NJ CHILD FATALITY & NEAR FATALITY REVIEW BOARD ANNUAL REPORT

2019 Data and Recommendations

The loss of life or near fatal injury of a child due to any cause is a loss to society that is beyond measure. This brief highlights the findings of New Jersey's Child Fatality and Near Fatality Review Board (CFNFRB) including demographic data, the cause(s) of the incidents, the relationship of incidents to governmental support systems, trends, and recommendations on child fatalities and near fatalities that occurred in 2019.

ISSUED 2024

WHAT'S INSIDE?

What is the purpose of the Child Fatality & Near Fatality Review Board?

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

The Child Fatality and Near Fatality Review Board (hereinafter the "Board"), is tasked with reviewing fatalities and near fatalities of children due to unusual circumstances and includes a total of six teams: the State CFNFRB, Northern Community-Based Team, Central Community-Based Team, Southern Community-Based Team, Suicide Subcommittee (SSC), and the Sudden Unexplained Infant Death (SUID) Subcommittee.

The purpose of the Board includes but is not limited to the following:

- Review child fatalities and near fatalities in New Jersey in order to identify the cause of the incident, the relationship of the incident to governmental support systems as determined relevant by the Board, and methods of prevention;
- Describe trends and patterns of child fatalities and near fatalities in New Jersey based upon case reviews and findings;
- Identify risk factors and their prevalence in child fatalities and near fatalities;
- Evaluate the response of governmental support systems to the children and families who are reviewed, and to offer recommendations for systemic improvements, especially those that are related to future prevention strategies;
- Identify groups at high risk of death from child abuse and neglect, in terms that support the development of responsive public policy;
- Improve data collection sources by developing protocols for autopsies, death investigations, and the complete recording of the cause of death;
- Provide case consultation to individuals or agencies represented by the Board;
- Make recommendations for system-wide improvements in data collection for the purpose of improved evaluation, potential research and general accuracy of the archive.

The Board team membership aligns with best practice recommendations from the National Center for Fatality Review and Prevention, including "representatives from law enforcement, child protective services, prosecutor/district attorney, medical examiner/coroner, pediatrician or other health provider, public health and emergency medical services"[1] as well as conforms with CCAPTA legislation (N.J.S.A. 9:6-8:.89).

The Board resides within the New Jersey Department of Children & Families (DCF) but is statutorily independent of "any supervision or control by the Department or any board or officer thereof." DCF dedicates professional staff who function as liaisons to help carry out the Board's duties. DCF's Fatality and Critical Incident Review Unit provides support to the Board, including assisting in issuing an annual report.

See Appendix B for a list of Board members and DCF liaisons to the Board.

[1] CDR Process – The National Center for Fatality Review and Prevention (ncfrp.org)

The CFNFRB is authorized to review child fatality and near-fatality cases. These are selected based on NJ State law. Cases are reviewable when the child's fatality is due to unusual circumstances, such as:

- Undetermined
- Substance misuse
- Homicide due to child abuse or neglect
- Child abuse or neglect
- Malnutrition, dehydration, medical neglect or failure to thrive
- Sexual Abuse
- Head trauma, fractures, or blunt force trauma without obvious innocent reason, such as auto accidents
- Suffocation or asphyxia
- Burns without obvious innocent reason, such as auto accident or house fire
- Families under the supervision of the Division of Child Protection & Permanency (DCP&P) at the time of the fatal or near fatal incident or within twelve (12) months immediately preceding the fatal or near fatal incident
- Suicide
- Drowning
- Motor vehicle accidents in which the child:
  (1) Had a positive toxicology screen
  (2) Was under the supervision of CP&P
- All Sudden Unexpected Infant Deaths (SUID); which include children whose cause of death is Sudden Infant Death Syndrome (SIDS)

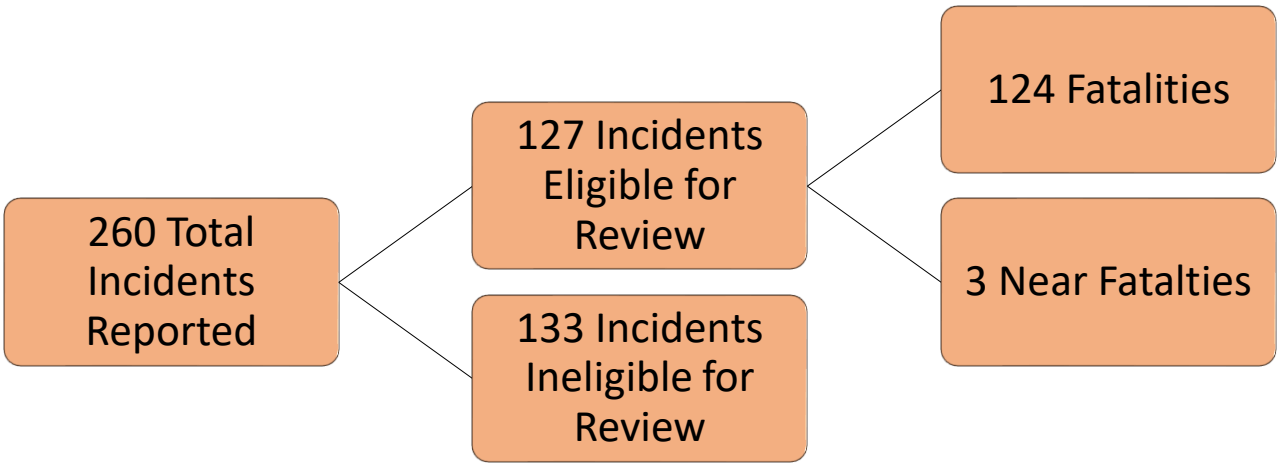
How many children died due to unusual circumstances?

The Board reviews fatal and near fatal incidents involving children 0-17 years old, both known and unknown to the child welfare system.

In 2019, the Board was notified of 260 child fatality and near fatal incidents that occurred in New Jersey. It was determined that 127 of those incidents (124 fatalities and 3 near fatalities) occurred under unusual circumstances and met the criteria for review. The 133 incidents ineligible for review resulted from a health condition or illness and/or an unavoidable, unforeseen event, absent of child maltreatment by a caregiver.

A near fatality is defined as a "serious medical condition, as certified by a physician, in which 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."

