

New Jersey Child Fatality and Near Fatality Review Board

2007 Annual Report



Issued June 30, 2008

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Introduction

New Jersey recognizes that children are an asset to our society and to our communities, and the long lasting impact of child deaths on the public is profound. The New Jersey Child Fatality and Near Fatality Review Board (CFNFRB) is driven and dedicated to informing strategies targeted to prevent child fatalities whenever possible. As with any prevention effort, it is not possible to prevent an occurrence until it is understood how and why it occurs. Therefore, the CFNFRB makes it a priority to understand how and why children die.

The CFNFRB is a multidisciplinary entity that concentrates on maintaining and analyzing data for a retrospective review of child deaths that provide meaningful system wide recommendations in an effort to prevent future deaths and to improve services to children.

The CFNFRB believes that a large number of child deaths (both inflicted and accidental) are preventable, and is unwavering in its efforts to prompt both local and statewide systems to improve intervention efforts as it relates to children who are at risk of injury or harm. The primary goal of the CFNFRB is to make concise recommendations to strengthen the system's response to children and families to prevent fatal or near fatal incidents from occurring.

The principal 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 fatalities and near fatalities in the State of New Jersey as specified in N.J.S.A. 9:6-8.90. "Child" is defined as any person under the age of 18.

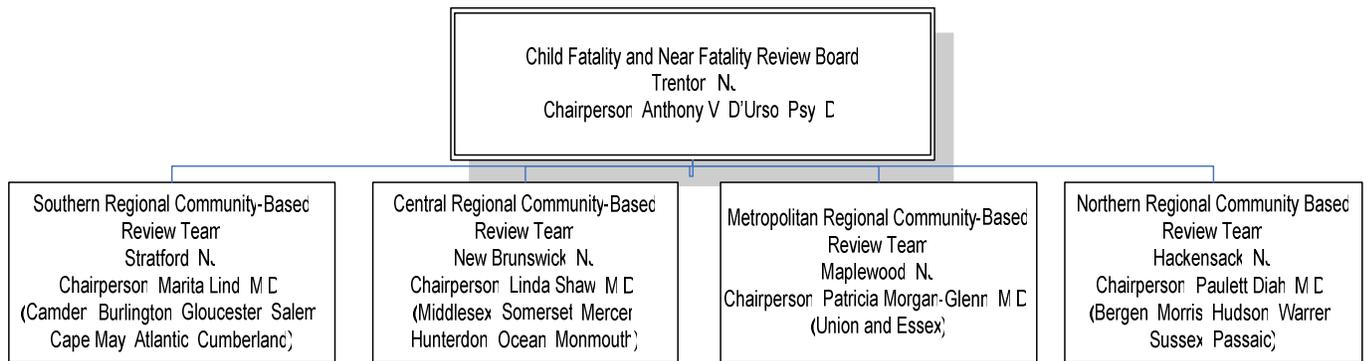
The CFNFRB has the following secondary objectives/tasks that guide them toward the prevention of child deaths:

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. Each regional team consists of a minimum of six core members: physician, law enforcement, public health advocate, prosecutor representative, medical examiner, and a DYFS case work supervisor. There are additional members on each team representing various disciplines.

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



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.”

This report encompasses the review of child fatalities and near fatalities that occurred in New Jersey in 2006 (in addition to a number of fatalities and near fatalities that occurred during 2004, 2005 and one from 2007) and summarizes the CFNFRB’s findings and recommendations for inter-systemic improvements to prevent future tragedies.

Pursuant to N.J.S.A. 9:6-8.90, the CFNFRB's requires the identification and review of “near fatalities” (defined as a serious or critical condition which is certified by a physician, in which a child suffers a permanent neurological or physical impairment; a life-threatening injury or a condition that creates a probability of death within the foreseeable future) and fatalities due to unusual circumstances 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

The 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 and regional teams do not review all fatalities and near fatalities that occur in New Jersey. In establishing its priorities, the Board excluded deaths due to medical causes that were not associated with medical neglect; motor vehicle accidents in which substance abuse, or child neglect were not contributing factors; and homicides committed by individuals other than a caregiver (unless the family was under DYFS supervision at the time of death or received DYFS intervention during the year preceding the fatality or near fatality).

Summary of Findings

- 130 fatalities and 9 near fatalities were reviewed.
- 9 children ranging in age from one month to 10 years old were near fatally injured.
- 31% of the children reviewed died by natural manner, followed by accidents (28%), homicide (27%), undetermined (17%) and suicide (9%).
- 87 male and 52 female children comprised 62.6% and 37.4% of the total number of cases reviewed, respectively.
- The 2-4 month old age group had the largest percentage of deaths among children 17 years of age and younger.
- African American children accounted for 56% percent of SIDS deaths in children, compared to 31% in white children.
- Given New Jersey's child population (2, 089,338) by race, 15% of children were African American, 19% were Hispanic/Latino, 56% were White and 10% were Other races. African American children were disproportionately represented at 42 % among child fatalities reviewed by the Board compared to 46% White.

- Children died more frequently in Essex County (17) followed by Camden (13), Ocean (11) and Hudson (10) counties.
- The leading causes of death in children were Sudden Infant Death Syndrome (SIDS) and Asphyxia from possible overlay which represented 75% of natural deaths and 46% of accidental deaths, respectively.

I. Natural and Undetermined Sudden Unexplained Deaths

The following section describes the fatalities that 1) occurred naturally (death resulting from a natural disease process, without the intervention and suppression of any type of injury, drug toxicity, or other significant environmental or other non-natural factors); and 2) infant deaths that occurred suddenly and for which the cause remained uncertain; such as deaths that are not conclusively Sudden Infant Death Syndrome (SIDS) but are consistent with SIDS and occurring with bed sharing (typically classified as Sudden Unexplained Infant Death/SUID).

In infant deaths that occurred suddenly, regardless of whether the cause of death was SIDS, the manner of death may be listed as undetermined or natural. When the circumstances surrounding the death are not consistent with SIDS, and the investigation does not reveal a reasonable cause of death, the cause of death may be certified as “Undetermined”, and the manner of death may be coded either “natural” or “Undetermined” (National Association of Medical Examiners).¹ **A Sudden Unexplained Infant Death (SUID)** is defined as the sudden and unexpected death of an infant (one to twelve months of age) for which there is no specific cause of death determined. A **Sudden Infant Death Syndrome (SIDS)** case (formerly referred to as a "crib" or "cot death") is a subcategory of SUID which remains unexplained after a thorough investigation, autopsy, and ancillary testing. The application of the term SIDS is variable for a variety of reasons. Some physicians consider SIDS deaths to be a specific medical entity of yet unexplained origin, while others believe the term comprises several entities which will some day be better elucidated. Some purists consider any opposite finding, such as a history of recent viral syndrome, to be incompatible with a diagnosis of SIDS, while others are less strict and some avoid the term altogether. A particular problem area is the occurrence of what in every other way appears to be a SIDS case, but the child is co-sleeping with a caregiver and thus presenting the possibility that the death is from "overlay." The CFNFRB prefers the use of SUID and undetermined manner of death in such cases. In an older child, specifically between one and three years of age, a sudden and unexpected death which remains unexplained death after an investigation, autopsy, and ancillary testing is termed a **Sudden Unexplained Death in Childhood (SUDC)**.

