; 2 males and 1 female were between 12 and 15 months old.

## RISK FACTORS

The American Academy of Pediatrics has identified a number of risk factors contributive to SUID and SIDS; including prematurity, co-sleeping, prone sleeping, soft bedding, crowded bedding, smoking and overheating. Several of these risk factors were prevalent in the cases reviewed and many of the deaths included multiple risk factors (see figure 5).



## Sudden Unexplained Infant Death Risk Factors

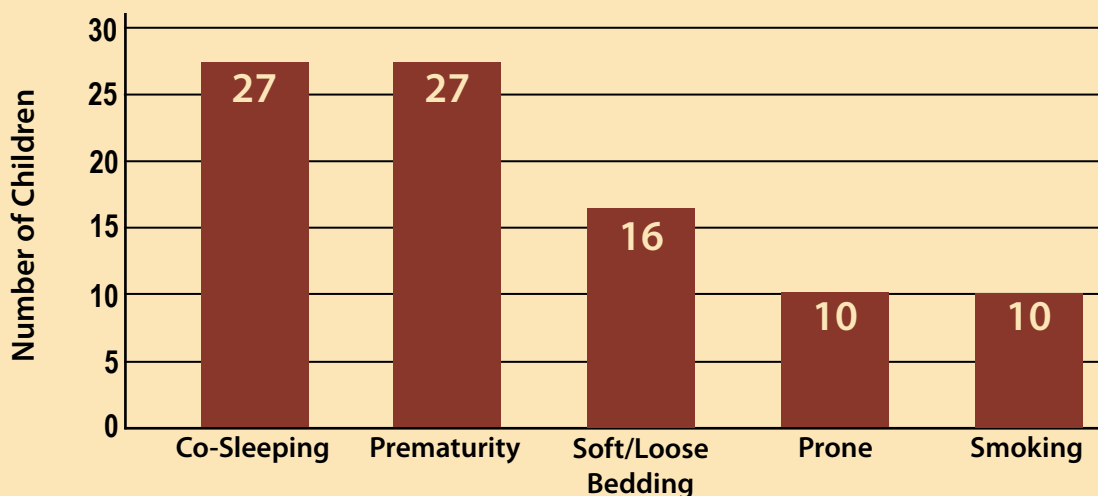


Figure 5

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Babies born premature accounted for 42% of all SUID/SIDS. According to the Centers for Disease Control and Prevention (CDC) premature babies are at the greatest risk of infant mortality, a category in which sudden explained death is the leading cause of death<sup>8</sup>.

Co-sleeping and bed sharing accounted for 41% of the sudden unexplained fatalities reviewed. In many of the cases reviewed, parents or caregivers chose to sleep with their babies for a variety of reasons, including a desire to nurture, out of fatigue, to provide the baby comfort from crying, a lack of bedding, lack of resources and education. Most often, when adults or caregivers co-sleep, their intention is well-meaning, but too often the outcome is tragic. In co-sleeping deaths, children are often rolled onto, slightly pinned beneath or obstructed in some form by another person, causing the child to cease breathing. Additional factors in co-sleeping include adult drug or alcohol use, obesity and several individuals sharing the bed with the child.

Based on the serious risks associated with co-sleeping, the CFNFRB strongly urges parents and caregivers to not allow their infants to share sleeping surfaces with anyone.

Other risk factors included prone sleeping (lying an infant on his or her stomach), (22%) and congested sleep environments (25%.) In cases of prone sleeping, some infants become fixed in the face down position and do not have the ability to maneuver themselves to a safe breathing position. The American Academy of Pediatrics has recommended non-prone sleep positioning since 1992 and today strongly recommends sleeping supine, or placing the infant on his or her back, as the preferred position for infants. Studies have shown a significant decrease in SIDS in countries where non prone sleep positioning for infants is advocated<sup>9</sup>.

Congested sleep environments included cribs, bassinets, adult beds and other sleep surfaces that were identified as containing stuffed animals, pillows, blankets and towels. The CFNFRB reviewed cases in which infants possibly became entrapped in, suffocated by, or rolled off some of the above listed sleep surfaces.

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8 Center For Disease Control , Sudden Infant Death Syndrome, 2008, <http://www.cdc.gov/SIDS/index.htm>

9 Pediatrics 2005;116:1245-1255, "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position"

## PREVENTION METHODS

### Tips to Reduce the Risk of SUID, SIDS & SUDC

- ▶ Supine or “on the back” sleeping for an infant. Statistics and information from the CDC, American Academy of Pediatrics and National Institute of Child Health and Human Development show that babies who sleep on their backs are less likely to die of sudden unexplained deaths than babies who sleep on their stomachs or sides.
- ▶ Place your infant to sleep in a baby crib or bassinet.
- ▶ Never co-sleep with your infant.
- ▶ Maintain a smoke free environment.
- ▶ Keep items out of the infant’s crib/sleep surface and away from the infant’s face (i.e. toys, pillows, blankets, etc.).
- ▶ Maintain a solid/firm (not soft) sleep surface for your infant with a fitted sheet. Pillows, blankets, bumpers, soft and loose bedding are major risk factors in SUD.
- ▶ Never use drugs or alcohol while caring for the infant.
- ▶ Make sure your infant maintains a pleasant body temperature and does not overheat while sleeping.

### Frequently Asked Questions:

#### ***1. What is the difference between SUID and SIDS?***

Both are unexpected and unexplained deaths. However in a SIDS a complete and thorough investigation has taken place and there is no evidence to suggest any other cause. In a SUID, there may be a possibility that some other factor contributed to the death (i.e. hypothermia, asphyxia, etc) but there is not enough evidence to be sure.

#### ***2. At what age is it safe for my child to sleep on his/her stomach and at what age can I sleep with them?***

While the CFNFRB can not recommend a specific age, data reveals a significant decrease in sudden unexplained deaths after one year of age. Three children older than one died of a sudden unexplained death, one at 13 months, one at 16 months and one at 21 months.

#### ***3. How do I ensure that my child is not going to be overheated?***

Experts say that infants should be kept warm, but NOT heavily clothed. A true indication of a suitable temperature is one that is warm to a lightly clothed adult.

# Suicide

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## INTRODUCTION

Suicide continues to be a daunting and in many aspects unexplainable phenomenon among children and adolescents nationwide. The CFNFRB may not review all child deaths due to suicide because cases in which an autopsy is not performed (possibly at the family's request) are excluded. With the exception of open DYFS cases, there is often very minimal, if any, psycho-social information available to gain insight in the dynamics and circumstances that may have contributed to a child committing suicide.

## OVERVIEW

Suicide is currently the third leading cause of death among youth ages 10 to 18, with adolescent depression being the leading contributing factor<sup>10</sup>. Teens who participate in risky behaviors such as drinking, using illicit drugs, sex, aggressive or delinquent behavior may be at greater risk for depression and suicide. Suicide may occur impulsively.

Major suicide risk factors include long term or serious depression, previous attempts, mental illness, substance abuse, childhood maltreatment, parental separation, interpersonal conflicts, previous suicide by a friend or family member, bullying and sexuality identification.

