NEW JERSEY & Child Fatalities Near Fatalities

Review Board Report

2016 – 2020 Data and Recommendations

RECOMMENDATIONS

Key Takeaways

- Cases referred to the Board increased in 2020 but remain below historic numbers of referrals.
- The Board reviewed 7.4 cases per every 100,000 children in New Jersey.
- Some groups of children were disproportionally represented in the cases reviewed.
  - Male children accounted 62 percent of cases.
  - Half of all cases involved children under the age of 1.
  - Black children were the only ethno-racial group with a rate of cases reviewed above the overall state rate.
  - In half of the cases reviewed, the family of the child had a history of child welfare involvement.
- **Sudden unexpected infant death (SUID)**: New Jersey's SUID rate was below the national rate, 60 compared to 92 deaths per every 100,000 live births. However, New Jersey's rate has increased since 2018. Most SUID cases involved an unsafe sleep characteristic, such as not sleeping in their crib or sleeping with another person.
- **Suicide**: In 2017, New Jersey's suicide rate increased from 1.5 to 2.6 suicides per every 100,000 children ages 9-to-17 and remained elevated. Older children, ages 15 to 17, drove this rise and accounted for two-thirds of youth suicide cases.
- **Homicide**: Of the 58 homicides, 41 resulted from abuse or neglect. The most frequent perpetrator was a mother alone followed by a non-relative.
- **Accidental Drowning**: The Board reviewed 53 cases of accidental drownings; the age group most frequently involved was children ages 1 to 4.

The death or serious injury of a child is a loss to everyone. New Jersey established the Child Fatality and Near Fatality Review Board on July 31, 1997, through the Comprehensive Child Abuse Prevention and Treatment Act to review fatalities and near fatalities of children due to unusual circumstances and to determine the cause, the relationship to governmental support systems, and methods for future prevention. From 2016 to 2020, the Board reviewed 725 cases. To help prevent child fatalities and near fatalities, the Board recommends better data collection and continued support services from both the government and community. The table below contains recommendations from 2020 cases; previous reports contain recommendations for 2016 – 2019 cases.

Audience	2020 Recommendations
American Academy of Pediatrics	▪ Require pediatricians to complete annual mental health screenings on children and adolescents. ▪ Ensure pediatricians provide families with mental health education and can quickly refer families to community services, when appropriate.
Department of Children and Families: Children's System of Care	▪ When a child is dually involved in CSOC and DCP&P, both systems should notify each other when a case closes or a child declines further services. ▪ Educate parents on how to obtain services, and ensure access to timely, quality services
Department of Children and Families: Division of Child Protection and Permanency	▪ Provide families with information regarding youth mental health services when concerns for a child with mental health and suicidal ideation arise. ▪ Ensure a primary caregiver, instead of several caregivers, is identified and responsible for the care of the child in the safety protection plan. ▪ Offer families lock boxes and education on safe medication storage, including methadone and other opioids. ▪ Train judges and legal community on safety and risk policies driven by structured decision making through the Children in Court Improvement Committee. ▪ Consider keeping cases open to provide services and supports for a defined period when a family experiences a significant life change such as the birth of a child.
Department of Education	▪ Ensure schools explore possible learning disorders that may contribute to behavioral issues prior to or in lieu of repeated disciplinary action. ▪ Provide schools with updated education and training on Safety Plans and Suicide Risk Assessments.
Judicial/Probation System	▪ Alert DCP&P of positive drug test results and provide results in timely manner for cases open with DCP&P.
Legislature & New Jersey Governor	▪ Revise Child Fatality and Near Fatality Review Board membership to include a public member from the NJ Department of Education. ▪ Enact a law requiring landlords to change safety/security locks when required by domestic violence survivors or when an active restraining order is in place. ▪ Include water safety as a component of public-school physical education curriculum.
Medical Examiner's Office	▪ Expand toxicology panels to capture additional substances including prescribed medications.
Military Base Personnel & Law Enforcement	▪ Improve communication and coordination between military base and law enforcement personnel when concerns arise related to mental health and access to firearms.

CHILD FATALITIES & NEAR FATALITIES OF UNUSUAL CIRCUMSTANCES

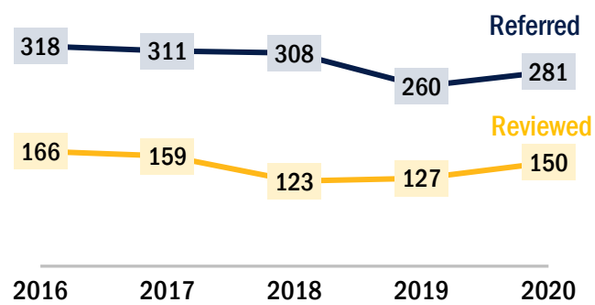
New Jersey's Child Fatality and Near Fatality Review Board examines fatalities and near fatalities involving children under the age of 18 due to unusual circumstances. The Comprehensive Child Abuse Prevention and Treatment Act sets the criteria for cases to be eligible for review.