In 2007 the CFNFRB and its four regional teams reviewed 36 SIDS deaths (30 for which the manner of death was natural and six for which the manner of death was undetermined). In addition to the 30 natural SIDS deaths, the other natural deaths included six infants who died of SUID, two children who died from a medical condition or complications, and two for whom the cause of death remained Undetermined.

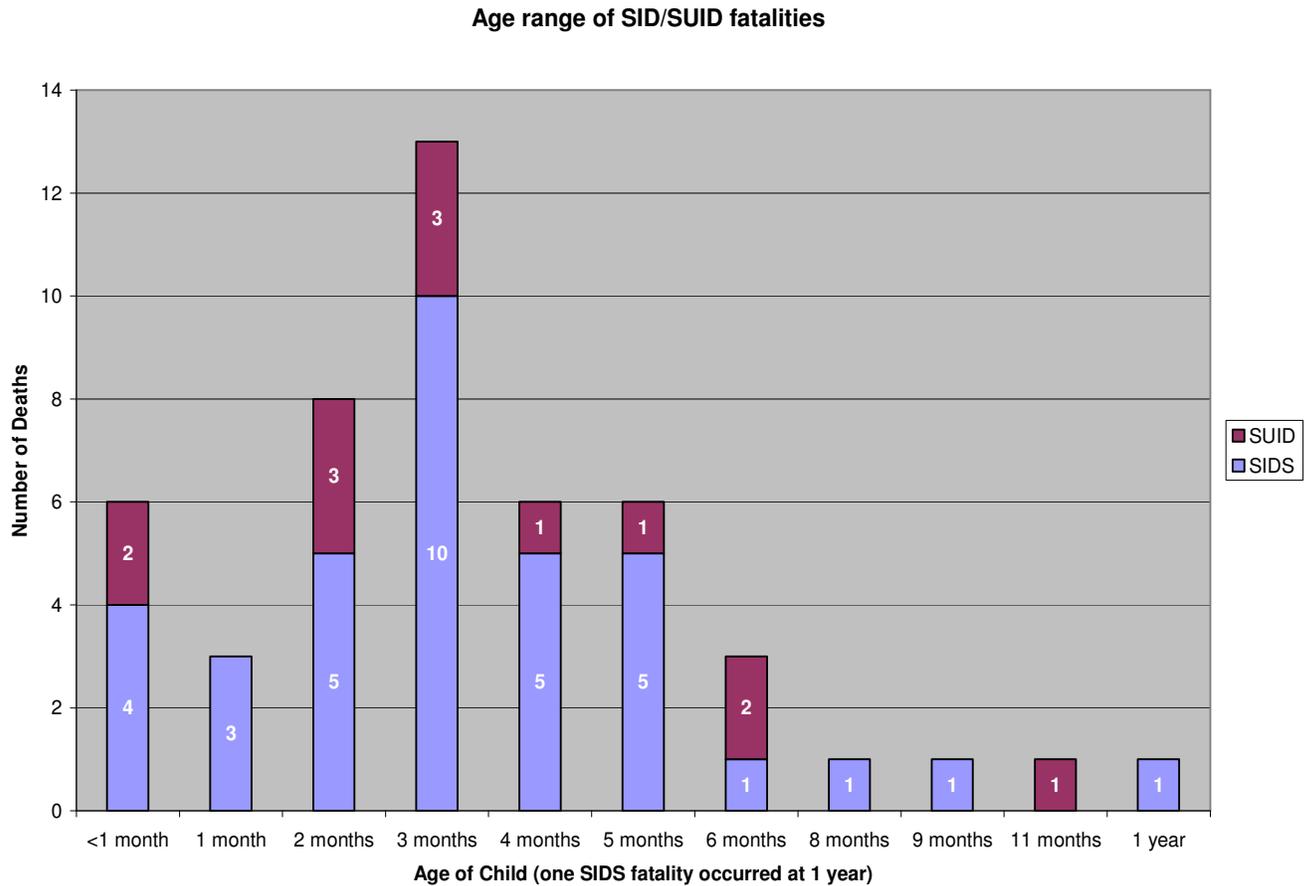
The CFNFRB reviewed an additional 14 sudden unexplained deaths that occurred in infancy or early childhood for which the manner was undetermined including 7 SUIDS and 1 SUDC.

- SIDS was the most prevalent cause of death among the natural or unexplained infant/childhood deaths. Of the 130 child deaths that were reviewed in 2007, 27.7% (36) of those were attributed to SIDS, and 11% (14) of those were attributed to the unexplained deaths of infants and one 15 month old child

whose death was certified SUDC. In two SIDS deaths medical conditions were also noted on the cause of death.*

- Of the 49 SUID fatalities (including SIDS), 24 were African American, 19 white, 5 Hispanic, and 1 Pacific Islander. Of those fatalities, 24 were male and 25 were female.
- The age range for the SIDS and SUID fatalities was less than one month to 11 months with the majority dying at two (9) and three (13) months of age (see Figure 1).

Figure 1



* one child was identified as having an upper respiratory tract infection and another infant was diagnosed with Trachetitis. The CFNFRB concluded that the respiratory infection developed post mortem. In the SIDS fatality with Trachetitis, the CFNFRB opined that since the infant was noted to have an illness at the time of death, SIDS may not have been an appropriate certification for the cause of death and accordingly the Board wrote the medical examiner to request reconsideration.

The Center for Disease Control (CDC), the American Academy of Pediatrics, and the SIDS Center of New Jersey have identified seven risk factors associated with SIDS, as follows:

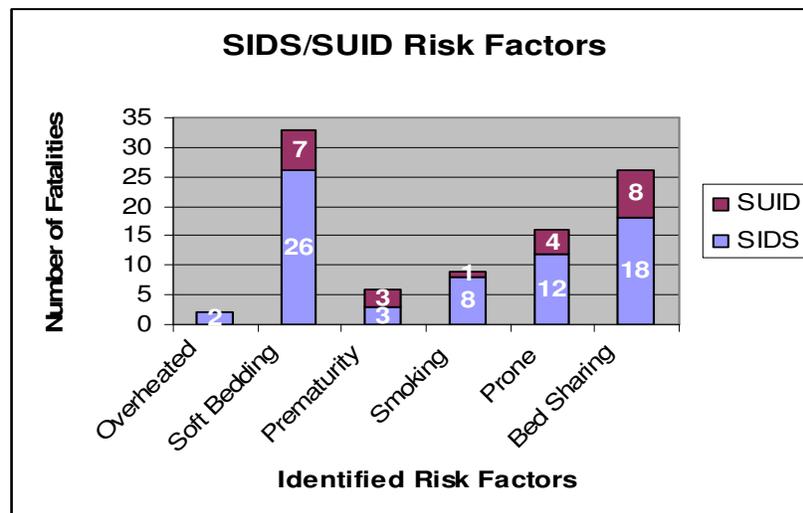
- 1) Prone sleeping,
- 2) Soft sleep surfaces such as a couch, sofa, pillows, futon, air mattress, bed mattress, or sleeping with stuffed toys,
- 3) Loose bedding (sleeping with pillows or loose bedding such as comforters, quilts or blankets),
- 4) Overheating because of being overdressed, sleeping with too many blankets, or sleeping in a room that is too hot,
- 5) Caregiver smoking,
- 6) Bed sharing (defined as a person sharing the same surface with an infant during sleep) and
- 7) Premature or low birth weight infants (Center for Disease Control).