## FINDINGS

Last year the CFNFRB reviewed 16 child suicide deaths. All but one of the suicides was committed by a child older than 13. The only non-teenage death occurred when a seven year old child committed suicide by hanging himself from his bed by a belt (see figure 6). There was no evidence to suggest this child was troubled, abused or experiencing any major stressors.

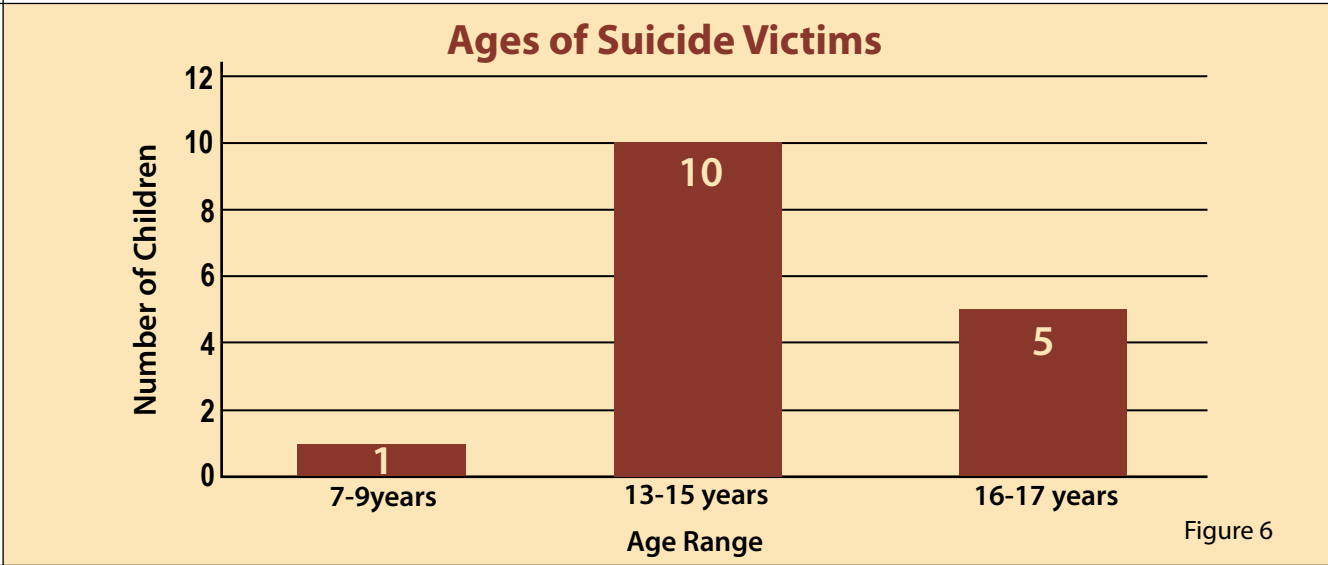
Due to limited questioning by first responders in many suicide investigations, identifying risk factors such as depression, academic or behavioral problems, history of suicidal ideation or attempts is extremely difficult. However, from the information available, it was ascertained that six out of 16 adolescents (37.5%) reported being victims of violence. Of these six, four victims reported being a victim of abuse perpetrated by their caregivers. The alleged abuse included one victim of sexual abuse, two reported physical abuse, and one reported both physical and emotional/verbal abuse. The two remaining children were assaulted by peers at school.

Another significant finding was the number of children who had difficulty adhering to rules or disregarded authority; including school staff, parents, and/or laws. Six out of 16 children (37.5%) were reported to have inappropriate behavior and truancy problems in school and one of those children also was involved with law enforcement.

Other trends noted were five out of 16 children (31.25%) had a history of previous suicide attempt or attempts. The same number of children made previous threats or remarks about suicide; were harassed, teased, or bullied other children in school; and had been involved with DYFS preceding their demise.

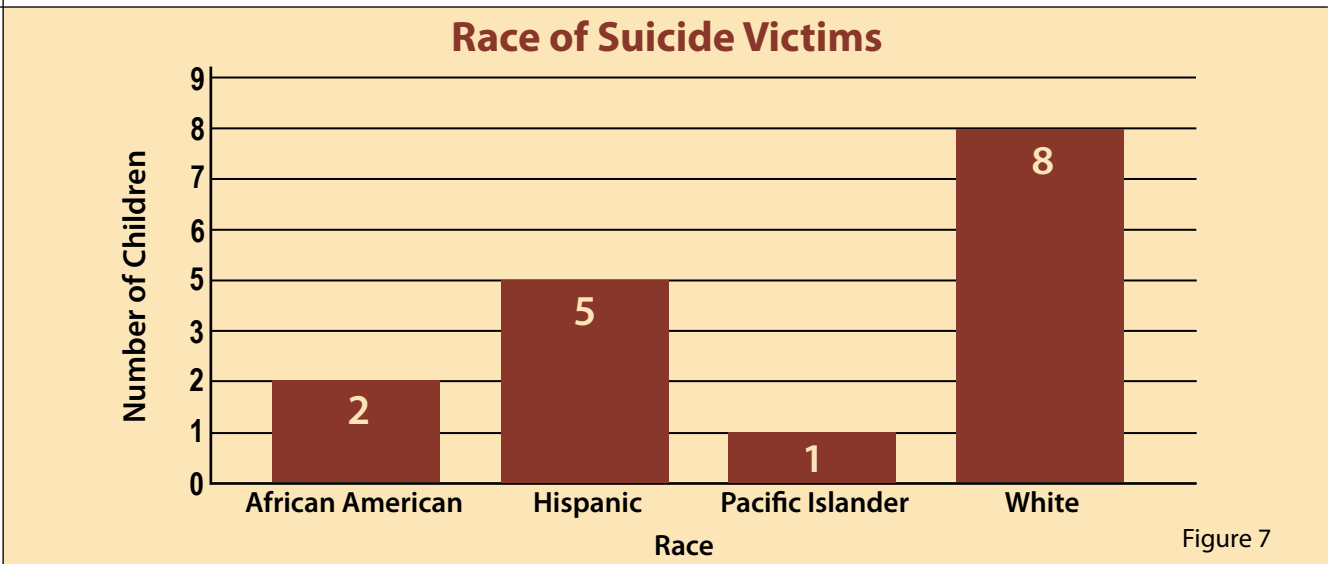
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10 Traumatic Loss Coalitions for Youth Newsletter (Spring 2009) p.12, <http://ubhc.umdj.edu/brti/TLC.htm>



Hanging continues to be the most frequent method of suicide used by children in New Jersey. In 2008, 10 of the 16 suicide victims choose to hang themselves. Two of the children died by shooting themselves, one child set himself on fire, one died of adverse effects of drugs and one jumped off a roof.

Consistent with national data from the Centers for Disease Control and Prevention (CDCP), non-Hispanic white children continue to commit suicide at a higher rate than any other race in NJ<sup>11</sup>. Caucasian children accounted for 50% (eight) of the suicides, followed by Hispanic children at 31% and African-Americans at 13% (see figure 7).



