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# 2013 CHILD FATALITY & NEAR FATALITY REVIEW BOARD ANNUAL REPORT

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NEW JERSEY | ISSUED 2014



# TABLE OF CONTENTS

<b>Child Fatality and Near Fatality Review Board Membership .....</b>	<b>2</b>
<b>Mission and Purpose .....</b>	<b>6</b>
<b>Case Selection Criteria .....</b>	<b>7</b>
<b>Cause and Manner of Deaths .....</b>	<b>8</b>
<b>Deaths by County .....</b>	<b>9</b>
<b>Natural Deaths .....</b>	<b>10</b>
<b>Undetermined Deaths .....</b>	<b>12</b>
<b>Sudden Unexpected Infant Deaths .....</b>	<b>14</b>
<b>Suicides .....</b>	<b>18</b>
<b>Homicides .....</b>	<b>21</b>
<b>Accidental Deaths .....</b>	<b>24</b>
<b>Asphyxia Related .....</b>	<b>24</b>
<b>Drug Related .....</b>	<b>25</b>
<b>Drowning .....</b>	<b>25</b>
<b>Child Protection and Permanency .....</b>	<b>29</b>
<b>CCAPTAs .....</b>	<b>30</b>
<b>Recommendations .....</b>	<b>33</b>

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## The Mission, Purpose, Mandate, and Scope of the CFNFRB

The New Jersey Child Fatality and Near Fatality Review Board herein referred to as the Board or CFNFRB, was established after the adoption of N.J.S.A. 9:6-8.88, the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA) on July 31, 1997. Although this Board is established within the Department of Children and Families, it is statutorily independent of "any supervision or control by the Department or any board or officer thereof." The CFNFRB also serves as a Citizen Review Panel, mandated under the federal Child Abuse Prevention and Treatment Act (CAPTA) and its subsequent amendments to examine the policies, practices and procedures of state and local agencies and, where appropriate, to examine specific cases to determine the extent to which the agencies are effectively discharging their child protection responsibilities.

The principal objective of the Child Fatality and Near Fatality Review Board is to provide an impartial review of individual case circumstances and to develop recommendations for broad-based systemic, policy, and legislative revisions for the purpose of preventing future tragedies. According to CCAPTA, the purpose of the Board includes but is not limited to the following:

- **To 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.**
- **To describe trends and patterns of child fatalities and near fatalities in New Jersey based upon its case reviews and findings.**
- **To evaluate the response of government 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.**
- **To identify groups at high risk for child abuse and neglect or child fatality, in terms that support the development of responsive public policy.**
- **To improve data collection sources by developing protocols for autopsies, death investigations, and the complete recording of the cause of death on the death certificate, and make recommendations for system-wide improvements in data collection for the purpose of improved evaluation, potential research, and general accuracy of the archive.**

Reviewing the circumstances surrounding cases of child fatalities and near fatalities is a critically important task for a multidisciplinary team of state and local professionals working in an array of fields, including child welfare, law enforcement, health, judicial, medical examiner, mental health, domestic violence, education, and substance abuse. Recognizing that deaths and near fatalities of children and youth are sentinel events, a comprehensive review by the community allows for a better understanding and identification of potential risk factors to surviving siblings and other children. In essence, the Board functions as a catalyst for needed change by making recommendations to prevent future deaths, develop needed service resources, and improve the safety and well-being of children overall.

A central and guiding principle of the CFNFRB is that the review enables the community to learn from each child fatality and near fatality and promotes ownership of prevention initiatives and strategies. Accordingly, the CFNFRB established regional community-based teams with the support and

cooperation of the four New Jersey Regional Child Abuse Diagnostic and Treatment Centers. The teams' membership is multidisciplinary and has expertise in the areas of pediatrics, child welfare, substance abuse, law enforcement, psychology, and public health.

The state board reviews cases which were open at the time of death or near fatality with Child Protection and Permanency (CP&P), New Jersey's child protection and child welfare agency. The Northern, Metropolitan, Central, and Southern Teams, review all other cases meeting review criteria described below and have no active DCP&P involvement at the time of the fatal or near fatal incident. The Sudden Unexplained Infant Death (SUID) Subcommittee reviews the deaths of children under the age of one (1), in which the cause or manner was ruled Undetermined or SUID by the medical examiner.

## Case Selection Criteria

According to N.J.S.A. 9:6-8.90, the duties of the CFNFRB include review of fatalities due to unusual circumstances, using 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 guidelines also mandate that the CFNFRB identify children whose families were under Child Protection and Permanency (CP&P) supervision at the time of the fatal or near fatal incident or within 12 months immediately preceding the fatal or near fatal incident.