Of the seven risk factors identified by the CDC, the most prevalent risk factors for the 49 SUID cases (including SIDS) were soft/loose bedding and bed sharing (see Figure 2). All but four of the 49 SUID cases (including SIDS) had multiple unsafe sleep risk factors; **almost 40% (18) of infants who died unexpectedly were both bed sharing and in soft bedding** (see Figure 2).

Bed sharing was identified in 88% of the eight infant positional asphyxia cases (see asphyxia section on page 17) and in 53% of the 49 SUID (including SIDS) cases. The CFNFRB recommends that infants should not bed share (co-sleep) with other persons, as this may lead to unintentional smothering of the infant (overlay). Although, the CFNFRB recognizes that bed sharing with an infant is a parent or caregiver’s choice for a variety of reasons, parents and caregivers should be well informed that this behavior increases the risk of death due to overlay.

Soft bedding was identified when the child slept on surfaces other than a crib or bassinet, such as a couch, futon, mattress, etc., and any case where it was identified that a child was pressed, wedged, or on top of a pillow, blankets or comforters. Soft/loose bedding was identified in 67% (33 of 49) of the cases.

Figure 2



Although research indicates that infants with mothers that are younger than 20 years old may be at higher risk of SIDS (Mayo Clinic),² the CFNFRB was unable to determine whether the mother's age was significant.

- 23 (47%) mothers who were between the ages of 20 and 25 years old.
- Six (12%) mothers were between the ages of 26 to 30 years old.
- Seven (14%) mothers were between 30 and 39 years old.
- In the remaining 12 cases the mother's age was not identified by either first responders or in case documents.

Recommendations to Prevent Sudden Unexplained Infant Deaths

Due to the ongoing trend that African-American children are disproportionately represented in SIDS and Asphyxia deaths, the following prevention strategies should be targeted to the African-American community:

- The CFNFRB to work in collaboration with the State Chamber of Commerce to identify New Jersey Corporations that produce baby products (diapers, formula, diaper wipes, and baby bottles, car seats) to provide warning labels on all merchandise regarding the risks associated with infant bed-sharing.
- The six Child Health Consortiums under the New Jersey Department of Health and Senior Services provide education through their own resources (i.e. Healthy Mothers Healthy Babies) to families they serve regarding the risks associated with infant bed-sharing.
- Mandate Federally Qualified Health Centers (US Dept. of Health and Human Services), WIC Centers and the Division of Family Services (NJ Department of Health and Senior Services) to provide education on safe-sleep practices, specifically regarding bed-sharing, to high risk families.
- The Department of Children and Families, Department of Health and Senior Services, the Department of Human Services, NJ Hospital Association, New Jersey Department of Education and the American Academy of Pediatrics should create a multi-system educational campaign about the risks of co-sleeping with infants. This multi-system campaign should include all pre-natal clinics, hospitals, pediatricians, obstetrician/gynecologists, pediatric nurses, DYFS, SIDS Center of New Jersey, Diagnostic Centers, day care centers and child care providers, and school districts.
- All hospitals need to provide education on breast feeding and discuss risk factors associated with co-sleeping. Such education should be reinforced at Well Baby visits throughout the first year of life.
- Hospital discharge staff should arrange for visiting nursing services prior to discharge of all pre-mature newborns. The visiting nurse should function as a

resource to educate parents about the risk factors their child(ren) face and provide examples of how to properly nurture and care for the newborn.

In addition to the above recommendations to target prevention efforts, the CFNFRB makes the following recommendations to first responders for investigation of infant fatalities:

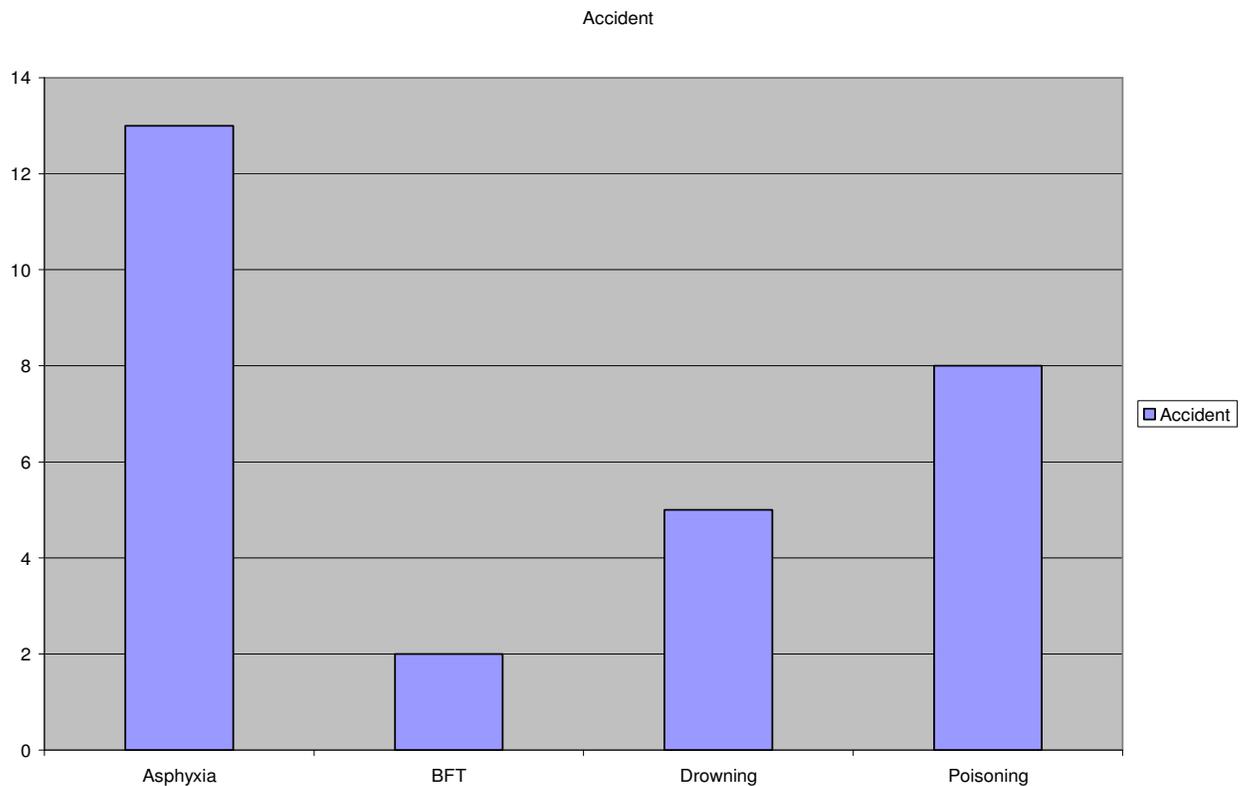
- All County Medical Examiner investigators should be mandated to utilize an infant-like doll in the course of their investigations to be able to accurately identify the sleep position of a child when placed to sleep and when found in order to ensure clarity in the investigation.
- First responders and/or the death scene investigators should consistently gather age of caregivers, the child's sleep position and the mother's pre-natal care history, as is mandated by the State Medical Examiner, for proper investigation of these deaths and to provide data to support prevention services/strategies.