Nationally, there are four male suicides for every female suicide, but three times as many females as males attempt suicide<sup>12</sup>. In 2007, CFNFRB data revealed that males accounted for 81% of all child suicides committed in New Jersey.

11 Centers for Disease Control and Prevention, <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5605a1.htm#tab5>  
 12 American Foundation for Suicide Prevention, <http://www.afsp.org/index.cfm>

# Homicide

## INTRODUCTION

Homicide is defined as a violent death from an intentional act of another individual, whether or not the individual responsible is prosecuted<sup>13</sup> (NJ Office of the State Medical Examiner's Report, 2007).

According to the New Jersey Office of the State Medical Examiner, in 2007 there were a total of 40 children, 17 years old and under, who were killed by homicide.

The Child Fatality and Near Fatality Review Board (CFNFRB) reviewed 28 homicide deaths during the 2008 calendar year<sup>14</sup>. Of the 40 homicide deaths that occurred in 2007 and were reported to the State Medical Examiner's Office, 23 were reviewed by the CFNFRB<sup>15</sup>. The CFNFRB is required to review only those child homicides caused by abuse and or neglect, or cases in which the family was under DYFS supervision at the time of the fatal incident or had been under DYFS supervision within 12 months immediately preceding the fatal incident (N.J.S.A. 9; 6-8.90).

The CFNFRB reviewed 28 homicide cases in 2008, 19 of them were due to child abuse which will be discussed later in this report (see page 28). The nine non-child abuse homicide victims were adolescent males who were killed by unrelated or unknown persons.

## FINDINGS

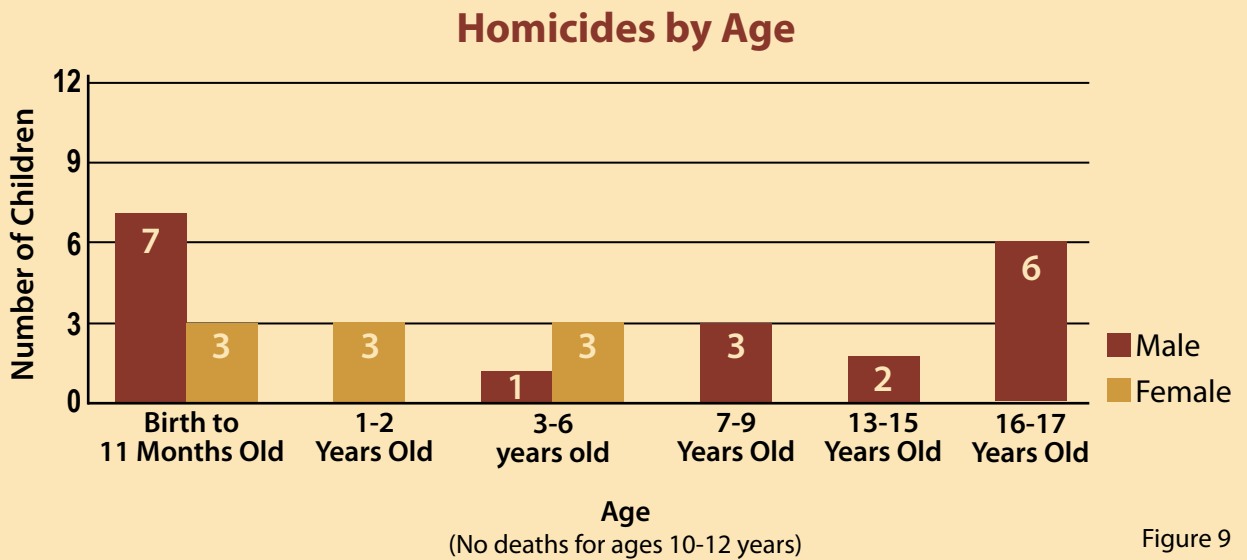
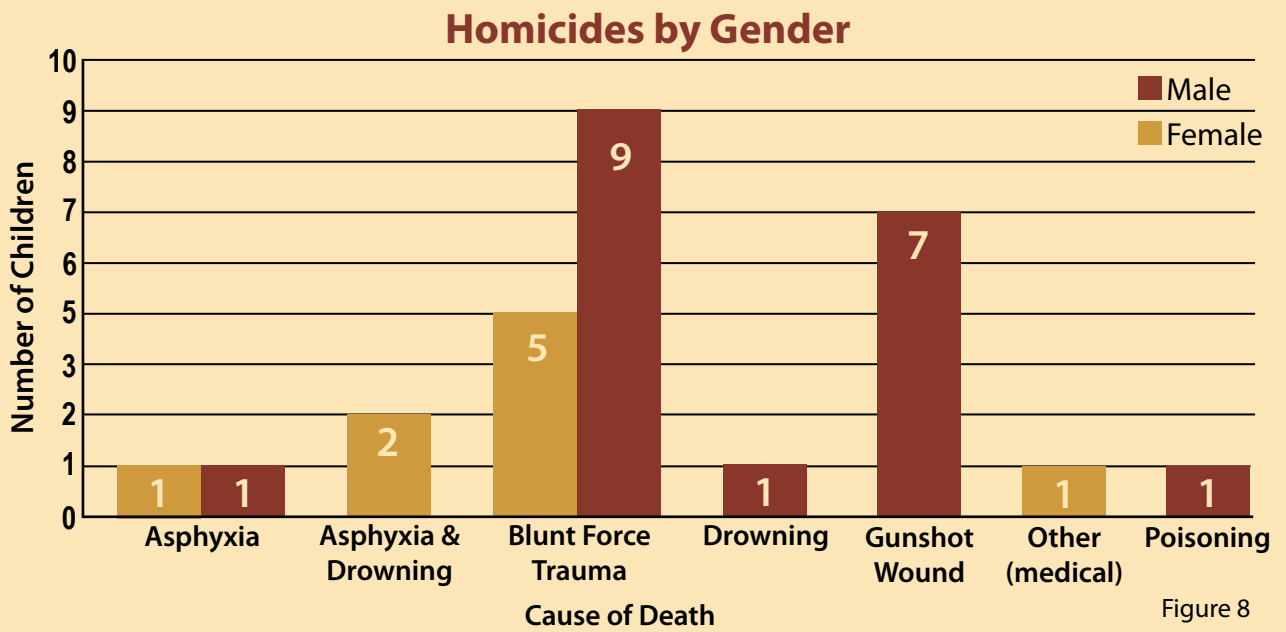
**The CFNFRB found that 68% (19) of the homicide victims were male with the incidence doubling for infants and adolescents between the ages of 16 and 17 regardless of gender.**

The deaths of the youngest victims were due to child abuse while the older victims were killed due to street violence (see figures 8 and 9).