The CFNFRB also requires the review of "near fatalities" (a serious or critical condition, as certified by a physician, in which a child suffers a permanent neurological or physical impairment, a life-threatening injury, or condition that creates a probability of death with in the foreseeable future); pursuant to N.J.S.A. 9:6-8.84. In addition to those reviews captured by the CCAPTA guidelines, the Board also elects to review:

- **All drowning fatalities**
- **Motor vehicle accidents in which the driver:**
  - 1) **Was under the age of 18 and toxicology results were positive**
  - 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)**

## Review Process

The CFNFRB is notified of child deaths by several sources, including the State Central Registry (SCR), the Office of the State Medical Examiner, and upon request, the Department of Health. Near fatal incidents are identified for review through the CP&P Director's Office. Once a case is identified for review, liaison staff is responsible for obtaining all relevant records, including but not limited to, autopsy, death scene investigation, medical, and social service records. The CFNFRB has the authority to subpoena and secure the required materials as necessary. The CFNFRB does not review all fatalities and near fatalities, but always reviews those which come to their attention involving abuse, neglect, domestic violence, or appear preventable. The Board's data and subsequently this report, is based on this selection.

All relevant documentation is posted in an on-line library so that members of the review teams are able to access for review, approximately two (2) weeks before a scheduled meeting for review in preparation for discussion at the meeting.

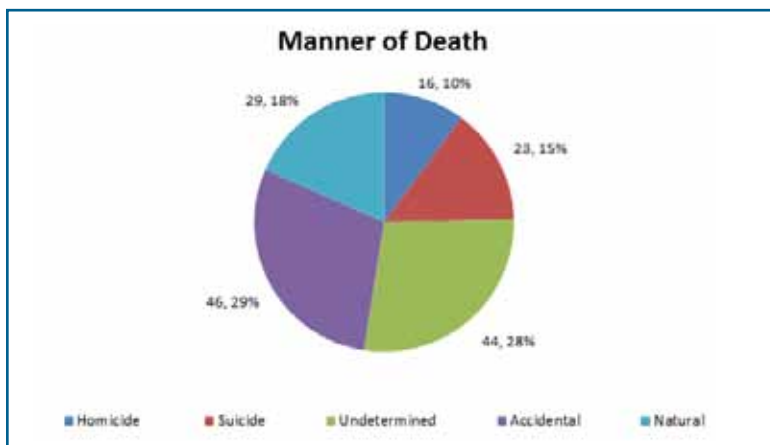
Some of the possible actions following each case review may include but are not limited to policy and practice changes in particular fields, strengthening interagency collaboration, staff training, public outreach and education, or changes to state law. Lessons learned from these tragedies lead to stronger prevention efforts that help protect children, keeping them safe and healthy.

## CAUSE AND MANNER OF DEATH

The New Jersey Office of the State Medical Examiner defines the cause of death as, "the underlying injury or disease that directly eventuates in death," and the manner of death as a "classification of death" based upon the cause of death and the circumstances surrounding the death. The five categories of manner of death are natural, homicide, suicide, accident, and undetermined.

The causes of death in the 158 fatalities reviewed included: medical illness, trauma / injury, asphyxia, Sudden Unexpected Infant Death, drowning, drug toxicity, and undetermined causes.

The manner of death in 18% (29) of the 158 fatalities reviewed was natural. In 29% (46) the manner was accident, in 28% (44) undetermined, in 10% (16) homicide and in 15% (23) the manner was suicide.



## County

The fatalities reviewed by County table below illustrated the number of fatalities by manner of death, per county, and reviewed by either the Board, one of its regional teams, or the SUID Subcommittee. A finding of note on this table is that the number of fatalities was greatest in Essex County; however, with county child population factored in, Cumberland County has the highest child fatality rate with 23.9 children dying per 100,000. No child fatalities in 2011 from Hunterdon County were reviewed giving Hunterdon County the lowest (0) child fatality rate of any county in the state.

Fatalities Reviewed by County <sup>1</sup>								
COUNTY	MANNER OF DEATH					% Total Fatalities	Child Population <sup>2</sup> (< 18 Years)	County Reviewed Fatality Rate <sup>3</sup>
	Accidental	Homicide	Natural	Suicide	Undetermined			
ATLANTIC	8	2	1	0	3	8.86%	63,098	22.2
BERGEN	2	0	1	0	3	3.80%	202,243	3.0
BURLINGTON	2	0	1	1	2	3.80%	102,503	5.9
CAMDEN	3	2	5	1	3	8.86%	123,178	11.4
CAPE MAY	3	0	0	0	1	2.53%	17,871	22.4
CUMBERLAND	2	1	1	1	4	5.70%	37,703	23.9
ESSEX	2	7	3	3	8	14.56%	193,144	11.9
GLOUCESTER	4	0	3	2	2	6.96%	69,096	15.9
HUDSON	1	0	3	0	4	5.06%	132,092	6.1
HUNTERDON	0	0	0	0	0	0%	29,065	0.0
MERCER	3	0	1	2	7	8.23%	82,222	15.8
MIDDLESEX	0	0	0	2	1	1.90%	184,013	1.6
MONMOUTH	4	1	3	5	0	8.23%	147,028	8.8
MORRIS	0	0	1	1	0	1.27%	115,329	1.7
OCEAN	4	1	3	2	0	6.33%	134,993	7.4
PASSAIC	2	0	0	0	1	1.90%	123,494	2.4
SALEM	2	0	1	0	0	1.90%	15,223	19.7
SOMERSET	0	1	0	2	1	2.53%	79,599	5.0
SUSSEX	0	0	0	1	1	1.27%	34,456	5.8
UNION	3	1	1	0	3	5.06%	130,558	6.1
WARREN	1	0	1	0	0	1.27%	24,810	8.1
STATE TOTAL	46	16	29	23	44	100%	2,041,718	9.8