II. Accidental Deaths

An accidental death is defined as a non-natural (violent or traumatic) death resulting from an event occurring by chance or unknown causes, with a lack of intention: an unintended and usually sudden, unexpected and unforeseen occurrence. The designation commonly reflects a number of physical injuries, toxic events, or environmental conditions. Please note the CFNFRB does not review fatalities resulting from motor vehicle accidents (unless the victim had a positive toxicology screen and/or was involved with DYFS).

Twenty-eight children died accidentally. Accidental deaths were the second leading manner of death identified among the children reviewed by the CFNFRB. Thirteen accidental fatalities were due to asphyxia, eight due to poisoning, five due to drowning and two were due to blunt force trauma. The children who died accidentally ranged from less than one year of age to 17 years old. 86% (24) of the accident victims were male and 14% (4) were female.

Figure 4



A. Asphyxia

Asphyxia is caused by the failure of cells to receive or utilize oxygen. The deprivation of oxygen can be partial (hypoxia) or total (anoxia). Asphyxia deaths can be loosely grouped into three categories: 1) Suffocation, 2) Strangulation and 3) Chemical Asphyxia (DiMaio, 229)³.

- Of the 13 fatalities due to accidental asphyxia, two of them were due to suffocation (deprivation of air).
 - A two month old was found under a pillow on a mattress while bed sharing with his mother.
 - A five month old rolled over on a couch and was found face down.
- Two were coded asphyxia
 - A four month old rolled onto a plastic bag after being placed on the floor.
 - A one month old was found face down between a mattress and a bouncer.
- Nine children died of Positional Asphyxia.
 - In 100% (all nine) of positional asphyxia deaths, inappropriate bedding was identified.
 - 69% of the (9) children who died of Positional Asphyxia became trapped in a restricted place and were unable move out of that area or position which resulted in the restriction of their ability to breath, followed by death.
 - All but one victim of positional asphyxia was between one and eight months of age. The exception was a 15 year old with Cerebral Palsy who was non-ambulatory and rolled off her bed onto the floor. (see Table 1 below).
 - 88% of the infants (seven of the eight) who died of positional asphyxia had been sleeping with at least one adult.
 - 76% (six of the eight) infant deaths, the infants slept on mattresses rather than a crib. Five of those families owned cribs but did not use them on the day (or evening) of the incident when they put their child to sleep. Lastly, it appears that the younger the infant, the higher the risk of death from positional asphyxia.
- Twice as many (8) of the 13 asphyxia victims were African American compared to (4) White infants. One victim was Hispanic.
- The caregivers ranged in age from 17 years old to 32 years of age.
- The CFNFRB determined all 13 accidental asphyxia fatalities to be preventable.

Table 1**Positional Asphyxia**

Age of Infant	Description of Incident	Risk Factors Identified	Owned Crib
1 month old	Infant was sleeping on a full mattress between parents	Bedding, Bed sharing	Yes
1 month old	Infant was sleeping on twin mattress adult and found underneath mother	Bedding, Bed sharing	Yes
1 month old	Infant was sleeping on twin mattress, found under mother.	Bedding, Bed sharing	Yes
2 month old	Father napping on recliner chair while infant was on lap, when infant fell into trash can from chair.	Bedding, Bed sharing	Yes
4 month old	Infant was sleeping on full mattress with father and found under sheets.	Bedding, Bed sharing	Unknown
5 month old	Infant was sleeping on couch with mother and found wedged between couch and cushion.	Bedding, Bed sharing	No
6 month old	Infant was sleeping on twin mattress with mother and rolled off of bed and onto pile of clothing.	Bedding, Bed sharing	No
8 month old	Infant was sleeping on twin mattress and was found wedged between mattress and wall.	Bedding	Yes
15 Year old	Adolescent had cerebral palsy/epilepsy and had rolled off of bed and onto floor and was found with head twisted.	Bedding (no bed railings)	N/A

Recommendations to Prevent Asphyxia

It is clear that bedding and bed sharing are identified as primary risk factors for positional asphyxia. DCF and the DHSS should continue educational campaigns about the dangers of bed sharing and inappropriate bedding that are also associated with Sudden Unexplained Infant Death (refer to recommendations under the SIDS/SUID section).

B. Poisoning

For the purpose of this report, poisoning refers to deaths that were caused by licit and illicit drugs and other substances (i.e. carbon monoxide).

There were eight child deaths that were classified as deaths due to poisoning. Five child deaths were related to drug overdose/acute toxicity/drug reaction. One death was related to drug exposure at birth, and two cases were related to carbon monoxide poisoning. **Drug overdose** is defined as an excessive use of a drug, resulting in adverse reactions ranging from mania or hysteria to coma or death. **Drug Toxicity** is defined as the critical or lethal reaction to an erroneous dosage of a medication or a

drug. Toxicity may occur due to human error or to intentional overdose in the case of suicide or homicide. **Drug Reaction** is defined as a harmful, unintended reaction to a drug administered at a normal dosage. (Mosby)⁴. **Carbon Monoxide** is a tasteless odor of combustion that acts as a poison by competing with oxygen for binding sites in hemoglobin, the molecule in red blood cells that carries oxygen from the lungs to the more remote tissue of the body (MedicinNet.com). The signs of Carbon Monoxide Poisoning can include seizures, coma and death. These signs can occur in minutes of even outdoor exposure to exhaust. Carbon Monoxide poisoning can occur from the use of generators, grills, camp stoves, or other gasoline or charcoal burning devices, and these devices should never be used in homes, basements, garages or near windows (Center for Disease Control).⁵

- Eight cases of poisoning included two cases of carbon monoxide poisoning, both male, ages 5 and 13.
 - The 5 year old child was left alone by a single father who was unable to obtain early morning child care; subsequently the house caught on fire causing the child to inhale carbon monoxide.
 - The 13 year old child was sleeping in his home and was killed as a result of his father utilizing a gas powered generator to heat their home after the family's utilities had been disconnected.
- In the six cases of accidental drug related deaths, the victims had a reported history of drug use and five of them had below average school grades and behavioral problems at school.
 - Of these six youth, five were male and one was female.
 - Five youth were between the ages of 16 and 17 years died of drug overdose/acute toxicity/drug reaction.
- One of the drug related fatalities was due to drug exposure of a newborn.