13 NJ Office of the State Medical Examiner's Annual Report, 2007

14 23 homicides occurred in 2007, 4 occurred in 2006 and 1 occurred in 2005

15 The 17 fatalities not reviewed did not meet review criteria



# Accident Fatalities

## INTRODUCTION

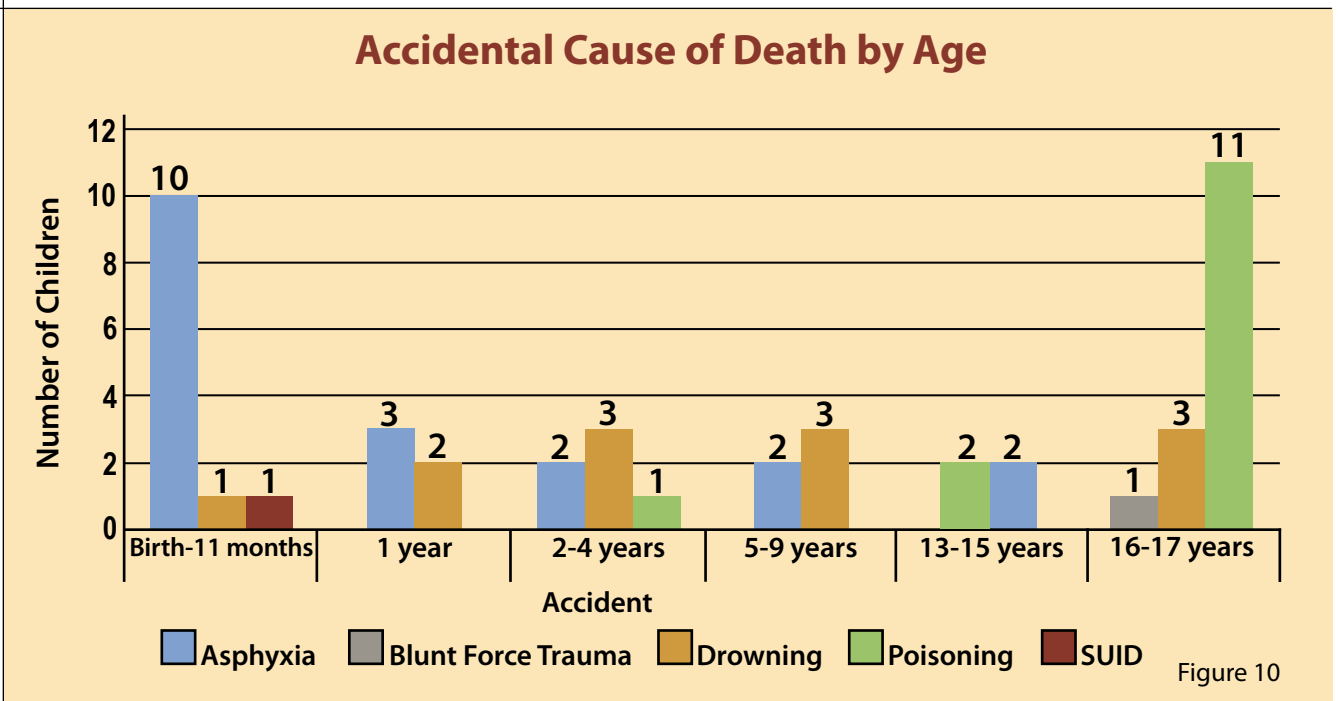
Accidental or unintentional injury deaths are the highest percentage of children deaths investigated by the NJ Office of the State Medical Examiner in 2007. Of those, motor vehicle accidents and asphyxia were the two leading causes. Given that with few exceptions, the CFNFRB does not review motor vehicle accidents, the findings for leading cause of death are consistent with those of the medical examiner. The CFNFRB found that the leading cause for accidental deaths was asphyxia followed by poisoning.

## OVERVIEW

According to the Center for Disease Control and Prevention more children die of unintentional injuries everyday than all other causes of death combined and more than 12,000 US children ages 0 to 19 die every year from preventable injuries. Suffocation is the leading cause of accidental death in children younger than one and drowning is the leading cause of injury death in one to 4 year olds<sup>16</sup>.

## FINDINGS

The CFNFRB findings are consistent with those of the CDCP. Asphyxiation was the leading accidental cause of death in children under one year old and drowning was the leading cause for children between the ages of two and four years old. Poisoning was the number one cause of death for children ages 13 to 17 years old (see figure 10). Poisoning (31%) was the second leading cause of accidental death overall. 38% (17) accidental fatalities were due to asphyxia, 31% (14) due to poisoning, 27% (12) due to drowning, 2% (one) due to Sudden Unexplained Infant Death and (2%) one due to blunt force trauma (See figure 11). 71% (12 of the 17) infants who accidentally asphyxiated were noted to sleeping unsafely (co-sleeping with another person).



16 American Academy of Pediatrics, (2009) "U.S. Child Fatalities from Injuries Top 12,000 Annually: CDC" February, Volume 30, P. 4.