<sup>1</sup> Reviewed Fatalities - fatality cases occurring in 2011 reviewed by the CFNFRB

<sup>2</sup> Population <18 – from US Census Bureau, 2010 Website: <http://quickfacts.census.gov/qfd/states/34000.html>

<sup>3</sup> Reviewed Fatalities per County \* 100,000 / County Child (<18) Population

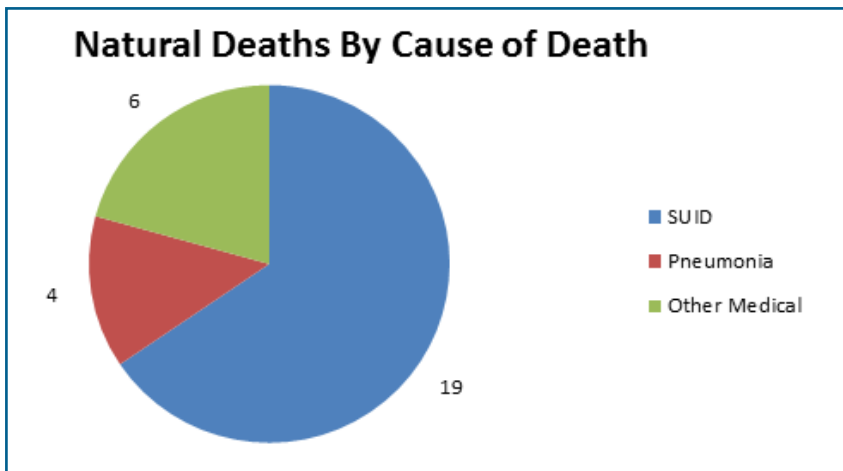
# NATURAL DEATHS

Of all the deaths reviewed by the CFNFRB in 2011, 18.4% (29 of 158) were determined to have a Manner of Death of Natural.

65.5% (19 of 29) of these deaths were due to Sudden Unexplained Infant Death (SUID), Sudden Unexpected Infant Death, Sudden Unexpected Death in Infancy or Sudden Infant Death Syndrome (SIDS).

13.8% (4 of 29) of these deaths were related to pneumonia and the remaining 20.7 % (6 of 29) were due or related to medical causes, such as: Hydrocephalus, intestinal obstruction / hemorrhage, abdominal sepsis due to appendicitis, respiratory failure / perinatal asphyxia and extreme prematurity.

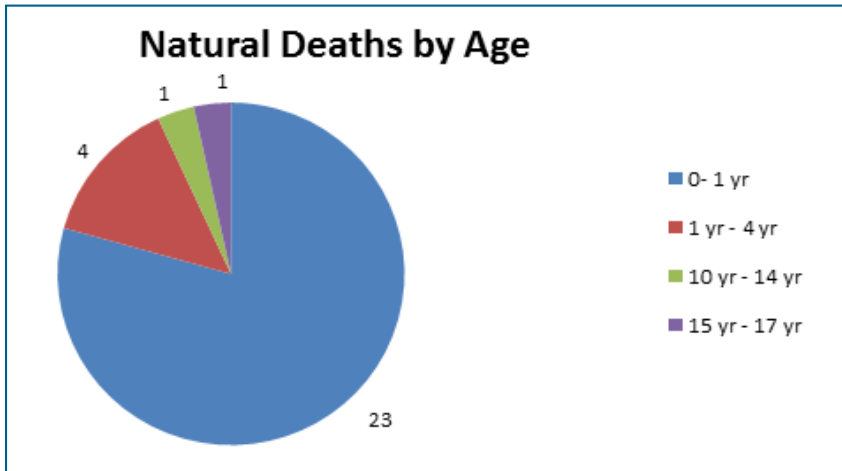
One case (3.4%) was of particular interest: a 16 year old white male collapsed in front of his friends after smoking “exotic marijuana.” His friends reported he smoked more marijuana that day than he usually did. The 6 foot tall and 250 pound child was classified as morbidly obese. His manner of death was natural and his cause of death was listed as “Fatty Liver and Morbid Obesity, Smoking Marijuana Contributed.” Toxicology reports indicated that he had “less-than-fatal” blood levels of marijuana metabolites.