Recommendations to Prevent Poisoning

The regional teams recommend increased education in the schools regarding the dangers, usage, dosage amounts, and risk of oxycodone (oxycontin) and other opiate use through the existing DARE (Drug Abuse Resistance Education) Programs at the local schools.

The CFNFRB and the regional teams recommend that the New Jersey State Fire Chief's Association educate the public of the risk of carbon monoxide poisoning especially if generators are being used.

C. Drowning

In 2007 the CFNFRB and the regional teams reviewed seven fatalities due to drowning. Five of the seven were accidental. **Note:** Two drowning cases were deemed a suicide and a homicide. (refer to homicide and suicide section)

Three of the five accidental drownings occurred in a pool (ages two, four, and five), caregivers were present and fencing around the pool was noted. In four of the five drownings, supervision had lapsed from 5 to 10 minutes. In one drowning, a two year old child was left unsupervised between 10 to 35 minutes (those present were unable to pinpoint an exact timeframe).

- A two and a half year old male child drowned in a pond when his uncle admitted to losing sight of him for approximately five minutes.
- A 10 year old child drowned in a reservoir while playing unsupervised with a thirteen year old friend (the CFNFRB identified damaged fencing around the reservoir which enabled the two children to enter).
- The caregiver's age was only identified by first responders/investigators in 1 of the 5 drowning deaths (some team members felt the caregiver's age may have been a factor in their ability to provide appropriate supervision).
- The CFNFRB and its Regional Teams deemed all five accidental drownings were preventable.

Recommendations to Prevent Drowning

The CFNFRB continues to support DCF efforts to provide education and Public Service Announcements (PSA) to parents/caregivers and others who are responsible for monitoring children who are swimming or near bodies of water.

D. Accidental Blunt Force Trauma

Blunt Force Trauma may be defined as an injury from a force applied against a blunt object or broad surface (i.e. abrasions, contusions, lacerations, or crushing impact (Forensic Education)⁶ as apposed to sharp force trauma which produce stab and incised wounds.

The CFNFRB does not review all child deaths related to Blunt force trauma; the CFNFRB reviews blunt force trauma fatalities and near fatalities due to child abuse or neglect (refer to homicide section), those that involve substance use, or those in which the family was receiving (or within the preceding 12 months) DYFS intervention. The board reviewed two child deaths that were caused by accidental blunt force trauma.

- The two accidental blunt force trauma victims died of injuries sustained in motor vehicle accidents. One victim was a 16 year old, who had been drinking alcohol and was a passenger in a car, and the other was a four year old who was not restrained in a car seat or seat belt and was killed.

Recommendations to Prevent Blunt Force Trauma Deaths related to Motor Vehicle Accidents (MVA)

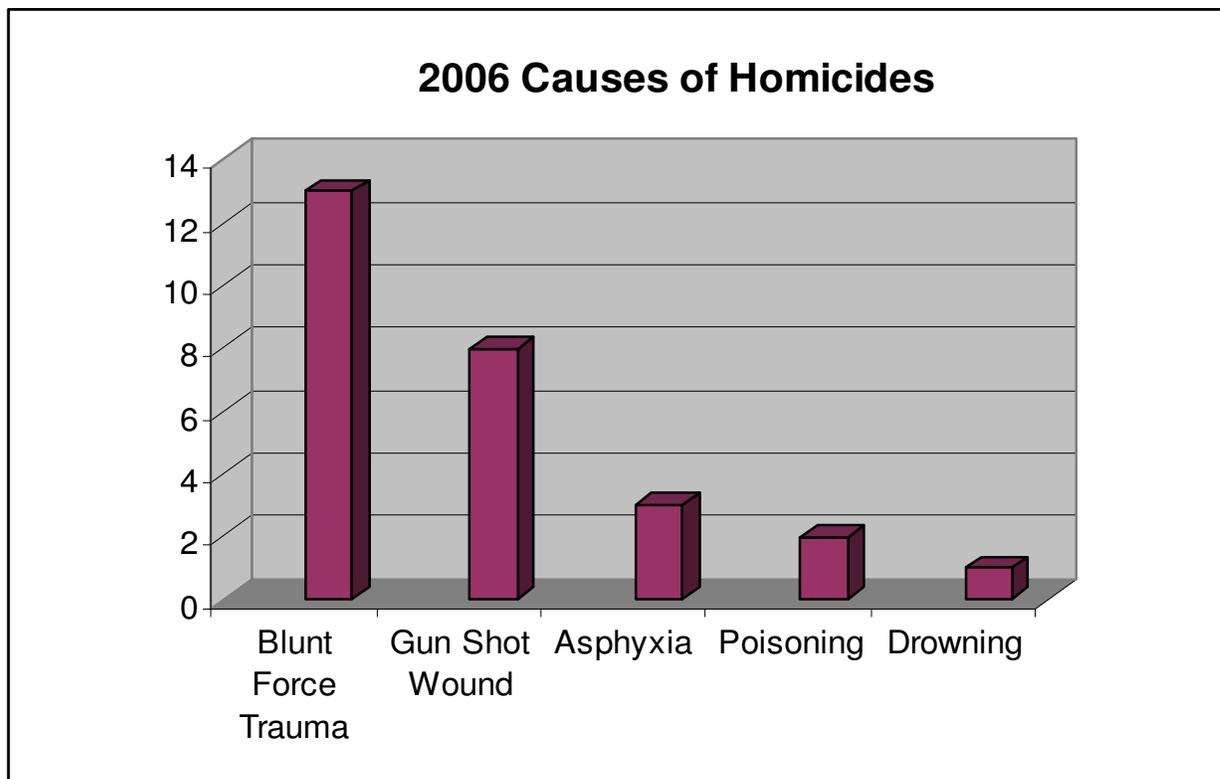
In deaths related to motor vehicle accidents where blunt force trauma was the cause of death, the regional teams have recognized these deaths to be related to the use of drugs or alcohol by the teen driver or the failure to use of a car seat restrain. The Board and the Teams feel strongly about continued and increased education and outreach as it relates to teen driving while under the influence and the use of car seats for infants and young children.

III. Homicide Fatalities

In this document, we use the term “homicide” to refer to the “manner of death” medical classification (rather than “natural”, “accident”, “suicide”, or “undetermined”), as is used by medical examiners on death certificates. However, the same term, “homicide”, is also used by prosecutors and courts to assign criminal responsibility for which a perpetrator should be prosecuted and punished. Due to the differing purposes, medical examiners and prosecutors will sometimes come to different conclusions as to whether to apply the term to a particular case.

- The CFNFRB reviewed 27 child homicide cases caused by blunt force trauma, firearms, asphyxia, poisoning and drowning (see Figure 5 below).