### Causes of Accidental Deaths

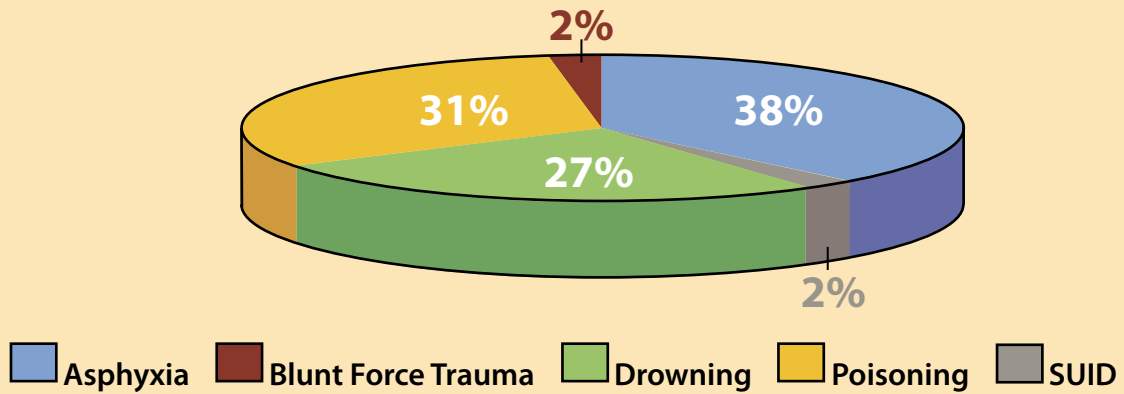


Figure 11

***Twenty-eight male children (62%) and seventeen females (38%) died accidentally (see figure 12).***

### Gender of Accidental Deaths

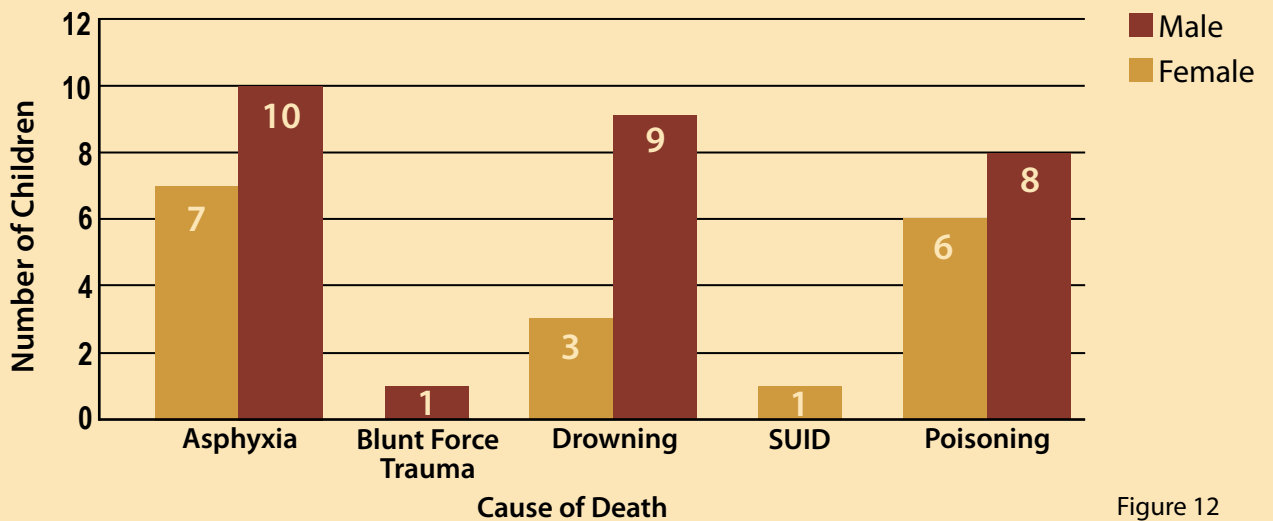


Figure 12

## MOTOR VEHICLE ACCIDENTS (MVA) DUE TO ALCOHOL USE

Nationally, nearly one-third of motor vehicle fatalities result from excess speed. The primary factors that contribute to motor vehicle occupant fatalities in New Jersey are speed, alcohol, and failure to use restraint options such as seat belts and infant seats<sup>17</sup>. In 2007 the NJ State Police reported there were seventeen motor vehicle fatalities involving 17 year old youths<sup>18</sup>. The CFNFRB reviewed three of these motor vehicle fatalities.

The CFNFRB reviews only those motor vehicle fatalities if the child victim's toxicology reports (upon autopsy) were positive for alcohol or drugs or the victim was under DYFS supervision or had been under DYFS supervision within 12 months preceding his death. The CFNFRB reviewed three motor vehicle related deaths. All three victims were male and 17 years old. All three were above the legal limit of alcohol intoxication. One youth died of alcohol poisoning after crashing head on into another car after driving on the wrong side of the road. He had a blood alcohol level of 0.21%. At a 0.21% blood alcohol level one may feel dazed or confused and may require help standing or walking and a blackout is likely. The second victim, who had a blood alcohol level of 0.135%, suffered blunt force trauma when his vehicle struck a tree. At a 0.135% level one's judgment and perception is severely impaired and there is gross motor impairment. The third victim, who had a blood alcohol level of 0.10%, drowned after driving his car into a pond. At this blood alcohol level, balance, vision, reaction time and hearing are impaired.

## DROWNING

Drowning is the fourth leading cause of accidental death in the United States, claiming 4,000 lives annually. Approximately one-third are children under the age of 14<sup>19</sup>. In New Jersey, between 1990 and 2005, over 800 people died of water-related injuries in the months of May through September. The water-related injury death rate decreased one-third in that time period<sup>20</sup>.

The CFNFRB reviewed 12 drowning cases in 2008, and of those drownings only two children were older than 14. The most significant findings were that more than three times as many males (nine) died by drowning compared to females (three), and the greatest number of drownings occurred to children between the ages of two and eight years. More White children, 59%, died due to drowning compared to Hispanic, 25%, African American 8% and mixed race, 8%. Most drownings (42%) occurred in a pool, followed by 25% in a bathtub, 17% in a lake, 8% in the ocean, and 8% in a hot tub. Two of the three children who drowned in a bathtub were left unsupervised for 30 minutes or more, and in both of those deaths DYFS substantiated neglect against the caregivers (see DYFS section for further information). There was one drowning case reviewed in 2008 due to a homicide (see homicide section for details).

## ASPHYXIA

The CFNFRB reviewed 17 asphyxia cases in 2008. In 12 of the 17 (71%) deaths, asphyxia was due to bed sharing with an adult caregiver/and or sibling and/or inappropriate bedding which caused the child to roll off the surface. These risk factors are also associated with Sudden Unexplained Infant Deaths (SUID). (See SUID section for safe sleep recommendations.)

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17 NJ Dept. of Health and Senior Services, Office of Injury Surveillance & Prevention, Preventing Injury in New Jersey: Priorities for Action Report, August 2008, P.9, [http://www.state.nj.us/health/chs/oisp/documents/injury\\_prevention.pdf](http://www.state.nj.us/health/chs/oisp/documents/injury_prevention.pdf)

18 NJ State Police, Fatal Accident Investigation Unit, 2007 Fatal Crash Comparative Data Report for the State of NJ, P. 15, [http://www.state.nj.us/njsp/info.fatalacc/2007\\_fatal\\_crash.pdf](http://www.state.nj.us/njsp/info.fatalacc/2007_fatal_crash.pdf)

19 Center for Disease Control and Prevention, Water-related Injuries Fact Sheet, [www.cdc.gov/Homesand Recreation/safety/water-safety/waterinjuries/factsheet.htm](http://www.cdc.gov/Homesand Recreation/safety/water-safety/waterinjuries/factsheet.htm)

20 NJ Dept. of Health and Senior Services, Center for Health Statistics, 2008 Health Data Fact Sheet, <http://www.state.nj.us/health/chs/monthly factsheet/watersafety.pdf>

The CFNFRB found that white children are at the greatest risk of dying of an accidental asphyxiation (asphyxia due to overlay, positional asphyxia, accidental hanging, and fire), and that white males are at the greatest risk of dying of accidental asphyxia between the of ages birth to 11 months old. Of the 17 accidental asphyxiation deaths, 41% were white and of the 10 children between the ages of birth and 11 months old, 40% were white children.

## **ACCIDENTAL BLUNT FORCE TRAUMA**

The CFNFRB reviewed only one accidental death that was caused by blunt force trauma. This was a 17 year old white male who crashed his vehicle while driving under the influence of alcohol. This case was noted in the Motor Vehicle section.

## **ACCIDENTAL POISONING**

Poisoning is the third leading cause of unintentional injury death nationwide and the second leading cause in New Jersey<sup>21</sup>. For the purpose of this report poisoning is defined as a death related to acute drug reaction toxicity, adverse drug reaction or adverse effect of drugs, as identified by the medical examiner through autopsy and ancillary testing.

The CFNFRB reviewed 14 child deaths caused by accidental poisoning and concluded that 17 year old white males died more frequently due to this cause. Of the victims , 79% (11) were White, 14% (two) African American and 7% (one) was Hispanic. 64% (nine) were 17 years old, 29% (four) were between 14 and 16 years old and 7% (one) was a two year old who died from ingesting medication left within her reach. Regarding gender, 57% (eight) were male and 43% (six) were female.