## Age

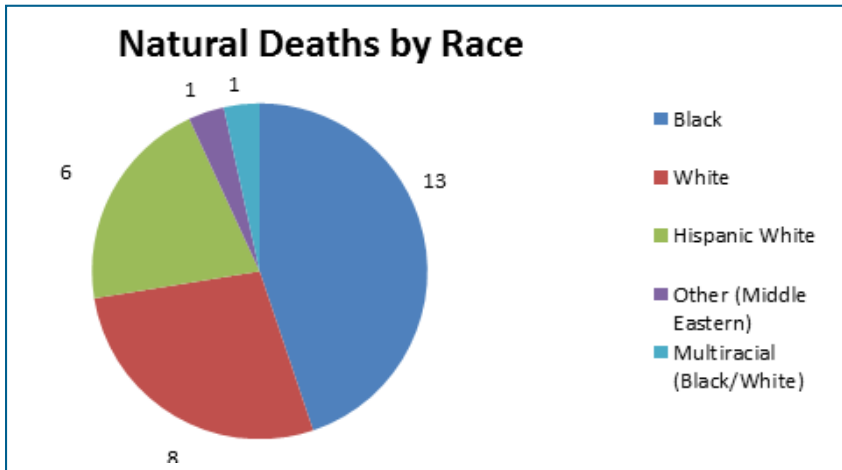
As has been shown in previous years, the CFNFRB data findings show that children under six months of age are at a considerably higher risk of dying a natural death than children in any other age group (74.5%).

Children between birth and one year old comprise 79.9% of the natural deaths reviewed. Children between 1 and 4 years old comprise 13.8%. The next two groups were of equal sizes: 15 to 17 years old (3.4%) and 10 to 14 years old (3.4%). No children between the ages of 5 and 9 that were reviewed died of natural causes in 2011.



## Race

Of those children who died a natural death, Non-Hispanic Black children were the most represented at 44.8% (13 of 29). Non-Hispanic White children were the next largest group, at 27.6% (8 of 29), followed by Hispanic White children, at 20.7% (6 of 29). One Biracial child (of mixed black and white ancestry) and one child whose family was of Middle Eastern origins died of natural causes and were reviewed by the CFNFRB (each 3.4%).



## Sex

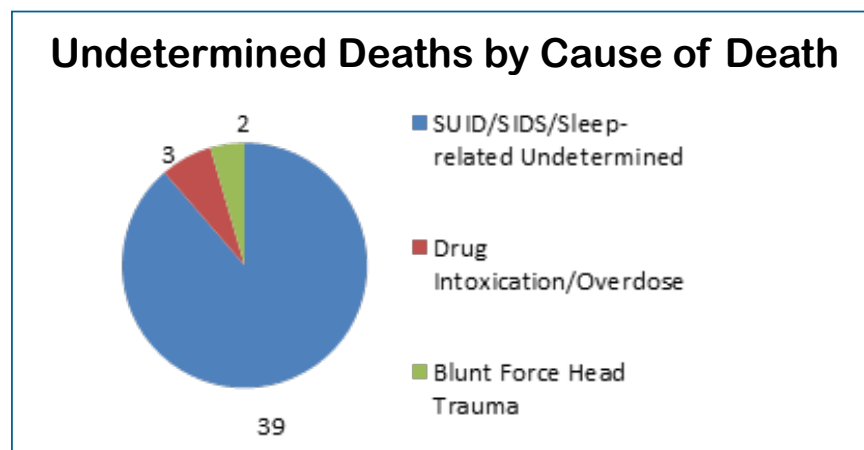
Female and male children were almost equally represented among the natural deaths: females were fifty-two point seven percent (52.7%), twenty-nine (29) out of fifty-five (55), and males were forty-seven point three percent (47.3%), twenty-six (26) out of fifty-five (55). No inter-sexed children were reported to have died naturally in 2010.

# UNDETERMINED DEATHS

27.9% (44 out of 158) of the deaths reviewed by the CFNFRB in 2011 had a Manner of Death of Undetermined. Of these, the majority (88.6% or 39 of 44) was infants whose death was listed as one of the following: Undetermined, Undetermined with Co-sleeping<sup>4</sup>, Sudden Unexpected Infant Death (SUID)<sup>5</sup>, SUID with Co-sleeping, SUID with another factor or possible etiology, and SIDS. See SUID Section to follow.

4.5% (2 of 44) were classified as related to Blunt Force Head Trauma (one with Subdural Hematoma). These deaths will be discussed in a later section.

6.8% (3 of 44) were classified as related to drug intoxication or overdose. One case was of a 16 year old Black Hispanic male who ingested various pills resulting in death with the cause certified as Morphine, Codeine, and Hydrocodone Intoxication. While there were reports that the child had talked about suicide, this death was ultimately classified as Undetermined because there was no suicide note or other indication that the child purposefully overdosed. Another case was of a 5 year old Black female who was found dead when she did not wake up in the morning; toxicology report indicated she had methadone in her system resulting in the cause of death of Methadone Drug Overdose. It is unknown if someone gave her methadone or if the child found it and took it on her own. It is unknown from where the methadone came or to whom it was prescribed. There was speculation that her mother, the last adult to supervise the child while she was alive, may have given her methadone to sedate her, as the child had behavioral issues. Given the multiple unknowns a manner of death of Undetermined is clearly warranted. A third case was of a 12 year old Asian female who was found unresponsive when her family went to wake her up in the morning. The child had a history of progressive, itching, and superficial ulcerations of the legs, etiology unknown. She became depressed due to the distress of the painful condition and was prescribed Doxepin, an antidepressant also used to treat Insomnia, as she had difficulty sleeping due to her condition. It is unknown if she purposefully ingested a toxic amount of Doxepin, if someone gave it to her or if she had a metabolic condition that resulted in turning what should not have been a toxic amount into a toxic amount in her body. Her cause of death was classified as Overdose of Doxepin, Chronic Deep Ulcerations of Legs.