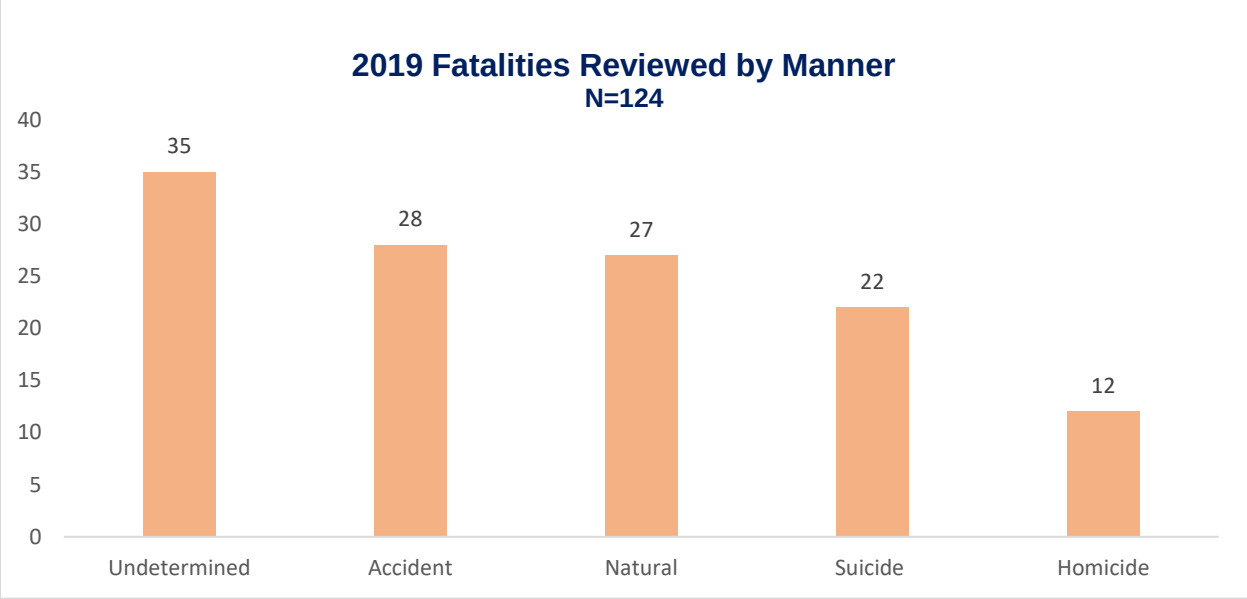
Most notifications of child fatalities and near fatalities come from DCF; however, the Board also draws on other data sources, including the medical examiners' office. This coordination of data collection contributes to better ascertainment of all child fatalities and near fatalities that have occurred, as not all incidents are reported to child welfare.



How did these deaths/near deaths occur?

All fatalities are classified according to the cause and manner of death. There are many complexities involved in these classifications, which are determined after an autopsy is performed by the medical examiner's office. It is important to note that an autopsy can be declined by the family, an example may be for religious reasons. The cause of death refers to the disease process, or injury that eventually led to death. The manner of death refers to the injury or disease that leads to death and is classified as natural, undetermined, accidental, suicide, or homicide.

- ***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 for which there is insufficient information about the circumstances to make a ruling, or in some instances, when the cause of death is unknown.
- ***Accident*** – 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.
- ***Suicide*** – A death resulting from the intentional actions of the deceased. Placing oneself in reckless disregard of harm and resulting in a death may also be ruled suicide.
- ***Homicide*** – A death due to another person's actions.



In 2019, the highest number of child fatalities statewide resulted from an undetermined manner of death (35 children, or 28%) due to a lack of information about the circumstances. These findings suggest an opportunity to improve data collection by developing protocols for autopsies, death investigations, and the sharing of complete records in deaths of children. Of the child fatality cases reviewed by manner of death, accidents were the second highest with 23%, followed by natural (22%), suicide (18%), and homicide (10%).

The Board reviews only the near fatalities that have been determined to be the result of abuse and/or neglect. In 2019, the Board reviewed three near fatalities, all caused by blunt force head trauma.

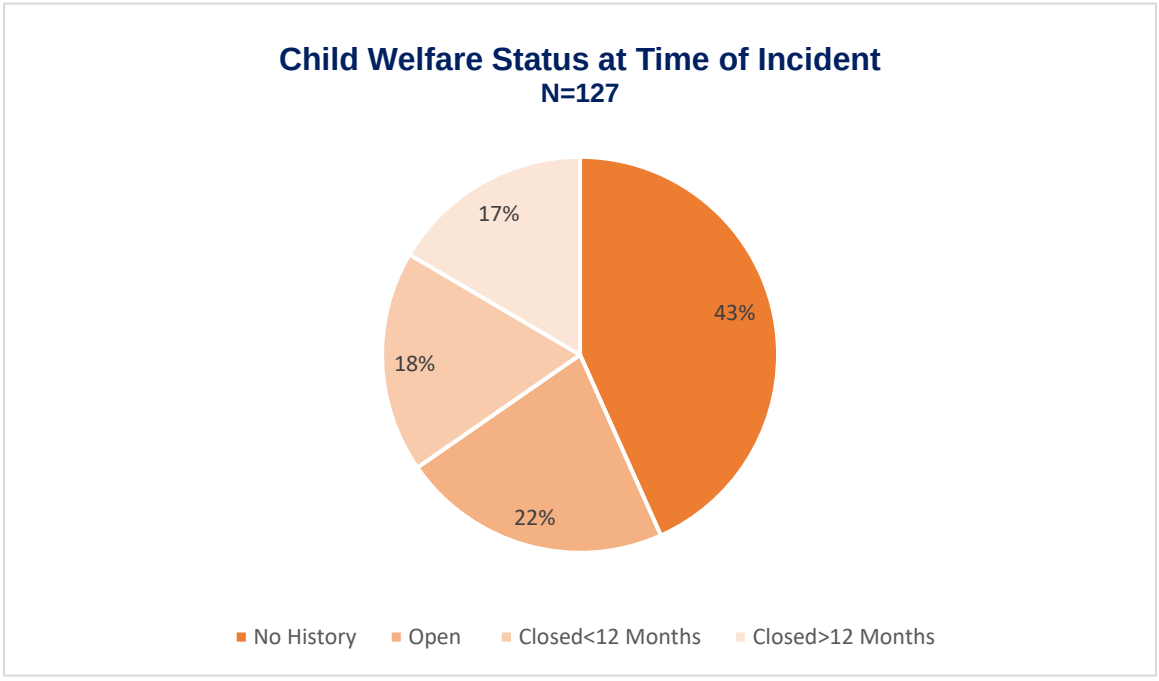
Was child welfare involved?