The Board receives notification about cases from several groups including the Child Abuse Hotline (the Department of Children and Families' State Central Registry), the Office of the Chief State Medical Examiner, Law Enforcement, and the Department of Health.

The Board determines whether a case is eligible for review based on the Comprehensive Child Abuse Prevention and Treatment Act. The Board obtains all relevant records to review a case such as the autopsy, death scene investigation, law enforcement records, medical information, and social service records. Coordination and collaboration among several groups is essential to ensure that the Board is informed about all incidents and has the necessary data to complete their review.

From 2016 to 2019, the number of cases referred to the Board fell 18 percent, from 318 to 260. In 2020, the number of cases referred increased but remained lower than in previous years. About half of the cases referred to the Board over this period met the criteria for review. Most cases reviewed by the Board were child fatalities. Near fatalities accounted for 5 percent of reviewed cases, ranging from 3 to 15 cases each year. For a near fatality to be eligible for review, a physician must certify the condition as serious or critical and the allegation of child abuse or child neglect must be substantiated.

Cases referred increased in 2020 but remained below previous years.



Reasons the Board reviews a child fatality case

Unclear Cause
- Undetermined cause of death
- Sudden unexpected infant death
- Burns without obvious reason such as a house fire
- Head trauma, fractures, or blunt force trauma without obvious reason such as a car accident

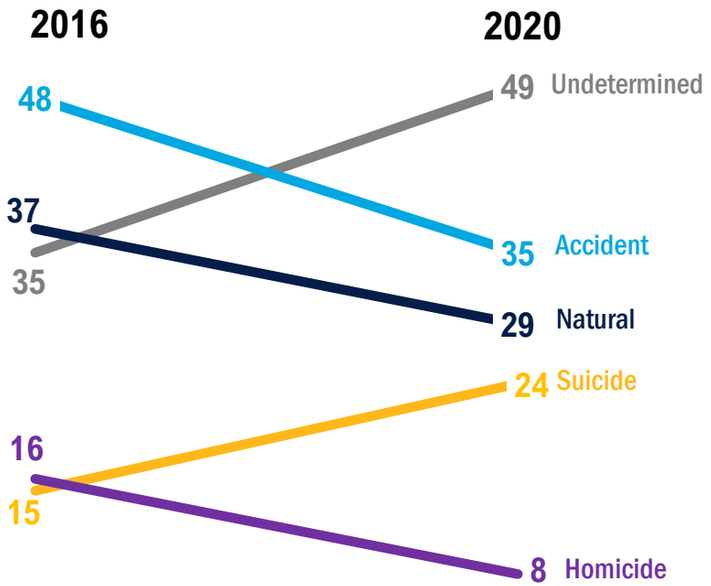
Abuse or Neglect
- Homicide resulting from child abuse or neglect
- Child experienced sexual abuse
- Suffocation or asphyxia
- Malnutrition, dehydration, medical neglect, or failure to thrive
- Child abuse or neglect may be a contributing factor

Substance Misuse
- Substance misuse may be a contributing factor
- Motor vehicle accidents in which the child or a caregiver driving had a positive toxicology screen

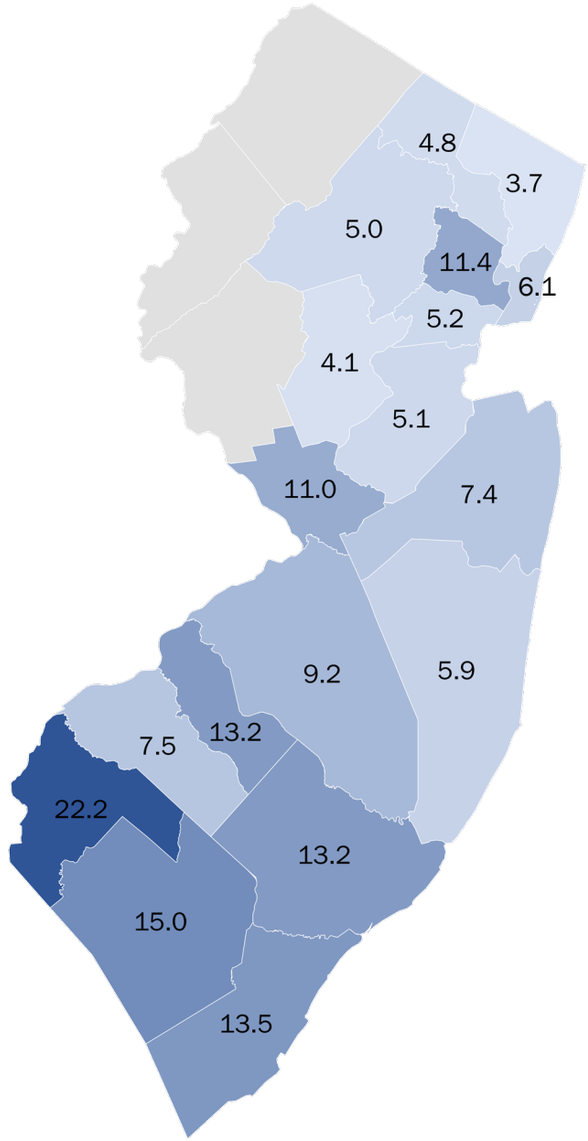
Self-Harm and Accidental Deaths
- Suicide
- Drowning