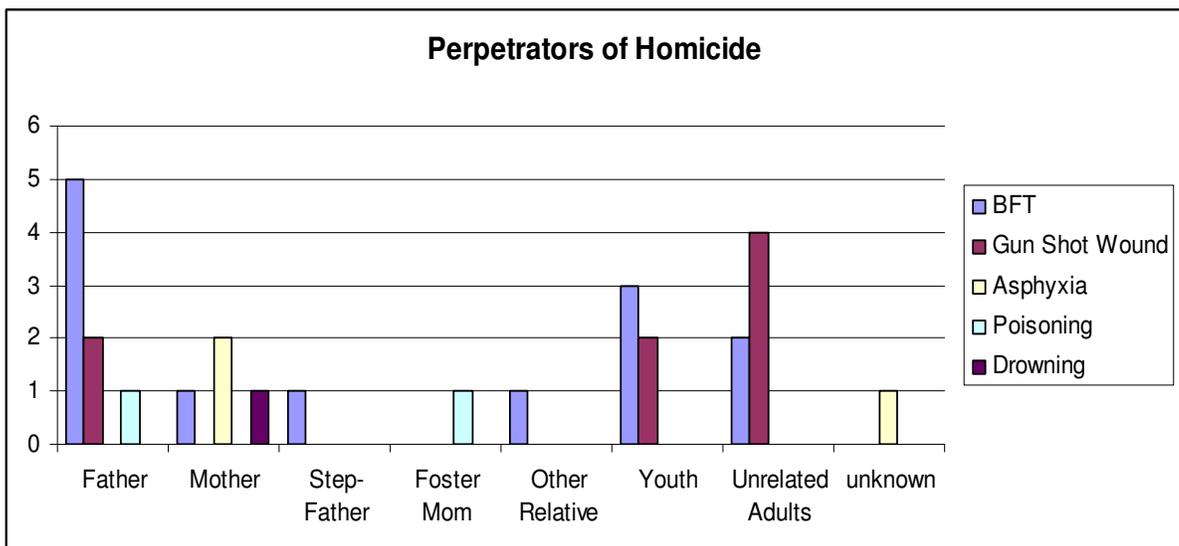
Figure 5



- Parents and caregivers were the most frequent perpetrators for all non-firearm homicides in New Jersey (see figure 6 below).
- Of the 27 homicides that occurred in 2006, 52% (14) were due to the actions of parents or caregivers.
- In 3 of the deaths, the parents/caregivers committed suicide after killing the child(ren).

- The parent/caregiver was charged with homicide in 7 of the remaining 11 cases (63%). The parent/caregiver was charged with child endangerment, child abuse, or aggravated assault in the other 3 deaths.
- In only one child abuse homicide case a perpetrator was not identified. In that case, two medical examiners differed in their opinion of the manner of death. The initial Medical Examiner (M.E.) did certify the cause of death as a pending. However, 10 months later, a second (M.E.) amended the certification to reflect homicide. The prosecutor's office re-interviewed all possible perpetrators but did not charge anyone.
- In the other non-indicted homicide, an infant ingested methadone medication belonging to an adult visiting the family's home. Although the person who left the methadone unattended was arrested and charged, the charges were later dropped.
- Amongst parents, biological fathers (8) committed the offense twice (4) as much as mothers.
- The CFNFRB data revealed that fathers are most likely to use (physical force) blunt force or a weapon to murder, whereas mothers are more likely to commit homicide by asphyxiating or drowning.
- There was known domestic violence history between the caregivers in 27% of the homicides caused by caregivers.
- Eleven of the homicides were caused by youth or non-caregiving adults and included random shootings, child on child accidental and non-accidental killings, and homicides by ex-spouses or other non-caregiving relatives.
- In the case of a 14 year old runaway who was found strangled in an abandoned house, the perpetrator was unknown.

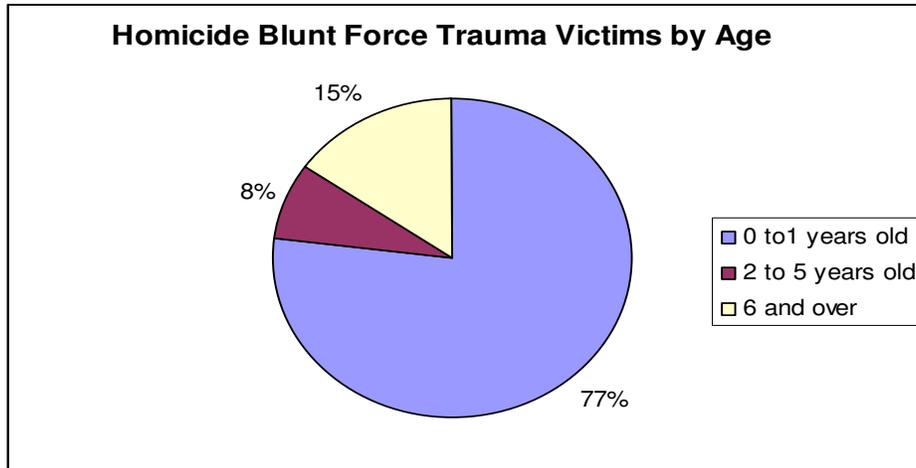
Figure 6



A. Blunt Force Trauma

- 48% (13) of the homicide victims died of Blunt Force Trauma, which continues to be the leading reviewable cause of death for child homicide victims in New Jersey, followed by firearms, asphyxia, poisoning and drowning.
 - Infants continue to be at the highest risk of Blunt Force Trauma. 77% (10) of the victims were under one year old (see Figure 7 below).

Figure 7



B. Firearms/Gunshot Wounds

- Eight homicides reviewed were due to gun shot wounds. This number is not a true representation of the actual number of New Jersey child fatalities due to gunshot wounds because other than those caused by abuse/neglect, the CFNFRB only reviews gunshot wound deaths if the case was open with DYFS or had been open within 12 months of the child's death.
- Of the eight gunshot wound victims, two were killed in drive-by shootings, two were unintentionally shot when the perpetrator played with a gun and two were killed in disputes on the street. The other two children were siblings who were killed when their father shot them, and also killed the mother and himself on the day he was due in court for allegedly raping his step-daughter.

C. Asphyxia

- The three homicide deaths due to asphyxia were caused by strangulation, intentional smothering and a child being placed in a garbage-can after being birthed at home.

D. Poisoning

- The two poisoning deaths by homicide occurred when one toddler ingested his father's prescribed oxycodone and another child ingested prescribed methadone. In both incidents the medication was improperly stored.

E. Drowning

- The lone drowning homicide occurred when the victim's mother gave birth in a bathtub and intentionally left the infant to drown.