DCF's Division of Child Protection and Permanency (DCP&P) is New Jersey's child protection and child welfare agency. DCP&P is responsible for investigating allegations of child abuse and neglect, and, if necessary, arranging for the child's protection and the family's treatment. The Child Abuse Hotline (State Central Registry) receives and prioritizes reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the DCP&P Local Office to investigate. See Appendix A for infographic "What happens after the child abuse hotline is called."

The Board reviews fatalities and near fatalities involving children both known and unknown to DCP&P. Reviews conducted by the Board include a broader spectrum of incidents viewed through the lens of social impact and concern for the safety and protection of children, strengthening families, and improving the delivery of child protection services. The activities of the Board are a component in the state's plan to transform its child welfare system. The Board also examines the roles played by other agencies and systems relevant to child fatalities and near fatalities, such as law enforcement, and health care providers, and makes recommendations regarding findings at both state and local levels.

In 2019, the Board reviewed 127 fatalities and near fatalities. The families in 55 cases (43%) had no prior involvement with DCP&P. Additional findings revealed:

- 22% (28) of the families had an open case with DCP&P at the time of the incident;
- 18% (23) of the families had cases that were closed with DCP&P fewer than 12 months at the time of the incident; and
- 17% (21) of the families had cases that were closed with DCP&P for 12 or more months at the time of the incident.



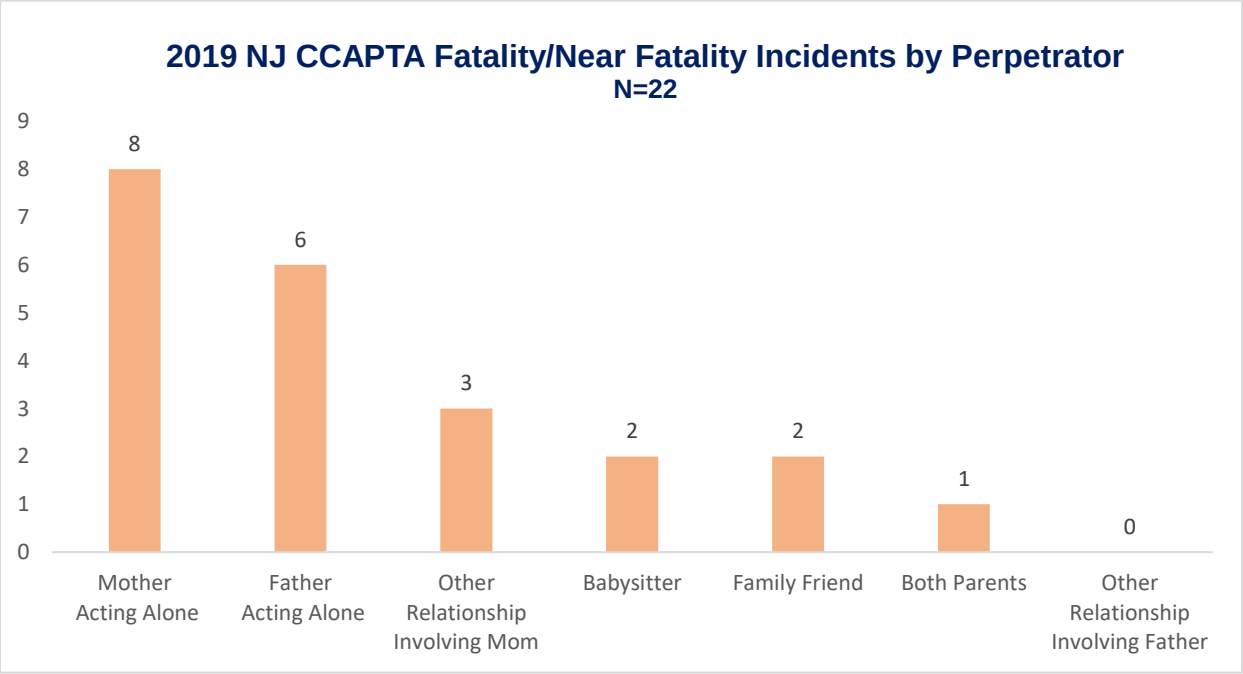
Who were the perpetrators?

Child abuse and/or neglect can result from acts of omission or commission (or both) on the part of the parent or caregiver. Sometimes a single incident will be sufficient to indicate that a child is abused or neglected. Other situations may exist in which the child abuse or neglect is the cumulative result of a pattern of behavior or conditions that together constitute child abuse or neglect.

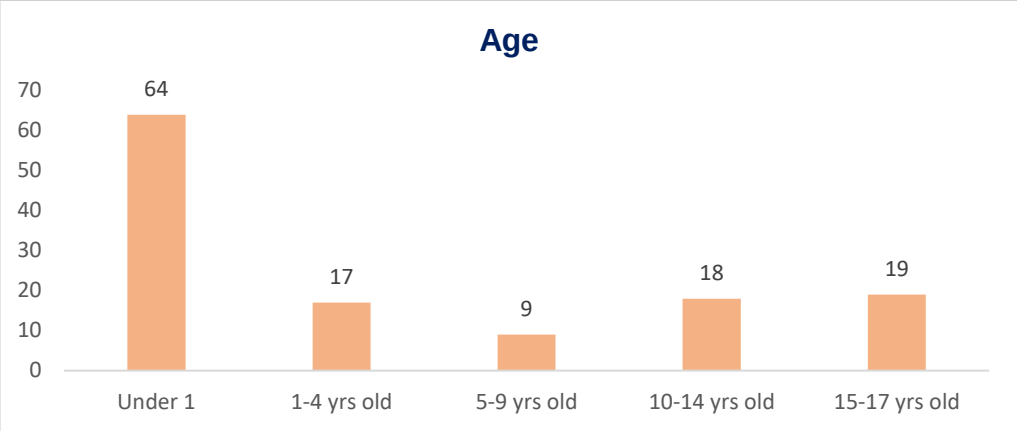
NJ CCAPTA law allows DCP&P to identify and release certain information regarding a child fatality or near fatality that was the result of abuse and/or neglect, including information on the alleged perpetrator and relationship to the victim. A perpetrator of child abuse or neglect must be the child's parent, guardian, caregiver, temporary caregiver, institutional caregiver, or anyone responsible for the care, custody, or oversight of the child.

In 2019, 22 child fatality or near fatality incidents reviewed were investigated by DCP&P and determined to have resulted from abuse and/or neglect. Of the 22 incidents investigated, 19 were fatal and 3 were near fatal.