Child Welfare Involvement
- Children whose families were under the Division of Child Protection and Permanency supervision at the time or within 12 months preceding the incident

The Board reviewed more suicides and undetermined fatalities in 2020 compared to 2016.



After an autopsy, the medical examiner's office determines the leading manner and cause of death for all fatalities. However, a family may choose not to have an autopsy conducted. The medical examiner's office classifies the manner of death as accident, homicide, natural, suicide, or undetermined. Compared to 2016, suicides and undetermined deaths in 2020 occurred more often among reviewed fatalities. The leading manner of death was undetermined in all years, except 2016.



The Board reviewed 7.4 cases per every 100,000 children from 2016 to 2020.

County	Cases Reviewed	Rate
Salem	15	22.2
Cumberland	27	15.0
Cape May	11	13.5
Camden	76	13.2
Atlantic	37	13.2
Essex	108	11.4
Mercer	43	11.0
Burlington	43	9.2
Gloucester	24	7.5
Monmouth	49	7.4
Hudson	42	6.1
Ocean	43	5.9
Union	34	5.2
Middlesex	46	5.1
Morris	26	5.0
Passaic	29	4.8
Somerset	15	4.1
Bergen	37	3.7
Warren	8	*
Sussex	7	*
Hunterdon	5	*
State Total	**725**	**7.4**

* Rate not calculated due to fewer than 10 observations.

Population data source: U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimate

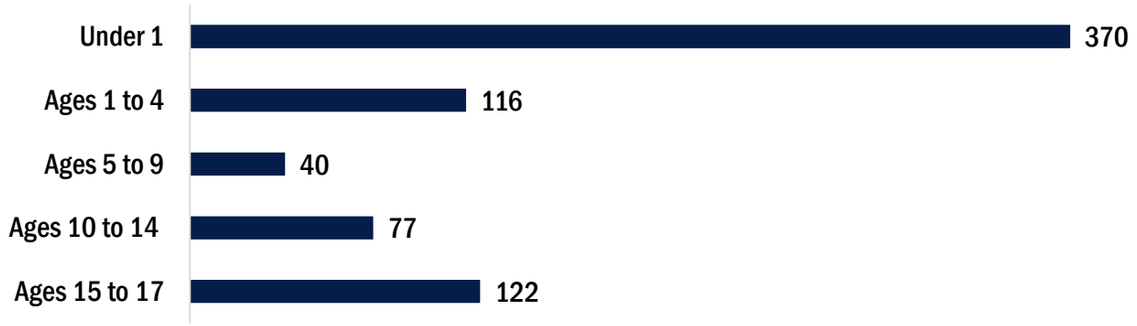
COMMON CHARACTERISTICS AMONG CHILDREN'S DEATHS

Most fatalities and near fatalities occurred among males (62 percent) compared to females (38 percent).

Infants under the age of 1 accounted for half of all fatality and near fatality cases reviewed. The second most frequent age group represented in cases reviewed were older children, between the ages of 15 to 17 years old. Children between the ages of 5 and 9 have the least number of cases reviewed by the Board (6 percent).

Black children had a higher rate of cases reviewed by the Board than the overall state rate, 22.5 compared to 7.4 cases per every 100,000 children. No other ethno-racial group exceeded the overall state rate. Asian and Hispanic children had the lowest rate of cases reviewed.

Infants under the age of 1 year old accounted for half of the cases reviewed.



The Board reviewed 3 times more cases per every 100,000 Black children than cases per 100,000 children in the state overall.