In the majority of deaths (79%) the adolescents used either a combination of various controlled dangerous substances, Oxycodone or Morphine, 14% (two) used Methadone and 7% (one) used alcohol.

***The CFNFRB determined that 86% (12) of the 14 accidental deaths due to poisonings were preventable.***

**The CFNFRB determined that 38 (84%) of the accidental deaths were preventable and only four (8%) were not preventable. The CFNFRB was unable to determine preventability in four of the cases (8%).**

The CFNFRB determination of preventability regarding these deaths is consistent with the CDCP, which states that 90% of child fatalities due to accidents are preventable. Preventability is determined by analyzing the various risk factors and circumstances of the death, and determining if an individual or community entity could have reasonably prevented the death. For instance, the CFNFRB identified lack of supervision, ranging from a time period of five to 30 minutes, in 10 of the 12 drowning deaths reviewed and determined that those deaths were preventable. Also, the CFNFRB found that those deaths associated with accidental overlay while co-sleeping were preventable due to unsafe sleep practices with an infant child.

21 NJ Dept. of Health and Senior Services, Office of Injury Surveillance & Prevention, Preventing Injury in New Jersey: Priorities for Action Report, August 2008 Report, P. 16 [http://www.state.nj.us/health/chs/oisp/documents/injury\\_prevention.pdf](http://www.state.nj.us/health/chs/oisp/documents/injury_prevention.pdf)

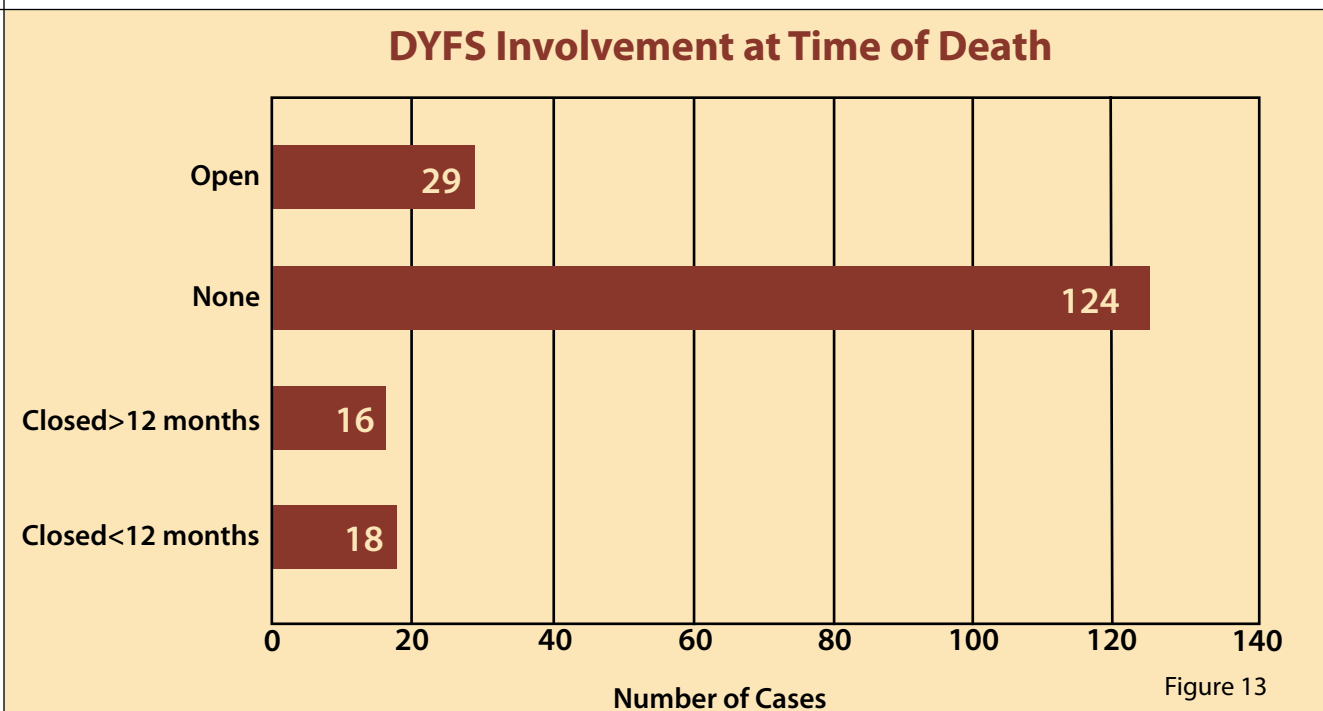
# New Jersey Division of Youth and Family Services Involvement

## INTRODUCTION

According to the United States Department of Justice, after spousal killings, children killed by parents are the most frequent type of family homicide<sup>22</sup>. In 2006, 2,089,338 children under the age of 18 resided in New Jersey<sup>23</sup>. Each month the State Central Registry (SCR) receives approximately 17,000 reports of possible abuse or neglect or concerns for a child's welfare<sup>24</sup>. The Division of Youth and Family Services (DYFS) is statutorily mandated to respond to those allegations or concerns by investigating or assessing for services. As of March 31, 2009, 48,008 children were receiving DYFS services<sup>25</sup>.

The CFNFRB reviewed the cases of 28 children<sup>26</sup> ranging in age from hours old to 14 years, who died from the abusive or neglectful behavior of their caregiver(s) - an individual responsible for the child's care and supervision at the time the child died.

Most fatality victims and their families were never involved with DYFS. Of the 181 fatality cases reviewed, 124 had never come to the attention of the child protection agency<sup>27</sup>, DYFS terminated involvement with 34 families prior to the fatality and 29 were open at the time the child died (see figure 13). The majority of children that died while DYFS was providing services died of natural deaths, followed by accidents, homicides, suicides and manners that could not be determined (see figures 13 and 14).



22 United States Department of Justice, Bureau of Justice Statistics, "Homicide Trends in the US, <http://www.ojp.gov/bjs/homicide/family.htm>