The review found that parents were responsible for 82% (18) of the abuse and/or neglect incidents that resulted in the deaths or near deaths of their child, as outlined in Figure below. Other caregivers, including babysitters and family friends were responsible for 18% (4) abuse/neglect incidents.



What population of children are most at-risk?



50% of incidents involved **infants under 1 year old.**

Race/Ethnicity

Of cases reviewed by the Board, the fatality rate for Black children was almost 4x that of white children and almost 7x that of Hispanic children.

Higher rate of mortality among **Males**

Gender

62% of all incidents involved males (79 of 127)

64% of SUID fatalities involved males (33 of 52)

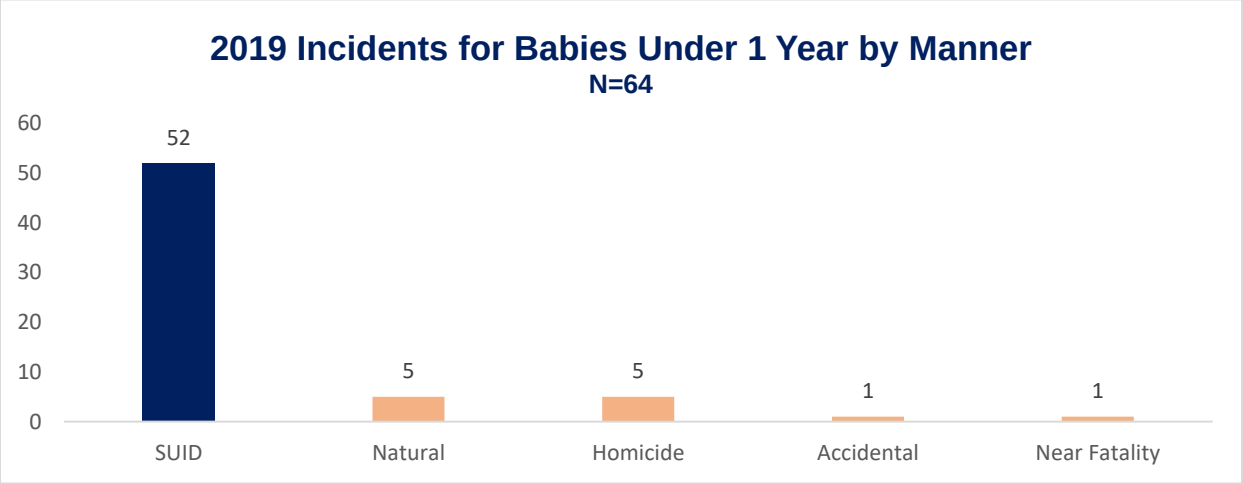
77% of homicide fatalities involved males (17 of 22)

71% of drowning fatalities involved males (5 of 7)

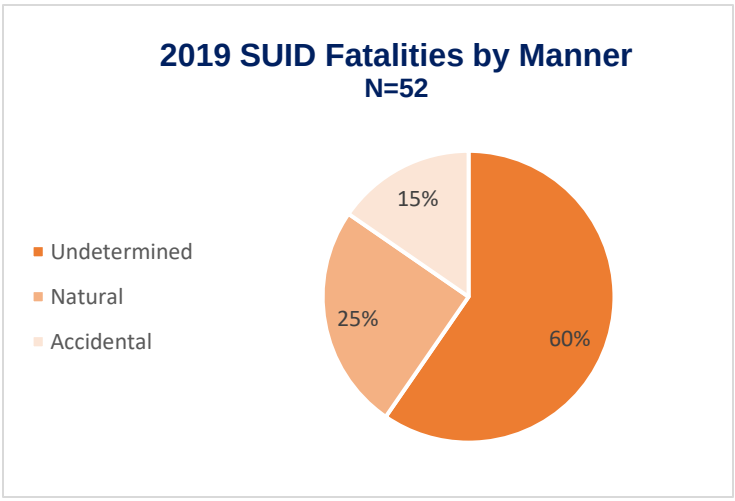
Sudden Unexpected Infant Deaths (SUID)

According to the Centers for Disease Control and Prevention (CDC), Sudden Unexplained Infant Death (SUID) is the death an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before an investigation. Approximately 3,400 babies in the United States die suddenly and unexpectedly each year. From 2016-2018, New Jersey's SUID rate was 0.59 deaths per 1,000 live births, well below the national rate of 0.91[2].

In 2019, 64 fatality cases reviewed involved children under 1 year of age, and 52 of those deaths met the CDC criteria for review by the Board's SUID subcommittee. Twelve cases did not meet the CDC's criteria, which included 5 natural deaths, 5 homicides, 1 accidental death and 1 near fatality.



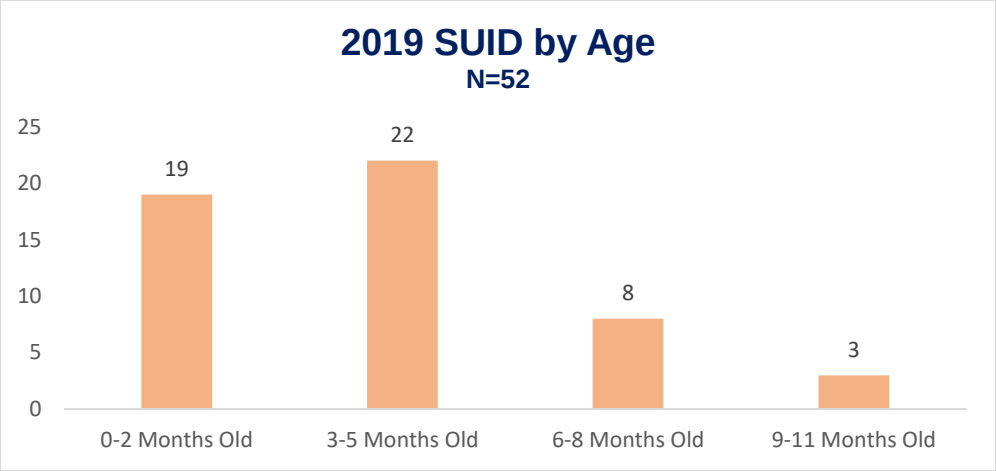
The CDC further categorizes SUIDs to include SIDS, accidental suffocation in a sleep environment, and other deaths from unknown causes. Parents or caregivers do not usually witness these deaths making it difficult to get a clear description of the circumstances, which are necessary for determining the cause and manner. This, compounded with different practices in investigating and reporting SUID, can affect the ability to reliably monitor SUID trends and risk factors.