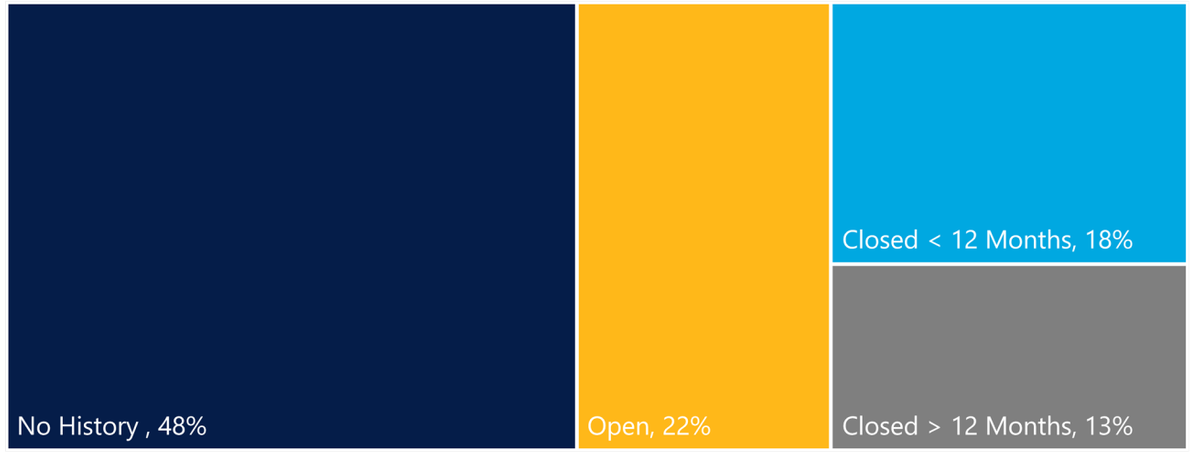
Population data source: CDC WONDER, 2016 – 2020 Single-race Population Estimates

CHILD WELFARE INVOLVEMENT

The Board reviews fatalities and near fatalities of unusual circumstances regardless of the child's involvement with child welfare. In reviewing these incidents, the Board aims to identify ways to improve social services and to prevent future incidents from occurring. The Board examines the roles of many agencies and systems, recognizing that the Department of Children and Families (DCF) is an important provider of social services to families.

Between 2016 and 2020, families' involvement with DCF's Division of Child Protection & Permanency (DCP&P) among cases reviewed by the Board remained stable over time. Nearly half (48 percent) of the children had no family history of prior involvement with DCP&P. At the time of the child's fatality or near fatality, 31 percent of families had a previously closed case with DCP&P and 22 percent of families had an open case.

Families had a history of child welfare involvement in half of the cases.



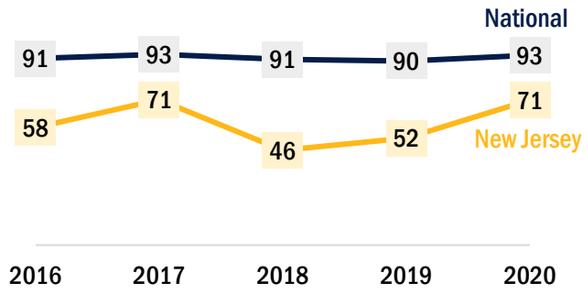
How a Family Becomes Involved with Child Protective Services

DCF's DCP&P investigates reports of child abuse and neglect that come in through the Child Abuse Hotline, which operates 24-hours a day, 7-days a week. If a report does not meet the criteria for an assessment or investigation, the caller is given information about services through community providers and a DCP&P case is not opened. For reports that meet the criteria, DCP&P local staff conduct an assessment or investigation to determine if neglect or abuse occurred. Once the assessment or investigation is completed, a decision is made whether to open a case for the family to receive services. Even if neglect and abuse were not found, a case may be open if other concerns are identified, or if the family may benefit from services. A family's involvement with DCP&P is voluntary unless the Court has approved care and supervision or the removal of a child from the home.

SUDDEN UNEXPECTED INFANT DEATH

The Centers for Disease Control and Prevention defines Sudden Unexpected Infant Death (SUID) as the death of an infant under the age of 1 that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before an investigation. SUID includes instances of sudden infant death syndrome, accidental suffocation or strangulation in bed, and other deaths of unknown cause (CDC, n.d.-d).

NJ's SUID rate increased but remains below the national rate per 100,000 live births.



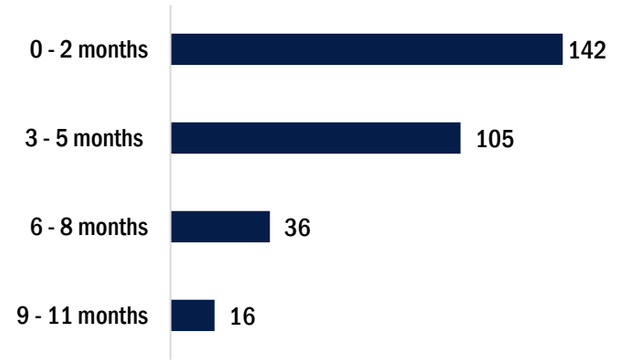
From 2016 to 2020, the Board reviewed 370 cases involving an infant under the age of 1; most of these cases (80 percent, 299 cases) had SUID as the cause of death. New Jersey had a SUID rate of 60 deaths per 100,000 live births, below the national rate of 92. However, the SUID rate in New Jersey increased since 2018, from 46 to 71 deaths per 100,000 live births.

The Board reviewed more SUID cases involving males (65 percent) than females (35 percent).

Younger infants experienced more SUID cases. Infants 2 months and younger accounted for nearly half (47 percent) of all SUID cases reviewed. This age group was the most common among SUID cases for all years, except in 2019, when the Board reviewed 22 SUID cases for infants 3 – 5 months old and 19 cases for infants 2 months and younger.