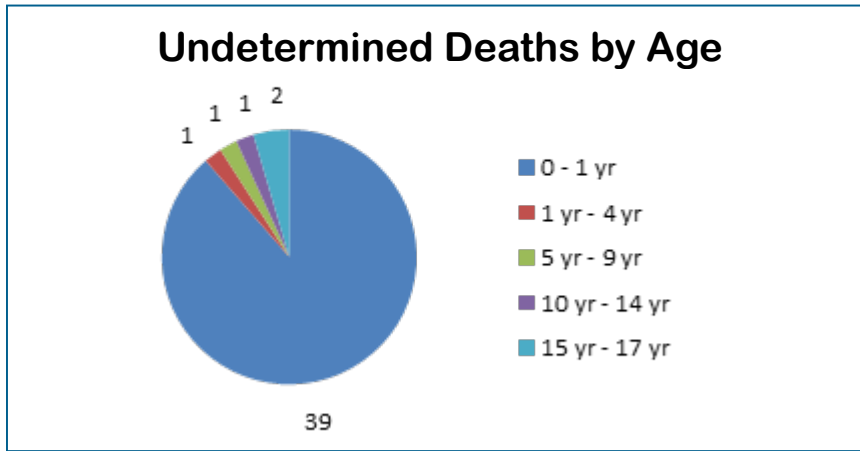


<sup>4</sup> Co-sleeping and Over-lay are considered to be synonymous for our analysis.

<sup>5</sup> There is no uniformity among New Jersey's Medical Examiner's with regards to how they describe Sudden Unexpected Infant Death (SUID). Some use Unexplained instead of Unexpected, some invert Infant and Death, and some include contributory causes.

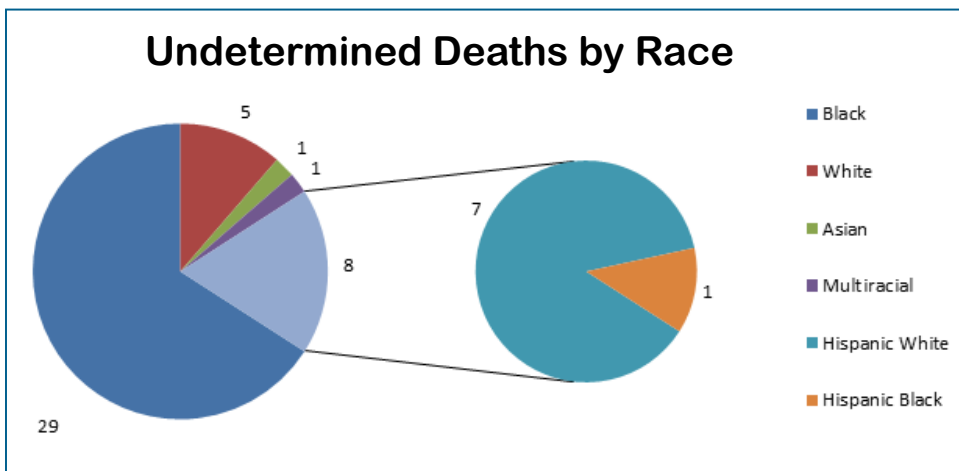
## Age

Of the 44 cases reviewed with an undetermined manner of death, 39 or 88.6% of the children were less than one year old. Between the ages of 1 and 4, 5 and 9, and 10 and 14, only one child (2.3%) per age group had an undetermined manner of death. Between 15 and 17 years old, 2 or 4.5% of the children had an undetermined manner of death.



## Race

Undetermined deaths reviewed by race give the following percentages: Non-Hispanic Black: 65.9% (29 of 44); Hispanic White: 15.9% (7 of 44); Non-Hispanic White: 11.4% (5 of 44); Hispanic Black: 2.3% (1 of 44); Asian: 2.3% (1 of 44); Multiracial (Black/White): 2.3% (1 of 44).



## Sex

Of the twenty-five (25) child deaths reviewed in 2010 with an undetermined manner of death, seven (7) or twenty-eight percent (28%) were female and eighteen (18) or seventy-two percent (72%) were male, showing once again that male children are at higher risk than female children.

## SUDDEN UNEXPECTED INFANT DEATH

In 2008 the CFNFRB's staff (housed in NJ's Department of Children and Families) in conjunction with NJ's Department of Health, applied for a grant from the Centers for Disease Control and Prevention (CDC). The grant was called the National Sudden Unexpected Infant Death Case Registry (SUID-CR). New Jersey was one of 5 states to receive this grant, which began in 2009 and was renewed in 2012, for another three year cycle.