Recommendations for Homicide Prevention

- Medical personnel and child protective services staff should educate parents to properly store prescription and non-prescription medication.
- The Office of Licensing should amend its regulations so that resource homes are required to have visible, a clearly posted written plan for what to do in a case of a medical emergency and/or poisoning in addition to calling 911.
- DYFS protocols regarding domestic violence should include coercive control and tangential spouse abuse. DYFS case workers and supervisors should receive relevant training to understand the dynamics of coercive control (threats, harassment, and emotional abuse) and tangential spouse abuse (using the child to control the spouse or partner) and assist in the identification of domestic violence.

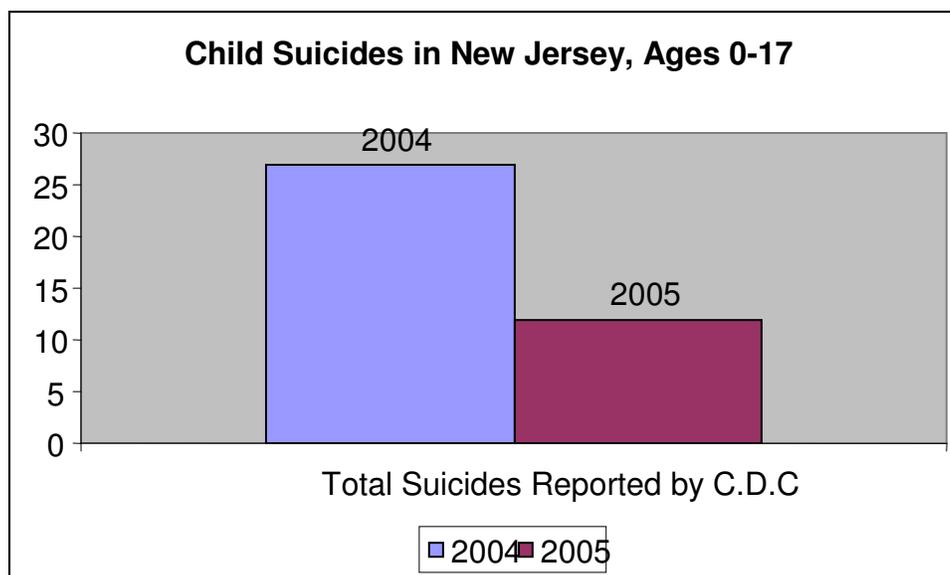
Over the years, the CFNFRB has reviewed a limited number of deaths of inflicted injury in which the parent/caregiver was not charged with homicide, although the M.E. certified the death as a homicide. Instead, perpetrators may have been charged with a lesser degree of criminal culpability (child endangerment, aggravated assault, child abuse, etc) or not charged at all. The CFNFRB recognizes the inherent difficulties of meeting the burden of criminal proof in charging a person with a homicide; however, the CFNFRB also recognizes that alternate investigative procedures may lead to better resolution of child deaths.

The Attorney General agreed with the CFNFRB's recommendation to convene an ad hoc committee consisting of representatives from the Office of the Attorney General, DCF and the CFNFRB to evaluate the practices in the early law enforcement investigation of child homicides. In February of 2008, a Supervising Deputy Attorney General from the Division of Criminal Justice attended a Board meeting to begin a preliminary discussion. The board continues to recommend that an ad hoc committee be convened by the Attorney General's Office as soon as possible.

IV. Suicide

Suicide is the deliberate and voluntarily taking of one's own life. Placing one self in reckless disregard of harm and resulting in one's death may be ruled a suicide. It should be noted that the CFNFRB may not review all child suicide deaths; cases in which an autopsy is not performed (possibly at the family's request) are excluded. **In addition, the CFNFRB may review suicide cases from multiple years.** Consequently, actual state numbers gathered from the Centers for Disease Control may differ from the number of cases reviewed by the CFNFRB.

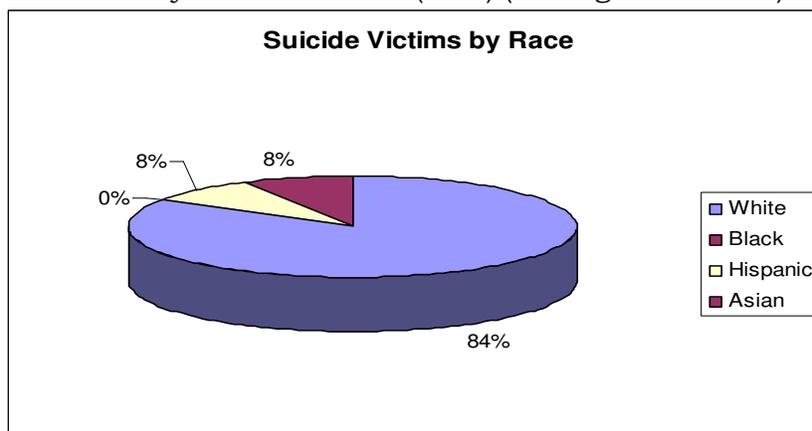
Figure 8



The State of New Jersey has one of the lowest suicide rates in the nation. According to the Centers for Disease Control most recent data, from 2004 to 2005 New Jersey saw a 56% decline in the number of child suicides from 27 to 12 (C.D.C)⁷. The CFNFRB reviewed a total of 12 child fatalities due to suicide during the 2007 calendar year (10 of which occurred in 2006). The CDC has yet to publicize its 2006 statistics.

Nationally, non-Hispanic whites have the highest rate of suicides (National Institute of Health)⁸. Similarly, in 2007, the majority of child suicide fatalities reviewed by the CFNFRB were committed by White children (84%) (see Figure 9 below).

Figure 9



- There was no major distinction in the number of suicides that occurred across counties. Multiple suicides were committed in Ocean (3), Camden (3) and Monmouth (2) counties. One suicide occurred in each of the Morris, Hudson, Bergen and Atlantic counties.
- Male adolescents committed suicide (8) twice as many times as females (4).
- Children in New Jersey who commit suicide were typically 15 years of age or older. Nine out of the 12 youth were between 15 and 17 years old. Two children were 13 and one was 14 years old.
- 75% (9 of 12) of the victims chose hanging as the method to end their lives. Nearly all of the hanging victims (8) hung themselves in their own home. One child hung himself in a local park. The other three suicides occurred when one child overdosed on prescription pills given to her for Tuberculosis, another jumped off a bridge, and one child jumped out of her bedroom window after being caught with company in her room.
- 10 of the 12 suicide victims had no previous history with the child protection system (DYFS).
- Nine of the 12 suicide victims experienced issues in school, which included being bullied, skipping class, tardiness, discipline problems, academic pressure, academic problems and language barriers. Other issues prevalent at around the time of suicide included break-ups with significant others, parent-turmoil and conflict over drug money.
- Four youth were presently receiving or had recently received Child Behavioral Health Services. Three children were reportedly on medication (one child took anti-depressants and two were on anti-anxiety medication). Two children had reported substance abuse issues. This data may not reflect the total number of children involved with the above mentioned categories due to the Board's difficulty in obtaining adequate information in suicide cases regarding children's life circumstances. Often, death scene investigators are reluctant to ask many questions of the families of suicide victims out of respect for the family's grieving process or families may be unwilling to disclose information due to the stigma attached to suicide.