Black infants were disproportionally represented in SUID cases reviewed by the Board. While Black infants only represent 13 percent of the infant population in New Jersey, they represented more than half (53 percent) of SUID cases.

SUID risk was highest among younger infants.



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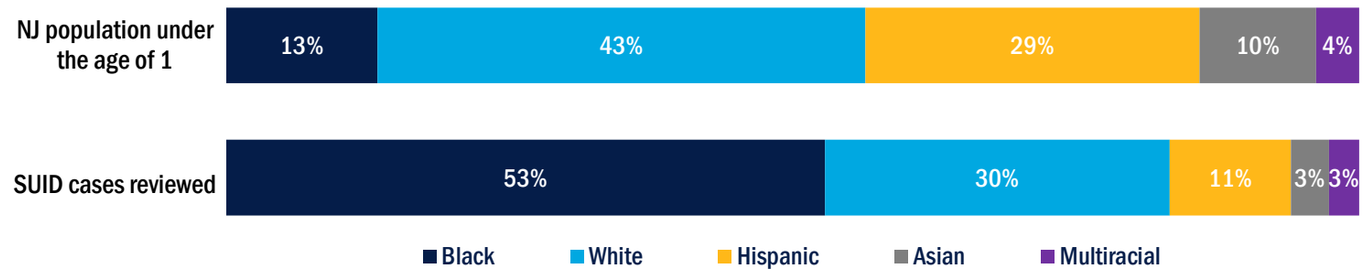


Population data source: CDC WONDER, 2016 – 2020 Single-race Population Estimates

On behalf of the Board, the Department of Children and Families participates in the Centers for Disease Control and Prevention's SUID monitoring program. This effort has improved the quality of SUID cases data and led to a better understanding of the risks associated with SUID. Data shared as part of the monitoring program shows most SUID cases in New Jersey had an unsafe sleep environment characteristic.

From 2016 – 2020, most SUID cases had an unsafe sleep environment characteristic.

73% of infants were not sleeping in a crib or bassinet

70% of infants had a toy or bedding when sleeping

53% of infants were not sleeping on their back

53% of infants slept with other people

Caregivers should follow the ABCs of safe sleep. The National Institute of Child Health and Human Development also recommends the following practices to reduce the risk of SUID:

- Share a room, not a bed, with your infant for the first six months
- Use a wearable blanket or sleep sack to keep your infant warm instead of a loose blanket that can cause tangling and/or asphyxiation.
- Keep your infant's surroundings smoke and vape free.
- Offer your infant a pacifier.
- Avoid swaddling once your infant can roll, around 3 months of age.
- Avoid letting your infant overheat; keep their head and face uncovered while they sleep.
- Follow health care provider advice and regularly attend checkups.
- Breastfeed your baby, if possible, or use appropriate formula alternative. F
- Give your infant plenty of supervised "tummy time".

ABCs OF SAFE SLEEP

Alone Infants should sleep alone. Sleeping with people or pets can be unsafe.

Back Infants should be placed on their backs to sleep, for naps and at night.

Crib Infants should sleep in a firm, flat, crib with no soft blankets or toys. Sleeping on couches is not safe for infants.

SUICIDE

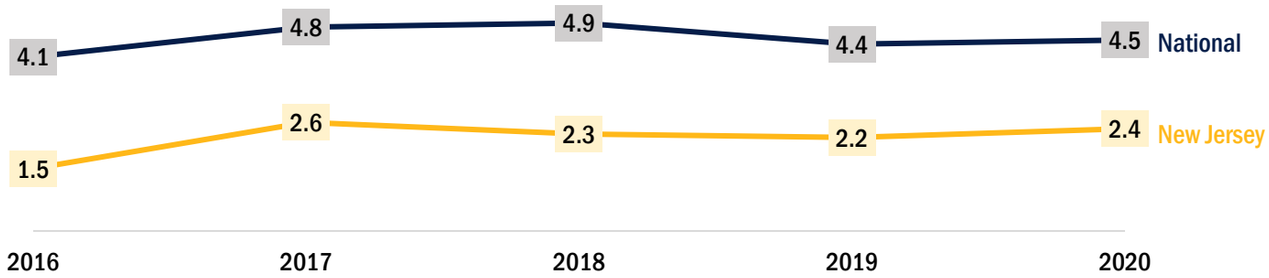
The Board reviews all suicide cases involving children under the age of 18, a total of 110 cases from 2016 to 2020. Among children ages 9 to 17, New Jersey had a lower suicide rate than the overall US rate, 2.2 compared to 4.5 per 100,000 children. In New Jersey, the youth suicide rate increased from 1.5 to 2.6 in 2017 and has since leveled off to rate of 2.3 to 2.4 per year.