As displayed in Figure, the manner of death for the 52 SUID cases reviewed by the Board's SUID Subcommittee in 2019 showed the majority, 60% (31) were undetermined, followed by 25% (13) natural and 15% (8) accidental.

On behalf of the Board, DCF's Fatality and Critical Incident Review Unit participates in the CDC's Division of Reproductive Health SUID monitoring program, working to improve data quality on SUID cases. This effort leads to a better understanding of circumstances that may increase the risk of SUIDs.

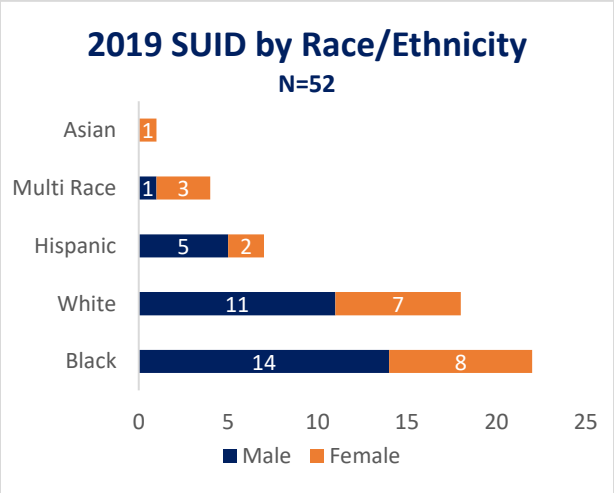
[2] NJSHAD - Complete Health Indicator Report - Sudden Unexpected Infant Death (SUID) (state.nj.us)

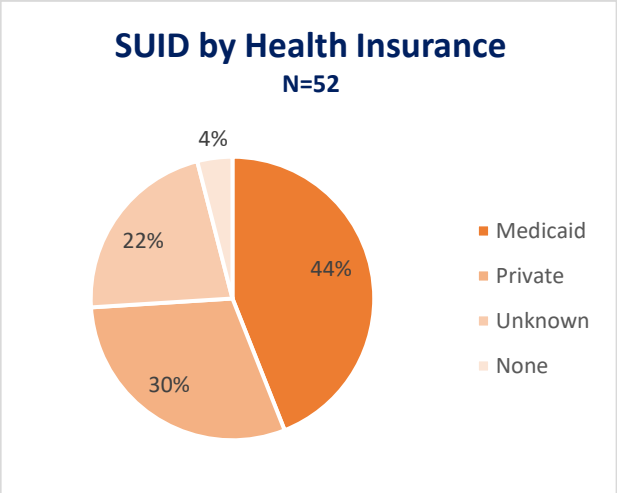


Age
is a risk factor for SUID, declining as infants approach 12 months old.

Racial and ethnic differences in SUID deaths continue. Although Black males represented the highest number of SUID fatalities, the number declined from 18 in 2018 to 14 in 2019. During the same period, two times more white infants died from SUID, with 9 in 2018 compared to 18 in 2019.

While health insurance information was difficult to obtain and is unknown for 22%, at least 44% of SUID infant fatalities reviewed by the Board in 2019 were insured by Medicaid.





Risk Factors in the Sleep Environment

There have been dramatic improvements in reducing infant deaths during sleep since the early 1990s, when recommendations were introduced to place babies on their backs for sleep.
However, since the late 1990s, declines have slowed. Those recommendations included;

A- Infants should sleep ALONE.

In 73% of SUID cases reviewed, soft bedding and/or toys were found in the sleep environment.

B- Infants should sleep on their BACKS.

In 65% of SUID cases reviewed, infants were not sleeping on their backs.

C- Infants should sleep in a bare CRIB with a firm mattress.

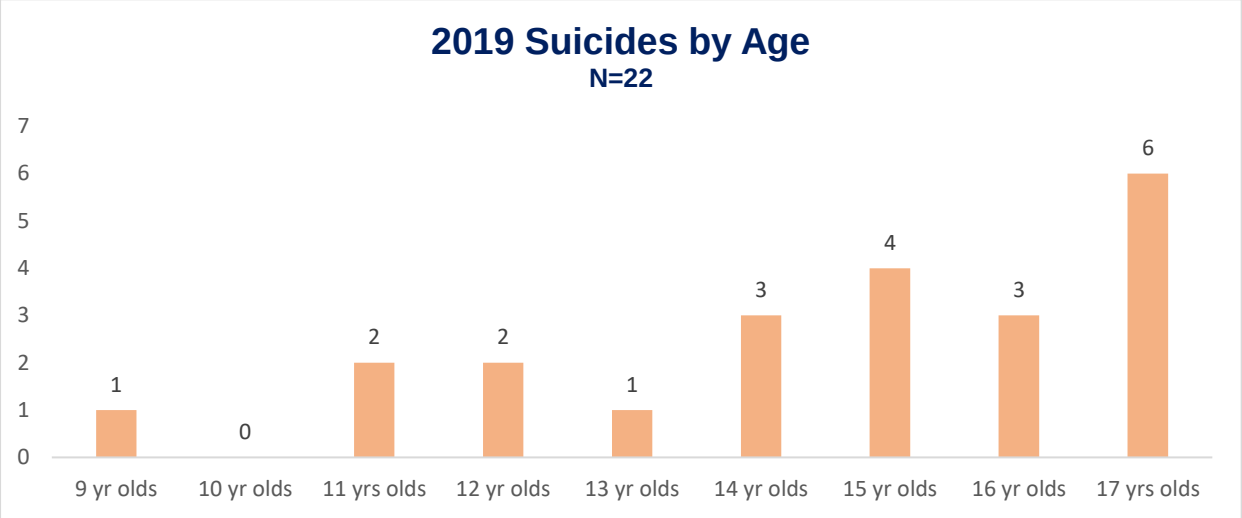
In 69% of SUID cases reviewed, infants were not sleeping in a crib or bassinette.

The American Academy of Pediatrics (AAP) recommends a safe sleep environment that can reduce the risk of all sleep-related infant deaths.

Suicide

According to the Child Mind Institute, suicide is a serious public health issue with 5,000 adolescents in the United States completing suicide each year, and another 600,000 requiring medical attention for self-injury. Youth of any age, race, ethnicity, or gender can experience suicide risk, but some groups have substantially higher rates of suicide than others.