As part of the SUID-CR grant, CFNFRB staff enters child death case information onto a web-based surveillance tool called the Case Reporting System, developed by the National MCH Center for Child Death Review (NMCHCCDR). The purpose is to learn from child death cases in order to create effective prevention strategies.

During the first cycle of the grant, staff focused on data acquisition: methods of information gathering were improved, as was the network of various state-wide agencies that provide records used during the CFNFRB's review. The CFNFRB also sponsored a conference / training in September of 2012 entitled: Enhancing Pediatric Fatality Investigations: Strengthening Collaboration to Promote Data Consistency and Prevention Efforts. Guest lecturers included: Roger Mitchell, MD, Asst. State Medical Examiner in Charge; Ernie Leva, MD, Director, UMDNJ-RWJ Medical School's Division of Pediatric Emergency Medicine; Gina O. Hart, MA, Forensic Anthropologist and Investigator, Regional Medical Examiner's Office; Bryan Hoffmann, BA, EMT-B(I)-MDI Team Leader Northern Regional Medical Examiner's Office; and Marita Lind, MD, NJ CARES Institute UMDNJ-SOM. Using grant funds, the CFNFRB provided Child Death Scene Investigation kits to every Medical Examiner's Office in New Jersey as well as to Prosecutor's Offices and Police Departments of targeted (high-incidence) New Jersey counties and cities. These kits included several dolls to be used in re-enactments, a vitally important aspect of the death scene investigation that will improve the data provided to the CFNFRB greatly. This data will in turn be used to develop prevention strategies, the focus of the second cycle of the CDC grant.

CFNFRB staff have also attended CDC trainings in Atlanta, GA, and presented at numerous conferences including the 17th Annual Maternal and Child Health Epidemiology (MCH EPI) Conference in New Orleans, the International SIDS Conference in Baltimore, and the American Public Health Association Annual meeting in San Francisco. The presentations included prevention activities that the State of New Jersey utilized based on the data gathered during the review process.

In 2010 the CFNFRB created the SUID Subcommittee. The SUID Subcommittee is a state-wide multidisciplinary team that reviews only cases with causes of death of: SUID, SIDS, Undetermined and Asphyxia, Suffocation and Strangulation in Bed (ASSB). The following is a data analysis of cases from 2011 reviewed by the SUID Subcommittee<sup>6</sup>.

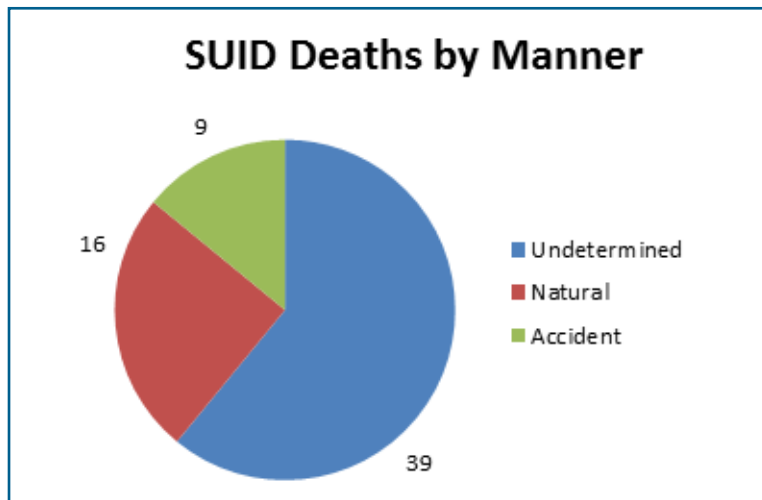
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<sup>6</sup> An additional six cases that the State Board reviewed will be included in this analysis as these were special cases that normally would have gone to the SUID Subcommittee except for their involvement with the New Jersey Child Protection and Permanency."

## Manner of Death

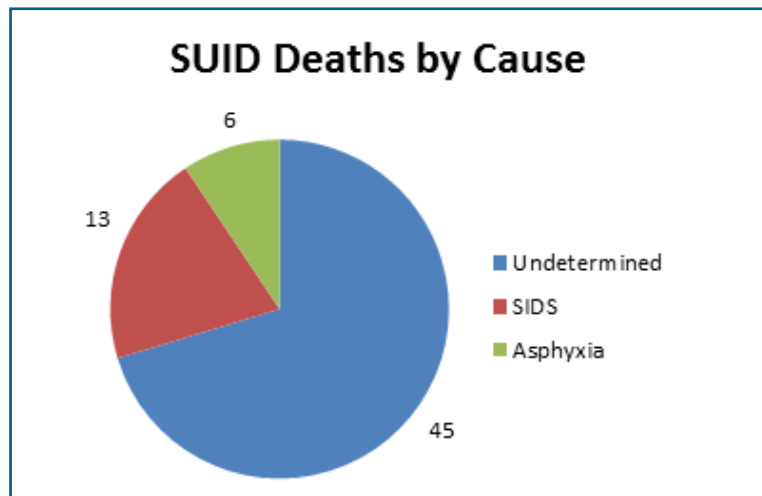
Of the five possible manners of death, three are used to classify sleep-related deaths. Often SIDS cases are determined to be natural, perhaps in part to alleviate a parent's self-imposed guilt. Cases with undetermined causes are, naturally, usually classified as having an undetermined manner of death. ASSB cases are usually classified as accidental. Classification of manner of death becomes somewhat more ambiguous when considering the SUID cause of death. These cases can be classified as any of the three possible manners of death, for the reasons given above.