Recommendations for Suicide Prevention

- The Department of Education should continue enforcing N.J.S.A. 18A:6-111 requiring all public school teaching staff to complete a minimum of two hours of suicide prevention instruction as part of their professional development.
- In order to gain information on psycho-social factors such as relationships with parents, school history and history of mental health services, all County Prosecutor investigators should record and document face to face interviews with involved parties in all child deaths, not just homicides and suspicious deaths.

- All New Jersey schools should provide supportive services to students who are new to the area to assess their adjustment as it relates to bullying and with students whose primary language is other than English.

V. Undetermined Cause and Manner of Death

- Six children died without a cause or manner identified.
- Five of the six children had normal birth and developmental histories.
 - One infant whose mother was on methadone maintenance during her pregnancy was born premature and pre-natal testing indicated the possibility of Trisomy 18. No autopsy was completed due to the family's religious beliefs.
- Five of the six children were described as healthy with the exception of one 2 year old white male who had a fever and was described as lethargic the day of his death.
- A 33 day old African American female was on an apnea monitor (although it was not used on the day of her death) at request of the mother due to a family history of SIDS.
- An 11 week old white female's death was described by the medical examiner as possibly "natural in terms of SIDS or could be asphyxia".
- A 2 month old African American male was co-sleeping.
- 3 year old Hispanic male was reported to have fallen forward hitting his forehead on a computer (blunt force trauma to the head, contusions of the face, swelling of the brain).

VI. Near Fatal Injuries

A near fatality is defined as a case 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, 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.

- Nine children were near fatally injured, seven at the hands of their caregivers (one family was open with DYFS at the time of the injury, six had no prior DYFS involvement, in one case DYFS had terminated services more than 12 months prior to the injury and in another DYFS termination occurred within 12 months of the near fatal injury).
- 5 children were African American, 2 Hispanic, 1 White, 1 Asian.
- 5 children were male and 4 female.
- 44% (4) of the children were 12 months of age or younger. The other five children ranged from one and half years old to 10 years old.
- One infant was a day old and was disposed of in a garbage can after his 15 year old mother gave birth at home.
- One 2 ½ year old was found in a parked car after he had been playing with his 5 year old sibling without adult supervisor.
- A blind 10 year old with Cerebral Palsy was found malnourished and near death in the motel room he shared with his mother.
- A 10 month old fell off a love seat he was standing on and hit his head on the floor.
- A 4 month old sustained near fatal injuries due to Shaken Baby Syndrome.
- A 19 month old climbed out of her crib and onto the window sill resulting in her falling from a second floor window.
- 18 month old sustained injuries that included old and new rib fractures as well as a bleed on the brain and intestinal damage.
- A 7 month old was found unresponsive next to a bed after sleeping with her mother and three siblings.
- 16 month old sustained injuries from a fall off a couch while in the care of a babysitter.

Child Protection/Child Welfare Involvement

- In 2006, between 28, 000 and 30, 000 families were under supervision of the Division of Youth and Family Services (New Jersey Department of Children and Families).
- DYFS was investigating, assessing or providing supervision to the families of 32 of the 139 children at the time of their fatality or near fatal injury.
 - DYFS was assessing six families for child welfare services at the time their children died or were injured.
 - DYFS was investigating or providing supervision to 26 families when their children died or were injured.
- Nearly a third (45) of the families were unknown to DYFS when their child died or was near fatally injured.
- Eight percent (11) children (or their families) received DYFS intervention within the 12 months prior to the fatality or near fatality.
- Almost 11 percent (15) children (or their families) had not had any DYFS intervention for more than twelve months prior to their fatality or near fatality.
- DYFS responded to 25% (36) of the fatality or near fatality reports to assess for services or investigate.
- The families of 11 of the 50 children who died of SIDS (36), SUID (13) and of SUDC (1) were receiving DYFS services at the time of death. Thirty-two of the families were never involved with DYFS; three families received services within the 12 months preceding their child's death, and four families had prior DYFS involvement more than a year before their child's death.

Additional Recommendations

The Department of Children and Families

- DYFS develop safe sleep training for all front line DYFS staff.
- Incorporate safe sleep in the risk assessment tool.
- Implement domestic violence protocol.
- DCF/DYFS create and implement a forum for monthly child fatality and near fatality sentinel event reporting as a tool to educate DYFS workers on investigative and case handling practices. The objective of the sentinel event forum is to provide an opportunity to share information regarding “best practices” with supervisory and frontline staff and to reduce on-going risk to children.
- The CFNFRB has received conflicting information regarding how DCBHS contracted agencies assess risk of adolescent suicide, substance abuse overdose and parental negligence and the degree of follow-up that is essential to mitigate child death. It is also unclear to the CFNFRB what relationships exist between agencies that assess emergent psychiatric risk. The Board recommends that the Division of Child Behavioral Health Services (DCBHS) publish its practices and procedures to all contracted agencies and conduct training efforts to implement these standards uniformly.

The Office of the Attorney General

- In January 2008, the Attorney General agreed with the Board’s concerns related to the limited authority of the State Medical Examiner to create and enforce uniform forensic investigatory policies and procedures. At that time, the Attorney General responded that this could be accomplished through appropriately crafted legislation. The Board continues to review practices and procedures that require systemic improvement. The State of New Jersey has at this time no effective mechanism to address faulty and inappropriate medical examiner practices and insure accountability. The Board continues to recommend that legislation be created and enacted immediately which would the State Medical Examiner (SME) to have statutory authority over every County Medical Examiner (CME) in the State of New Jersey.
- The CFNFRB also suggests that the State examine its practices to ensure that uniform forensic investigatory policies and procedures are consistent with the recommendations of the National Association of Professional Medical Examiners.

¹ “Writing Cause of Death Statements in SIDS”, National Association of Medical Examiners. 03 September 2005. <<http://www.thename.org/index.php>>

² “Sudden Infant Death Syndrome” Mayo Clinic. 13 June 2007. <<http://www.mayoclinic.com/health/sids.htm>>

³ DiMaio, Vincent & Dominick. Forensic Pathology. 2nd Edition. CRS Press, New York, 2002

⁴ Mosby’s Medical Dictionary, 2nd Edition. 2008. Elsevier Inc. <[http://medical-dictionary/adversedrugreaction.com](http://medical-dictionary.adversedrugreaction.com)>

⁵ “Carbon Monoxide Poisoning” Department of Health and Senior Services, Center for Disease Control and Prevention. <<http://www.cdc.gov/co/basics/htm>>

⁶ “Forensic Education”, 1998-2005.<<http://www.forensiceducation.com/sourcebook/glossary.htm>>

⁷ “Injury Mortality Rates 1999-2005.” Web-Based Injury Statistic Query and Reporting System/ Center for Disease Control and Prevention. 1/23/08 <http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html>

⁸ “Suicide in the U.S. Statistics and Prevention.” ,National Institute of Mental Health 4/30/08 <www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prvention-shtml>