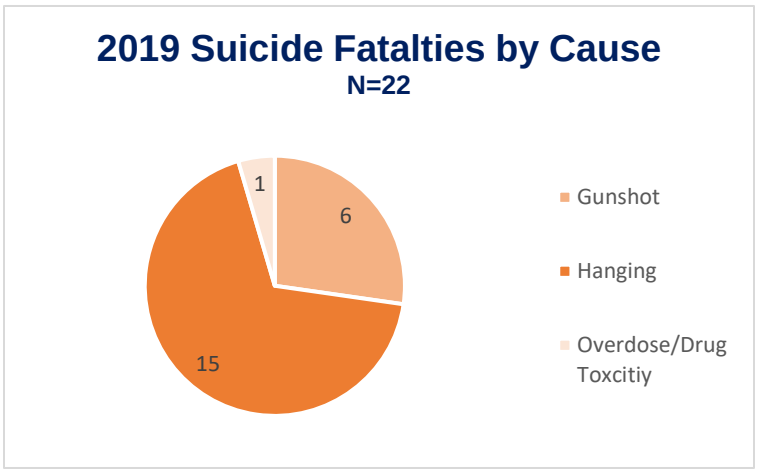
In 2019, the Board reviewed 22 suicides of youth between the ages of 9 and 17 years old. An analysis of the findings revealed an increase of incidents among older youth, with 17-year-olds completing suicide at the highest rate.



Many of the youth were involved in governmental support systems. Of the 22 youth suicides, 82% were enrolled or engaged in school while 9% were involved with DCF's Children's System of Care, for emotional and/or mental health care needs, at the time of or within the 12 months preceding their deaths.

The cause of death for the majority of the suicide fatalities was hanging: 68% (15). Additional findings revealed:

- 27% (6) of suicides completed by gunshot/use of firearm.
- 5% (1) of suicides completed by overdose/drug toxicity.



All six of the younger youth, aged 9 -13 years old, completed suicide by hanging, while all six suicides by gunshot were completed by older youth, aged 14-17 years old.

The Centers for Disease Control and Prevention (CDC) reported rates of suicide attempts and deaths among children have increased in the U.S. over the past decade, making suicide the eighth leading cause of death in children aged 5–11[3] and the second leading cause of death among high school-aged youths 14–18 years old, after unintentional injuries[4]. During 2009–2018, suicide rates among youths aged 14–18 years increased by 61.7% from 6.0 to 9.7 per 100,000 population. Understanding the factors that put a child at risk for suicide is a critical step toward preventing such outcomes and protecting youth. Suicide is rarely caused by a single circumstance or event. Instead, a range of factors—at the individual, relationship, community, and societal levels —can increase risk. These risk factors are situations or problems that can increase the possibility that a person will attempt suicide.

The Board identified the following top three individual risk factors from the 22 suicides reviewed in 2019:

Relationship, community, and societal risk factors identified by the Board included: loss of relationships, history of trauma and access to lethal means.

2nd Floor: Youth Helpline of NJ
1-888-222-2228
If you are between the ages of 10 and 24, live in New Jersey, and need to talk about an issue or problem that you are facing call 888-222-2228 anytime or text us at 888-222-2228.

988 Suicide & Crisis Lifeline
988
988 connects people to the existing National Suicide Prevention Lifeline. Compassionate, accessible care and support is available for anyone experiencing mental health-related distress, thoughts of suicide, mental health or substance use crisis. People can also dial 988 if they are worried about a loved one who may need crisis support.

Children's Mobile Response and Stabilization Services
1-877-652-7624
Mobile Response and Stabilization Services are available 24 hours a day, seven days a week, to help children and youth who are experiencing emotional or behavioral crises. The services are designed to defuse an immediate crisis, keep children and their families safe, and maintain the children in their own homes or current living situation (such as a foster home, treatment home or group home) in the community.

[3] Characteristics and Precipitating Circumstances of Suicide Among Children Aged 5 to 11 Years in the United States, 2013-2017 - PubMed (nih.gov)
[4] Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019 | MMWR (cdc.gov)

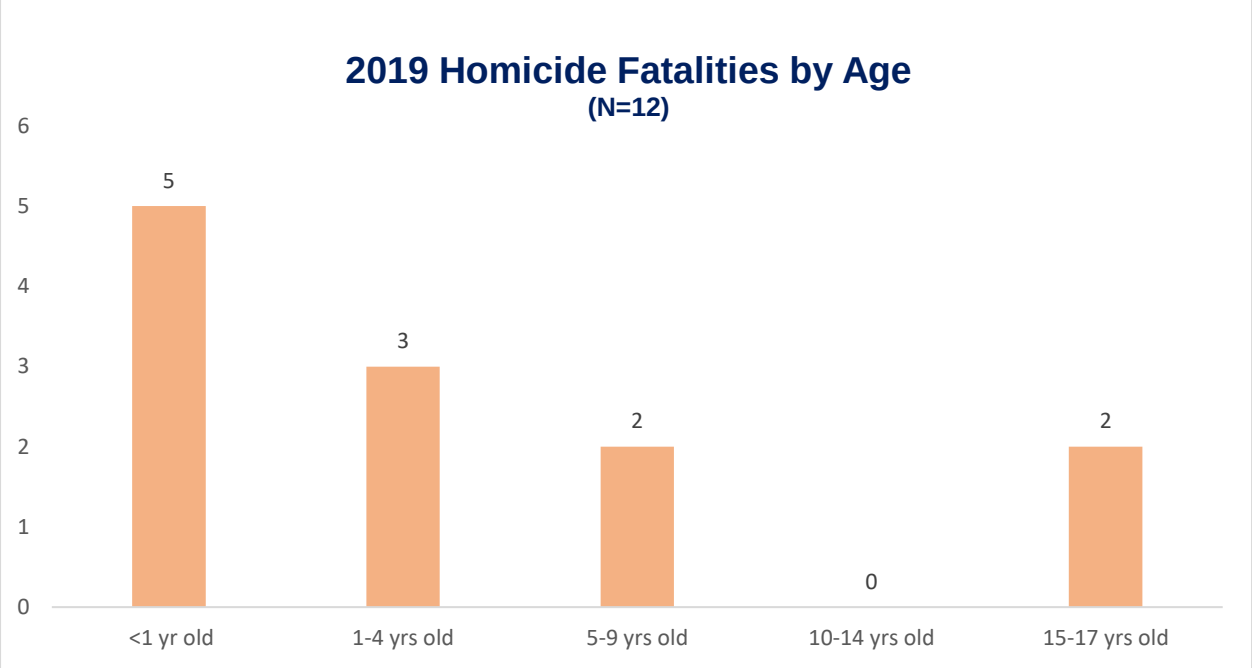
Protective Factors

There are protective factors that can reduce suicide risk. Actions at the individual, relationship and society level can protect against suicidal thoughts and actions.