The most common method of suicide used by children in New Jersey was asphyxiation (66 percent), including hanging, strangling, and suffocation. Other methods of suicide included the use of firearms (15 percent) and drug overdoses (8 percent). Less common methods (11 percent) included blunt force trauma and poisoning by carbon monoxide.

Suicide occurred more frequently among older children. Children aged 15- to 17-years old accounted for two-thirds of child suicides. The rise in suicides among this age group in 2017 drove the overall rise in the suicide rate for children in New Jersey.

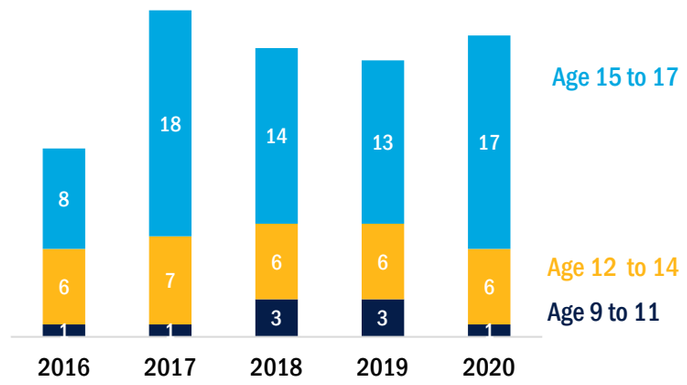
Before 2019, the Board reviewed a similar number of male and female child suicides. In 2019 and 2020, twice as many child suicides involved males compared to females.

Suicide rates among children ages 9 to 17 increased in 2016 and remain elevated.

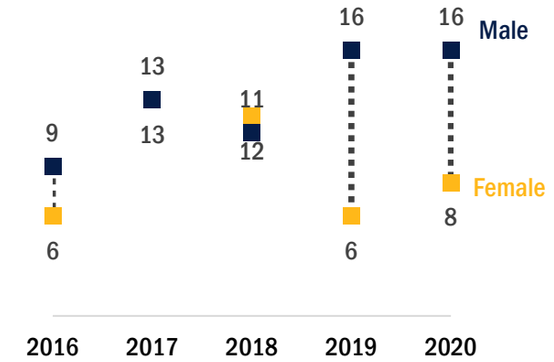


NJ suicide rate per 100,000 children: suicides reviewed by Board and CDC WONDER, 2016 – 2020 Single-race Population Estimates
U.S. suicide rate per 100,000 children: CDC WONDER, 2016 – 2020, Underlying Cause of Death

Older children drove the rise in NJ's child suicide rate.



Since 2019, child suicides involved more males than females.



A single event or circumstance rarely causes suicide. Several factors contribute to child suicide. In 2020, two-thirds of suicide cases involved a child with a mental health or psychiatric condition, one-third had a previous suicide attempt, and one-third experienced feelings of isolation.

The American Foundation for Suicide Prevention identified protective factors to reduce the risk of suicide:

- Access to mental health care and being proactive about mental health
- Feeling connected to family and community support
- Problem-solving and coping skills
- Limited access to lethal means
- Cultural and religious beliefs that encourage personal connections and create a strong sense of self

Suicide Prevention Resources for Families

2NDFLOOR

People ages 10 to 24 can anonymously call or text **1-888-222-2228** to talk to someone about a problem or issue they are facing.

PerformCARE®

Call **1-877-652-2764** to receive treatment and referrals for children and youth including emergency mobile response services.

988 SUICIDE & CRISIS LIFELINE

Anyone can call **988**, a 24/7 free confidential lifeline for themselves or someone they know.

THE TREVOR PROJECT

Visit www.thetrevorproject.com for crisis intervention and suicide prevention services for LGBTQ+ youth ages 13 to 24.

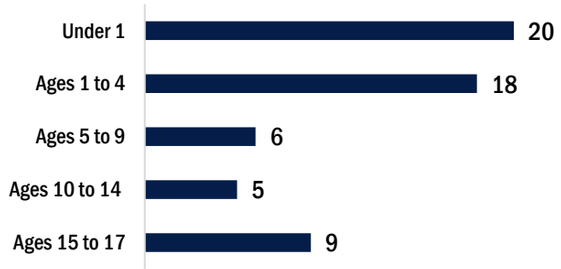
HOMICIDE

The Board reviewed 58 cases of child homicides from 2016 to 2020. Since 2018, the number of homicides reviewed by the Board has fallen.

The Board reviewed more homicide cases involving males (38 cases) than females (20 cases).

Homicides reviewed by the Board involve younger children most frequently. Children under the age of 5 account for two-thirds of homicide cases reviewed.