The CFNFRB's SUID Subcommittee reviewed 64 cases of sleep-related deaths in 2011. 39 or 60.9% were undetermined, 16 or 25.0% were natural and 9 or 14.1% were accidental.



## Cause of Death

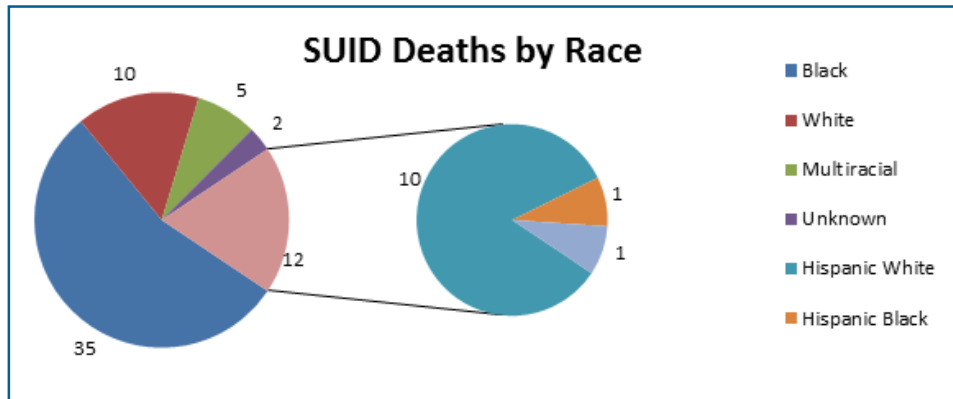
Below is a chart detailing the rates of the three main causes of sleep-related death. These were taken from the NMCHCCDR database, and therefore we used their definitions (so Asphyxia instead of ASSB). "SUID" is not a data entry option.



45 or 70.3% of the sleep-related deaths from 2011 reviewed by the SUID Subcommittee were classified as having causes of death of undetermined. 13 or 20.3% were classified as SIDS and 6 or 9.4% were classified as asphyxia.

## Race

Rates of sleep-related deaths for individual races/ethnicities are comparable to that of all child deaths. 35 or 54.7% were Non-Hispanic Black, 10 or 15.6% were Non-Hispanic White, 10 or 15.6% were Hispanic White, 1 or 1.6% were Hispanic Black, 5 or 7.8% were Multiracial, 1 or 1.6% were Unknown and 2 or 3.1% were unknown. No sleep-related deaths of Asian children were reviewed in 2011.

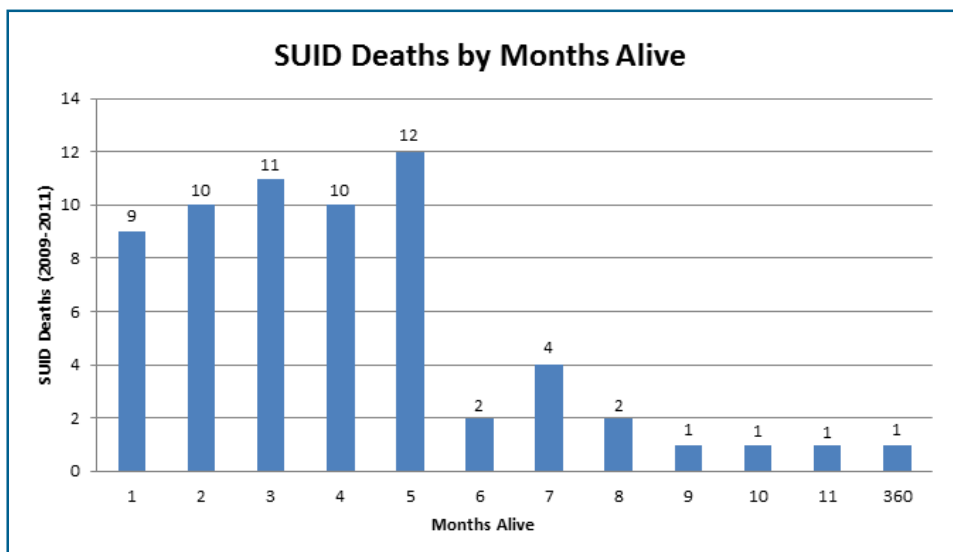


## Sex

Like race, gender of SUID deaths is comparable to gender of all child deaths. 39 or 60.9% were male and 25 or 39.1% were female.