Homicide

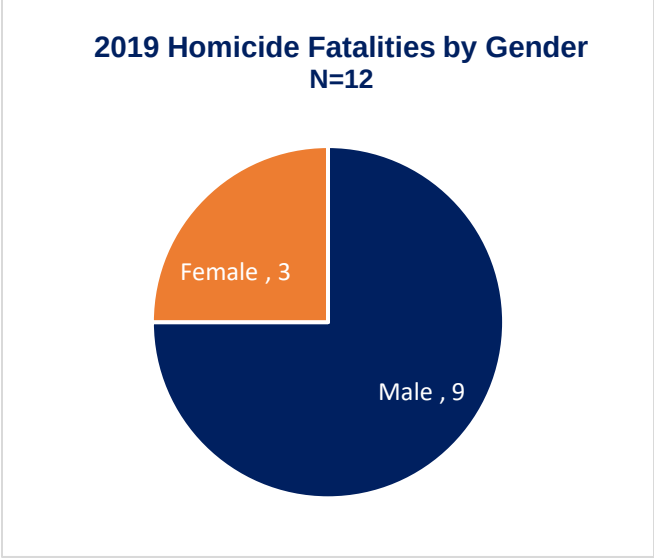
The Board reviews homicides of children under 18 years old in which abuse and/or neglect contributed to the death, or a positive toxicology and drug involvement may have been a contributing factor.

In 2019, the Board reviewed 12 homicides. Children younger than 1 year accounted for 42% (5) of homicide fatalities and 66% (8) of homicide fatalities involved children younger than 5 years old.



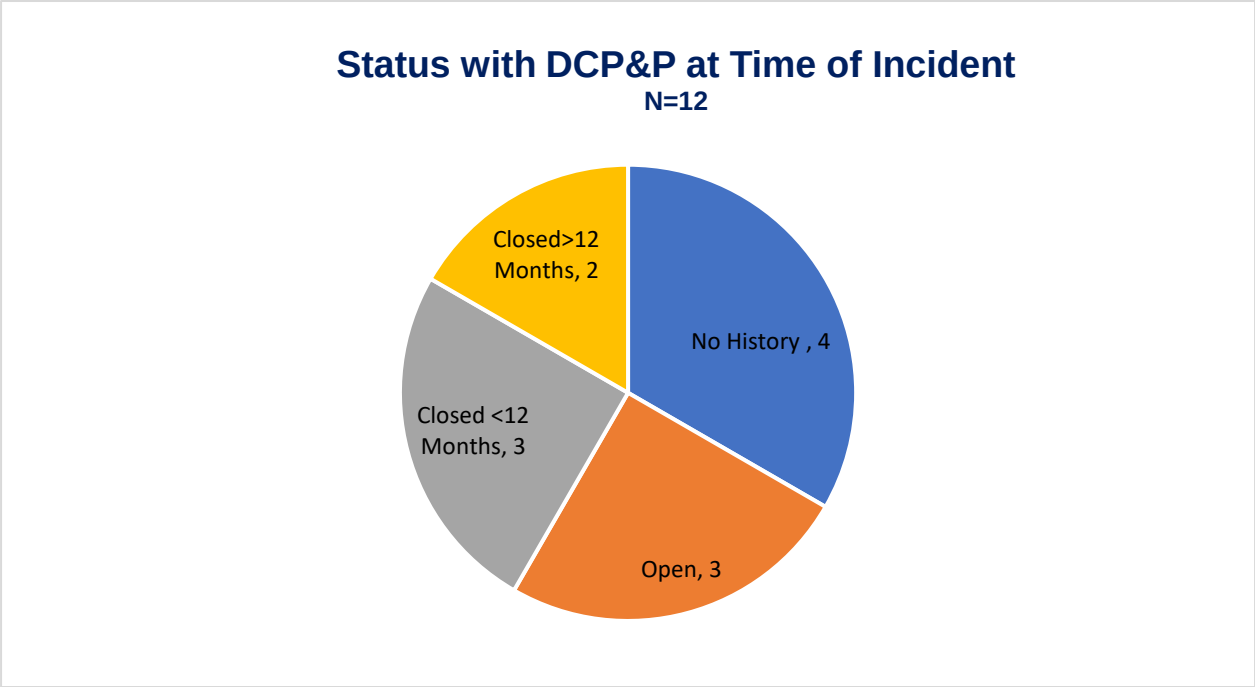
Additional analysis of homicide fatalities reviewed in 2019, found the majority of victims 75% (9) were male, while 25% (3) were female. A noteworthy finding revealed the trend of male overrepresentation in all manners of death.

In 2019, five children died from blunt force trauma, which was the leading cause of homicide fatalities. The other causes include: 2 from gunshot wounds, 2 from suffocation, 1 from drug toxicity, 1 from starvation and 1 from an undetermined cause.