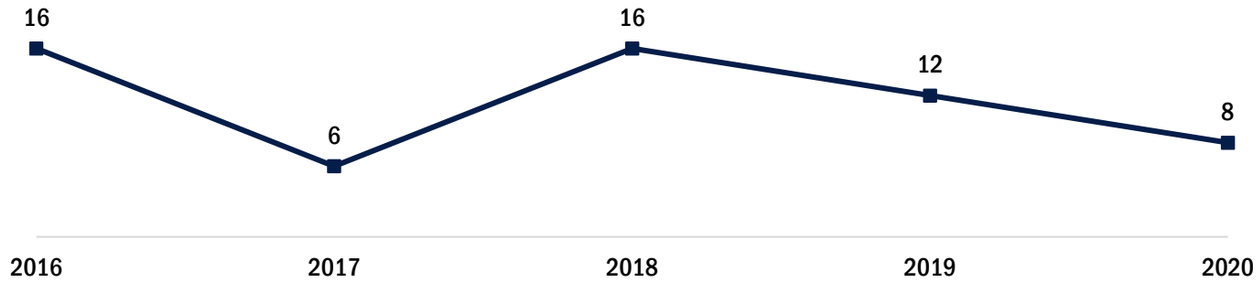
Younger children were most frequently involved in the homicides reviewed.



Most homicide cases reviewed by the Board (41 of 58 cases) involved an identified caregiver perpetrator.

Homicide cases without an identified caregiver perpetrator (17 of 58 cases) typically involved a firearm fatality of a child whose family had an open child welfare case. Eight of nine cases involving youth ages 15 to 17 did not involve a caregiver perpetrator.

The number of homicides reviewed by the Board has fallen since 2018.

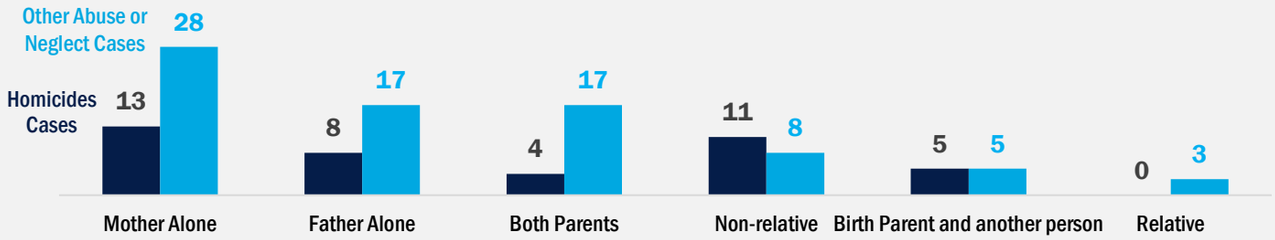


Perpetrators of Child Abuse or Neglect

For homicide and other cases, the Board examines information about the perpetrator when abuse or neglect occurred by a caregiver. These fatalities include accidental overdose, inflicted injuries, and heat exposure from being left in a hot car.

In both homicide and other cases, mothers acting alone were the most common perpetrator. However, non-relatives were the second most common perpetrator in homicide cases. In contrast, non-relatives were the fourth most common perpetrator in other abuse and neglect cases.

Non-relatives rank second in homicide cases and fourth in other cases of abuse or neglect with an identified perpetrator.



ACCIDENTAL DROWNINGS

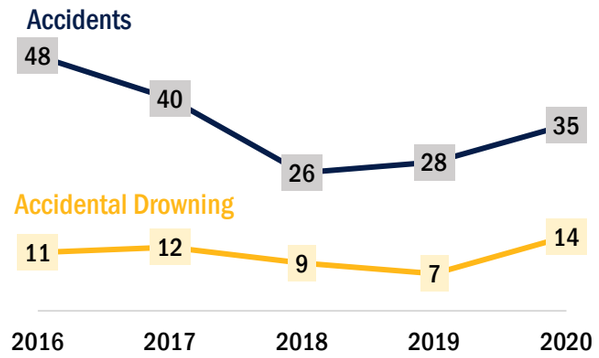
The Board reviewed 177 accidental deaths between 2016 and 2020; drownings accounted for 30 percent of accidental deaths. The number of accidental drownings reviewed by the Board doubled from 7 in 2019 to 14 in 2020. Between 2016 and 20202, New Jersey's accidental drowning rate was 0.60 per 100,000 children, nearly half the national rate, which was 1.11 per 100,000 (CDC, n.d.-e).

While children of all ages can experience a fatal accidental drowning, it most often involves children ages 1 to 4 years old. Of the 53 accidental drownings reviewed, nearly half (49 percent) involved children 1 to 4 years old. Among this age group, the leading cause of death nationally is drowning (CDC, n.d.-c).