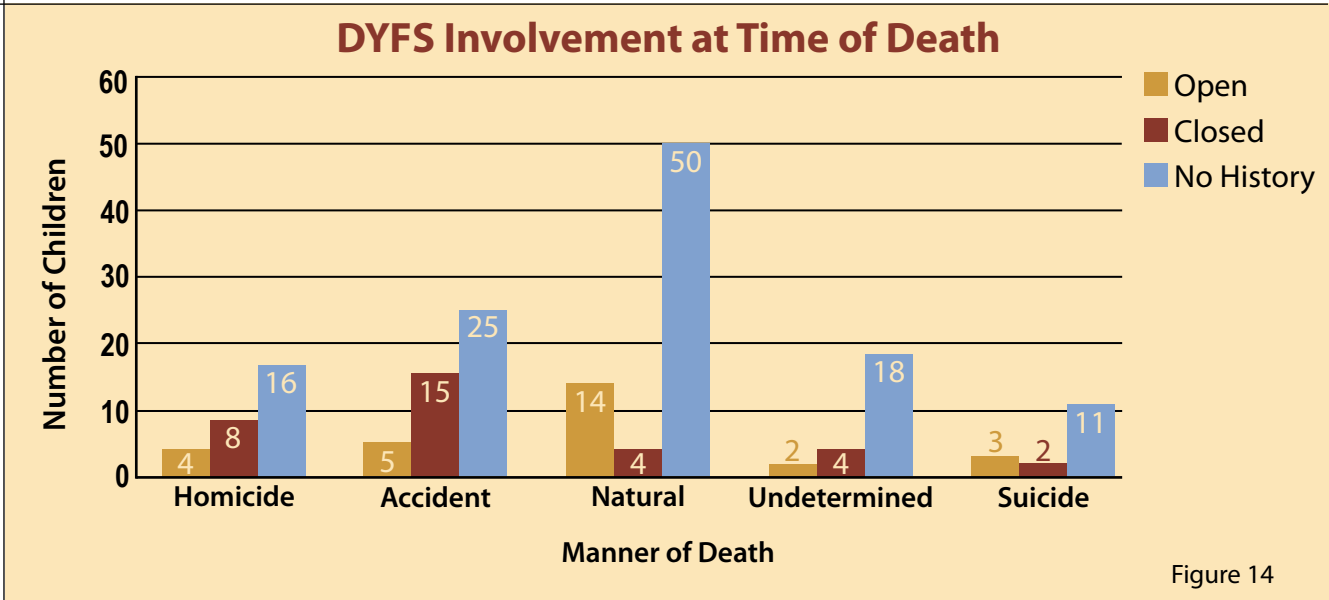
23 U.S. Census Bureau, <http://www.census.gov>

24 NJ Department of Children and Families [http://www.state.nj.us/dcf/about/DCFAnnualAgencyPerformanceReport\\_12.23.08.pdf](http://www.state.nj.us/dcf/about/DCFAnnualAgencyPerformanceReport_12.23.08.pdf)

25 NJ Department of Children and Families <http://www.state.nj.us/dcf/home/childdata/dyfs>

26 one fatality occurred in 2005, three in 2006 and 23 in 2007, and one in 2008.

27 17 families were reported to SCR in response to the death.



## FATALITIES DUE TO ABUSE OR NEGLECT

### Age

According to the Center for Disease Control and Prevention, homicide risk is greater in the first year of life than in any other year of childhood before the age of 17<sup>28</sup>. More than 80% of infant homicides are considered to be fatal child abuse and males are typically at greater risk<sup>29</sup>.

**61% (17) of those killed by abuse or neglect were infants who never reached their first birthday and more than half (10) of those never lived past six months.**

### Race

There was a slight difference in the number of African American and White children who were victims of fatal child abuse or neglect. 46% (13) were White, 36% (10) were African American, 11% (three) were Hispanic and 7% (two) were of mixed race. In examining race, although there was little difference in the number of children who died of abuse or neglect, African American children are significantly overrepresented given the size of New Jersey African American child population.

### Cause of Death

Of the child abuse victims, 57% (16 of the 28) died violently - 12 children were killed by blunt force trauma and four were killed by manual strangulation. Five children drowned, three were poisoned, two smothered and two children died when their caregivers' failed to seek medical attention for their illnesses.

28 Murphy, SL. Deaths: final data for 1998. National vital statistics reports; vol.48. no11. Hyattsville, Maryland: National Center for Health Statistics, 2000.

29 New England Journal of Medicine, "Risk Factors for Infant Homicide in the United States", 1998, 339 (17):1211-1216

## Perpetrator Relationship to Victim

More female caregivers (19) than male caregivers (13) were responsible for the deaths of the children in their care. In 15 of the 28 deaths due to child abuse or neglect, 10 mothers and four fathers (one father was responsible for a double homicide) acted alone. In five cases both the mothers and fathers were equally responsible for their child's death. Other female perpetrators included a father's live in girlfriend, a babysitter, an aunt and a great grandmother. Male perpetrators other than the child's father included three mothers' live in boyfriends and one step-father.

Three of the four fathers acted alone in killing their children violently by blunt force trauma. The fourth father strangled his two school age children. Five of the nine mothers who acted alone also killed their children violently by blunt force trauma. The other four mothers caused their children's deaths by being neglectful; three by leaving their children unattended which resulted in the children drowning and one mother provided access to prescription medication which her teenage daughter ingested and died.

The ages of the female caregivers varied from age 19 to 61 years old with the average age of 33.9 years. Male caregivers ranged in age from 18 to 45 years old with an average age of 29.7 years.

## Non Child Abuse Fatalities and DYFS Involvement

The CFNFRB reviewed 114 fatality and near fatality cases unrelated to child abuse but the families had prior or current DYFS involvement. These infants and children died from Sudden Unexplained death (including SIDS), disease, accidental asphyxia and poisoning, drowning, suicide and undetermined causes.

## NEAR FATAL INJURIES

### Introduction

A near fatality is defined as an incident in which a child is in serious or critical condition, as certified by a physician (N.J.S.A. 9:6-8,84). It is further defined in Chapter 16 of the N.J.A.C. as a serious or critical condition, as certified by a physician, when a child suffers either a permanent mental or physical impairment, a life-threatening injury or a condition that creates a probability of death within the foreseeable future. A near fatality may be the result of different causes including, but not limited to, drowning, blunt force trauma, poisoning, gunshot wounds and even attempted suicide or homicide.

### Findings

The CFNFRB concluded that male infants under the age of one are at the greatest risk of near fatal physical abuse.

The CFNFRB identified and reviewed six near fatalities all due to physical abuse perpetrated by a parent or a caregiver. In all six cases the child suffered a life threatening and irreversible physical impairment.

**In 100% of the cases the children were less than a year old; with four of the six being five months old or younger.**

These included two children who were beaten and suffered serious head trauma, and one was suffocated by their father; three children were shaken and suffered traumatic brain injuries with rib fractures.

## In 83% of the cases the victim was male.

In four of the six near fatalities cases the family had no prior DYFS involvement, one case had prior DYFS involvement over six years earlier, and one case was opened with DYFS at the time of the incident.

In three of the six near fatalities, fathers acted alone in physically abusing their children, in one case both the mother and father were involved. In the remaining two cases, one perpetrator was a babysitter and the other was never identified.

All of the parents who near fatally injured their children were between the ages of 19 and 21. In all six cases the perpetrators were charged with child endangerment and/or aggravated assault.

## FINDINGS

The aforementioned information provides a valuable statistical overview of the nature of child fatalities and near fatalities in New Jersey, and identifies several important risk factors affecting child safety and well being. This information substantively contributes to the understanding of how and why children die or experience near fatalities. As a result we can identify factor to prevent future tragedies.

Additionally, the Board and regional teams examine the detailed circumstances of these cases to identify areas where improvements are needed in system practices and policies. The Board works to identify factors that are needed to respond and prevent child deaths. Other areas of focus include pinpointing what community services are needed to better assist families and protect children. Areas where legislative changes are necessary are also noted. The Board tracks these findings throughout the year as cases are reviewed. These findings serve as the foundation for the recommendations that accompany this Annual Report.