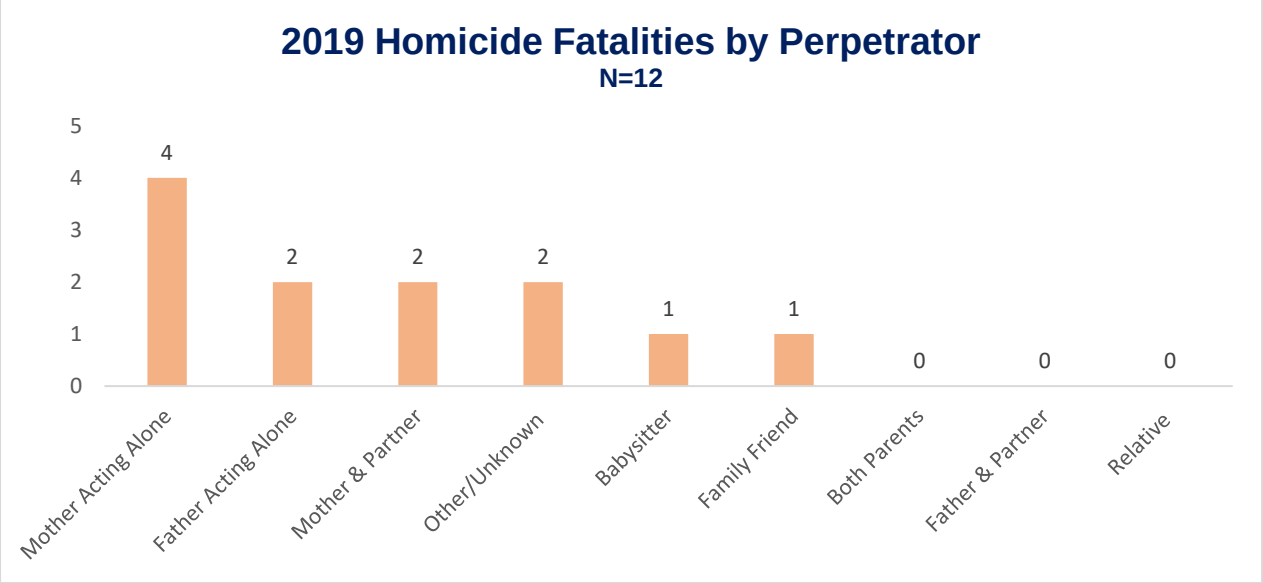


Of the 12 homicides reviewed by the Board, 33% (4) families had no prior history. Additional findings revealed:

- 25% (3) of the families had an open case with DCP&P at the time of the incident;
- 25% (3) of the families had cases that were closed with DCP&P fewer than 12 months at the time of the incident; and
- 17% (2) of the families had cases that were closed with DCP&P 12 or more months at the time of the incident.



Parents were responsible for 66% (8) of the homicides reviewed in 2019.



Recommendations

The Board reviewed 127 child fatalities and near fatalities that occurred in 2019 under unusual circumstances. There were challenges to reviewing these cases timely due to delays in data collection related to the notification of incidents as well as delays in receiving records (e.g., education, medical, legal, etc.) required for the review. The Board also found that responses to child fatalities and near fatalities are often hindered by inconsistencies, lack of information sharing, and uncoordinated investigations. These factors underscoring the need for continued focus on coordination and collaboration among state and local agencies, as well as system-wide improvements in governmental support services. Additionally, many family, community and society factors play into the prevention of child fatalities and near fatalities. To address these challenges and factors, the Board has made the following recommendations:

Suicide Prevention Recommendations:

NJ Department of Health

- Require mandatory child mental health and referral training for emergency department staff.

American Academy of Pediatrics

- Require mandatory child mental health and referral training for Pediatricians.

SUID Prevention Recommendations:

NJ Department of Health

- Promote Nurses **LEAD** the Way program throughout hospitals to reinforce nurses' knowledge and provide them with more tools for ***Learning about safe sleep, Educating families, Affirming knowledge and Documenting***.

NJ Dept of Human Services & County Board of Social Services

- Provide safe sleep education and safe sleep products (cribs/pack and plays/sleep sacks) to families with infants.

NJ Dept of Community Affairs

- Mandate places of public accommodation (motels/hotels) offer families with infants a crib or other infant approved sleeping space. (Portable cribs/pack and plays)

Other Recommendations:

NJ Department of Education

- Provide additional oversight and communication with parents of students who are home schooled.
- Launch a campaign to educate school personnel, courts, and DCP&P of families' rights and system roles & responsibilities when home schooling concerns arise

NJ Department of Health

- Support community-based pilot programs that are treating children with asthma.

NJ Department of Child Protection & Permanency

- Revise and update the public campaign addressing the risk of leaving kids unattended in cars, which should include exploring the use of technology (car seat alarms, navigation awareness alerts).

NJ Department of Health, Office of the Chief State Medical Examiner

- Follow child autopsy protocol to ensure standardization and consistency across the state.

NJ Legislature

- Require NJ Safe Haven publications (brochures/posters) to be made available and posted in public middle and high schools.
- Establish a state information sharing environment to facilitate coordinated responses, open communication and information sharing across all disciplines (Police, Prosecutors, Medical Examiner, Child Welfare) involved in child death investigations.

WHAT HAPPENS AFTER THE CHILD ABUSE HOTLINE IS CALLED?

Call comes to NJ Child Abuse Hotline 1-877 NJ Abuse.

A concerned caller can reach DCF at any time to report child abuse/neglect or to request child welfare services. The caller does not need proof and can make the call anonymously.

In NJ, the law requires any person having reasonable cause to believe that a child was abused/neglected to immediately report the concern to DCF. Failure to report is a disorderly persons offense, punishable by fine or incarceration.

Information and Referral

If the caller's concerns do not meet the criteria for assessment or investigation, DCF providea the caller with information about services and referral options through community service providers.

Assessment or Investigation

Related Information

If the caller provides updated or additional information on an open assessment/investigation or an open case, the information is recorded and shared with the assigned worker.

Child Welfare Services (CWS) Assessment

A CWS assessment results when there is a request for services or an expressed concern about a family who may need assisstance in ensuring the basic health and welfare of a child. A worker assesses child welfare issues and what supportive sevices might be needed. If the worker learns information during the CWS assessment that potentially meets the statutory definition of abuse/neglect, the CWS assessment can be converted to a CPS investigation.

If a person or family participation in an assessment is entirely voluntary.

Child Protective Services (CPS) Investigation

During a CPS investigation, CP&P seeks to understand the facts surrounding the allegations and ensure the child(ren)'s safety. The worker interviews the source of the report, each child and caregiver, and others involved in the family's life, i.e., doctors, teachers, etc. CP&P may request and review clinical and social service reports and may request forensic examinations of children. Ulitmately, a worker makes an investigative determination, concluding one of four findings, and assesses whether the family would benefit from ongoing supportive services.

If a person or family refuses to cooperate with an investigation, CP&P can seek court intervention.

At the conclusion of an assessment or investigation, the investigator determines whether to open the case for services or terminate involvement. Even when an allegation is determined to be "not established" or "unfounded", CP&P may find that there are service needs and/or other concerns that warrant opening a case. A family's decision to accept ongoing services with CP&P is voluntary **UNLESS** CP&P has sought the Court's approval to:

- **remove child(ren) and place in state custody; or**
- **provide ongoing care and supervision**

CP&P ma seek the Court's permission to remove children and place them into State custody at any point, and regardless of whether or not there is a substantiated or estab lished CPS report.

- **SUBSTANTIATED**
- **ESTABLISHED**
- **NOT ESTABLISHED**
- **UNFOUNDED**

*Substantiated findings are disclosed for a Child Abuse Information (CARI) check

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