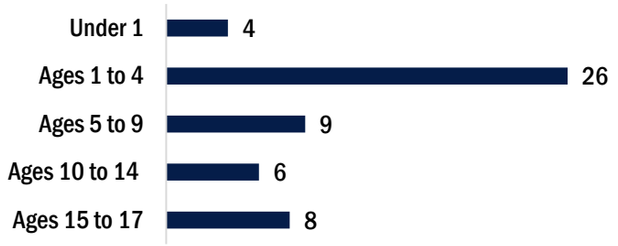
Water Safety Practices for Caregivers

- Never leave a child unattended in water.
- Empty inflatable pools, buckets, pails, and bathtubs after each use.
- Stay within an arm's length of small children in water.
- Fully enclose pools with a fence.
- Remove all pool toys that may attract children.
- Never swim without a lifeguard.
- Wear a life jacket instead of relying on air-filled or foam toys.
- Help children understand the difference between pools and natural bodies of water.
- Teach children to swim at an early age and about water safety.
- Learn CPR.

In 2020, the number of accidental drownings reviewed by the Board increased.



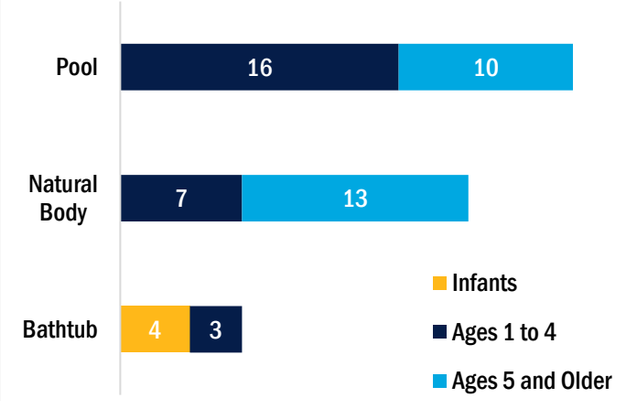
Nearly half of accidental drownings involved children ages 1 to 4 years old.



The accidental drownings reviewed occurred most often in pools, followed by natural bodies of water such as the ocean and lakes, and least often in bathtubs. Adopting water safety practices may help prevent accidental drownings.

The most frequent setting of the accidental drowning varied by age group. All drownings involving infants occurred in a bathtub. Children between the ages of 1 and 4 most often drowned in a pool. No children above the age of 5 drowned in a bathtub; they most frequently drowned in a natural body of water.

Pool drownings most often involved children ages 1 to 4.



APPENDIX 1. THE BOARD MEMBERS

The Board reviews fatalities and near fatalities as a team that includes representatives from law enforcement, child protective services, prosecutors and district attorneys, medical examiners and coroners, pediatricians, and other health providers. The composition of the Board aligns with best practice recommendations from the National Center for Fatality and Review Prevention. The Board contains six teams: State Child Fatality and Near Fatality Review Board, Northern Community-Based Team, Central Community-Based Team, Southern Community-Based Team, Suicide Subcommittee, and Sudden Unexpected Infant Death Subcommittee. The Board is in, but not of, the Department of Children and Families, but it operates independently without control or supervision from the Department. Professional staff from the Department of Children and Families act as liaisons that carry out the duties of the Board, including issuing this annual report. Below is a list of all Board Members and Department of Children and Families liaisons.

Department of Children and Families Liaisons to the Board

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Dr. Laura Brennan[1], M.D., Chair
Pediatrics
Center for Children Support School for Osteopathic Medicine

Kathryn McCans, M.D., F.A.A.P., Chair
St. Christopher's Hospital for Children
(2016-2020)

Elayne Weitz[1], Ph.D., Co-Chair
Psychologist

Lea DeGuilo[1],
Assistant Section Chief
DCF North of the Division of Law

Kathleen Lyons-Boswick[1], Esq. BSN, RN (ret)
Supervising Assistant Prosecutor
Essex County Prosecutor's Office

Robyne Jile[1], MSW
Assistant Director of DCP&P Central Operations
Department of Children and Families

Brian Ross[1]
Assistant Commissioner for Legal and Regulatory Affairs
Department of Children and Families

Alex X. Zhang[1], M.D.
Acting Chief State Medical Examiner
Office of the State Medical Examiner

Bethany D'Amelio[1]
Executive Coordinator
New Jersey Task Force on Child abuse and Neglect
Department of Children and Families

Adam Brozek[1]
Detective Sergeant First Class
New Jersey State Police
Major Crime North Unit

Jennifer Pax[1], Ph.D., JD, MSW, LCSW
New Jersey City University

Nichole Lane[1]
Deputy Public Defender
Office of Law Guardian

Lakota Kruse, M.D., M.P.H.
Department of Health
(2016-2019)

Aubrey C. Powers, Assistant Commissioner
CP&P, Department of Children and Families
(2016-2020)

Christopher Gramiccioni, Esq.,
Prosecutor, Monmouth County
(2016-2020)

Andrew L. Falzon[1], M.D.,
State Medical Examiner

Col. Rick Fuentes, Superintendent,
New Jersey State Police
Designee: Lt. Thomas Wieczerak
(2016-2020)

Daniel Yale
New Jersey Task Force on Child Abuse and Neglect
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Lillian Brennan, Esq
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Carmen Diaz-Petti, Assistant Commissioner,
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APPENDIX 2. REFERENCES

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