It is important to note that during the course of the review, the Board or regional teams may opt to take immediate action on a particular issue and bring the matter to the attention of a relevant party. That party is asked to take action or provide a specific action plan.

As a result of examining the circumstances and details surrounding New Jersey child fatalities and near fatalities that occurred primarily in calendar year 2007 and reviewed by the Board in 2008, several core policy areas emerged that require greater examination and attention.

Specifically, these involve the issues of safe sleep environments for infants and children, the need for the Department of Children and Families to examine its use of safety and risk assessment tools utilized in child protection investigations, the need to ensure that mental and behavioral health consultant contracts conform to a set of standardized, basic elements, and the need for consistency and standardized practices in the State Medical Examiner system. The Board believes these areas to be immediately important to ensuring child safety and well being.



# Recommendations

**ISSUE #1 PROMOTING A SAFE SLEEP ENVIRONMENT:** Unsafe sleep environments are contributing to the leading cause of infant deaths – asphyxia, SIDS and SUID. Some of the most common risk factors for SIDS and SUID are an unsafe infant sleeping position, exposure to smoke, parental substance abuse, overheating, inappropriate infant bedding and bed sharing with older siblings or adults. In cases of sudden unexplained deaths, 41% of infants were co-sleeping, 25% were in soft bedding, and 22% percent were sleeping on their stomachs-conditions which are believed to have contributed to their deaths. In the accidental asphyxia cases, 71% of the infants were sleeping unsafely with another person or inappropriate bedding. The ongoing need for education for parents, caregivers and service providers to promote safe sleep environments is essential to further prevent infant deaths.

The Department of Health and Senior Services and the Department of Children and Families should convene an ad hoc committee to assess current educational efforts to promote infant safe sleep environments and to develop an integrated strategic plan that is consistent throughout the state. The committee will consist of, but not limited to, governmental and private entities such as the New Jersey Chapter of the American Academy of Pediatrics, SIDS Center of New Jersey and the Maternal Child Health Consortia. The focus of the committee will be to assess what safe sleep education currently exists, to assure that there is not duplication of educational efforts and to target high risk populations.

The Department of Children and Families (DCF) should ensure that staff who work directly with children and families are trained in safe sleep practices so that they may support the safe sleep education of caregivers. DCF should also ensure that licensing regulations and provider contracts also mandate safe sleep training to all licensed and contracted providers.

**ISSUE #2 HIGH RISK ENVIRONMENTS:** Since 2004, the Department of Children and Families, Division of Youth and Family Services has used uniform, researched and evidence-based instruments that structure the process of assessment and response to information related to child safety to assist in the investigation of alleged child abuse/neglect. These tools assist field staff in applying uniform standards as they make important decisions, rather than relying on individual judgment. Referred to as Structured Decision Making (SDM), this assessment is performed through not only the completion of forms, but is also an ongoing process that prioritizes the safety of children by, "gathering and analyzing information that supports sound decision making."

DYFS workers conduct child protection and child welfare assessments through personal contact with the caregiver in the home and they use these uniform tools to assist in identifying factors affecting the child's immediate safety (Safety Assessment) and future risk of harm (Risk Assessment). Additional SDM tools are used by DYFS to assess a caregiver or child's strengths and needs (Strengths and Needs Assessments). Combined, these tools help to uniformly assess a child's safety and well-being, regardless of whether the child is living at home or in an out-of-home placement setting, and are important components in the overall decision-making and handling of the case.

In its review of cases in calendar year 2008, the Board identified concerns with how safety and risk assessments were completed. Problematic practices included incomplete assessments, as well as the undervaluing of mental health problems, violence histories, and substance abuse when completing the assessment tools.



The Board believes there is a need to periodically re-evaluate the efficacy of the SDM tools. Additionally, there is a need to evaluate the instruction and training that seasoned and new DYFS case work and supervisory staff receive on the use of SDM tools and to examine the practices involved with using these assessments to identify safety concerns and future risk of harm.

**RECOMMENDATION:** The Department of Children and Families (DCF) should re-evaluate the efficacy of their Structured Decision Making Tools, particularly their safety and risk assessment tools for validity. To facilitate this review, DCF should utilize a standing committee to assess and evaluate the tools. Such a committee should include input from both internal and external stakeholders to ensure a qualitative review. Additionally, once this review is completed and based on the information obtained, DCF should evaluate the instruction and training DYFS staff receives, including training given to new and seasoned workers and supervisors on the use of SDM tools. While DCF has the capacity to inform and reinforce casework standards as per the Case Practice Model, the Board recommends that DCF review the Board's recommendations regarding case practice on a monthly basis and communicate the recommendations to local office staff in writing.

**ISSUE #3 DCF CONTRACTED CONSULTANTS:** In the course of their work with children and families, DYFS caseworkers frequently use psychological and psychiatric assessments and evaluations to determine the nature of a person's or family's problems, the extent and kind of services needed, and to prescribe a course of service delivery or treatment. Additionally, the court often seeks in-depth evaluations to address legal issues before the court. In these situations, the role of the evaluator is to provide the court with an objective recommendation. The findings of these evaluations and assessments, whether sought by DYFS or the court, can significantly influence the decisions made and actions taken in the family's DYFS case. DYFS contracts with third party mental health professionals to provide these evaluations and assessments.

The Board identified concerns with the quality of the evaluations and assessments received from some mental health professionals involved in DYFS-supervised cases. Some of the concerns include whether clinicians consistently applied standardized measures to their psychological or psychiatric evaluations conducted on a parent or child.

The Board opined that the clinicians relied primarily on the client's self-report without verifying information through collateral contacts or historical documentation, found discrepancies in the results of the tests used by the clinician and the clinician's reported overall findings, and that additional standard psychological tests should have been used to more fully evaluate the parent prior to the clinician reaching a finding and issuing a recommendation.

Based on these concerns, and the significance of psychological and psychiatric evaluations in making case-related decisions, the Board believes there should be minimal standards identified for and required of all professionals who provide mental and behavioral health evaluations and assessments for cases under DYFS supervision.

**RECOMMENDATION:** DCF should review its contracts with mental health and behavioral consultants to ensure that all evaluations conform to a set structure or a minimum set of assessment elements.

## Recommendations (continued)

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**ISSUE #4 MEDICAL EXAMINER INVESTIGATIONS:** The CFNFRB has concluded that the current system does not ensure compliance with standard medicolegal death investigation procedures. The current system is fragmented with state regional offices coming under the authority of the State Medical Examiner while some county offices maintain a level of autonomy. As a result, the quality of death investigations is impacted throughout the State. Therefore, the ability to find out what caused the death of a child and where appropriate, hold individuals accountable for their actions is negatively impacted.

The CFNFRB strongly recommends the revision of the State Medical Examiner Act to allow the State Medical Examiner to direct and advise the county medical examiners in matters relating to the duties of their office and shall maintain a general supervision over said county medical examiners with a view to obtaining effective and uniform application of death investigation standards as recommended by the National Association of Medical Examiners (NAME). The CFNFRB further recommends that county medical examiners shall be subject to the authority of the State Medical Examiner in the performance of their duties under the Act.