## Age

By definition, all SUID deaths are of children under 12 months of age. When broken down into month-long increments, it is clear children under 5 months old have a higher chance of expiring due to sleep-related causes. 81.25% (52 of 64) of SUID deaths from 2011 reviewed by the CFNFRB took place when the infant was less than 5 months old.



## Sleep Environment

Infant sleep environment is a significant factor in determining risk of sleep-related death. Some types of furniture are designed for infants to sleep in (cribs, bassinets, play pens) while others are not (adult bed, couch). The incidence of SUID deaths that took place in an adult bed is higher than the rest (43.8% or 28 of 64 as compared to the next highest, deaths that took place in a crib, 17.2% or 11 of 64). This may be related to the fact that infants sleeping in adult beds are often also sleeping with adults (See section on Sharing of Sleep Surface).

Besides the actual environment, what is in the environment with the infant is also an important factor leading to risk of SUID. 15.6% (10 of 64) of the SUID cases from 2011 reviewed by the SUID Subcommittee had pillows in the sleep environment. 9.4% (9 of 64) had blankets in their sleep environment; the same amount had some other, undefined object in their sleep environment.

## Sharing of Sleep Surface

One of the most interesting findings from the data obtained from 2009 to 2011 sleep-related deaths reviewed is related to the sharing of sleep surfaces. Also known as Co-sleeping, bed-sharing is increasingly being incorporated in official causes of death, i.e. COD: Sudden Unexpected Death of Co-sleeping Infant, Sudden Unexpected Infant Death, Contributing factor: Co-sleeping. Although some propose that bed-sharing is good for maternal-infant bonding and facilitates breastfeeding, the AAP recommends against it, citing the potential risk of accidental roll-over (of adult onto infant) or suffocation outweighs any potential benefits. Of the 64 sleep-related infant deaths in 2011 reviewed by the SUID Subcommittee, 37 or 57.8% were sleeping with at least one other person at the time of their death.

## Maternal/Child Health Indicators

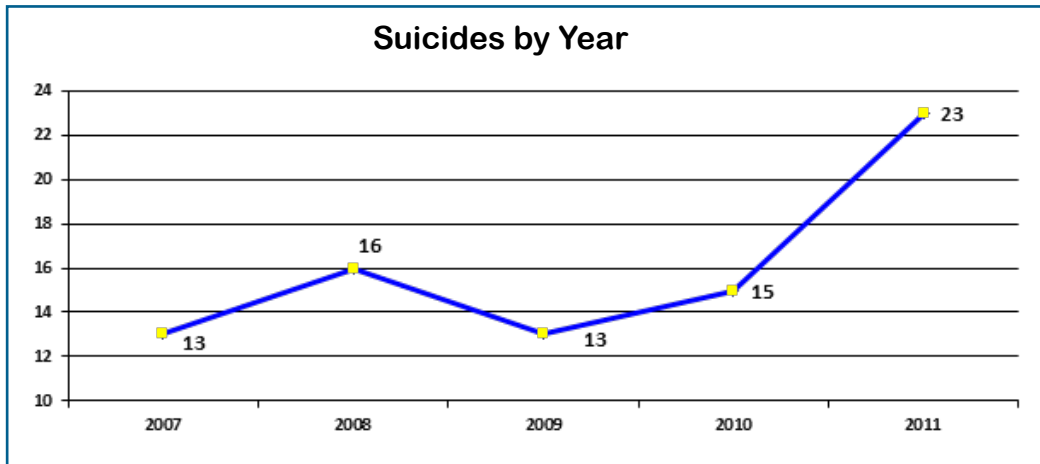
Many studies have shown a correlation between the lack of prenatal care and preterm birth (less than 37 weeks gestation) as well as a correlation between in utero exposure to tobacco smoke and preterm birth. The AAP recommends women receive regular prenatal care and avoiding smoking while pregnant as well as exposing infants to second-hand smoke, as SUID prevention measures. Below a chart shows rates of these maternal/child health (MCH) indicators among the 2011 sleep-related/SUID deaths reviewed by the CFNFRB's SUID Subcommittee as compared to rates for the entire State of New Jersey, as provided by the NJ Department of Health's MCH Epidemiology Program. The state-wide data is taken from Electronic Birth Certificates from 2011 and is considered provisional, as data from NJ residents born outside of NJ may not have been included. The difference between the provisional data and actual data is very small.

## Maternal / Child Health Indicators: SUID and NJ Births

In 2011, 1.0% of New Jersey births had no prenatal care, while 4.7% of the 2011 SUID cases reviewed by the CFNFRB had no prenatal care (a rate 5 times higher). 17.3% of NJ births had late prenatal care (prenatal care that began after the first trimester) as compared to 29.7% of the SUID cases. Tobacco use while pregnant occurred for 5.9% of NJ births in 2011, while the 2011 SUID cases were five times more likely, at a rate of 29.7%. NJ births in 2011 were 9.9% preterm, while the 2011 SUID cases were at a 2.5 times higher rate of 25.0%. Finally, 4.5% of NJ's births were of twins, whereas 10.9% (more than double) of the 2011 SUID cases were twins.

# SUICIDE DEATHS

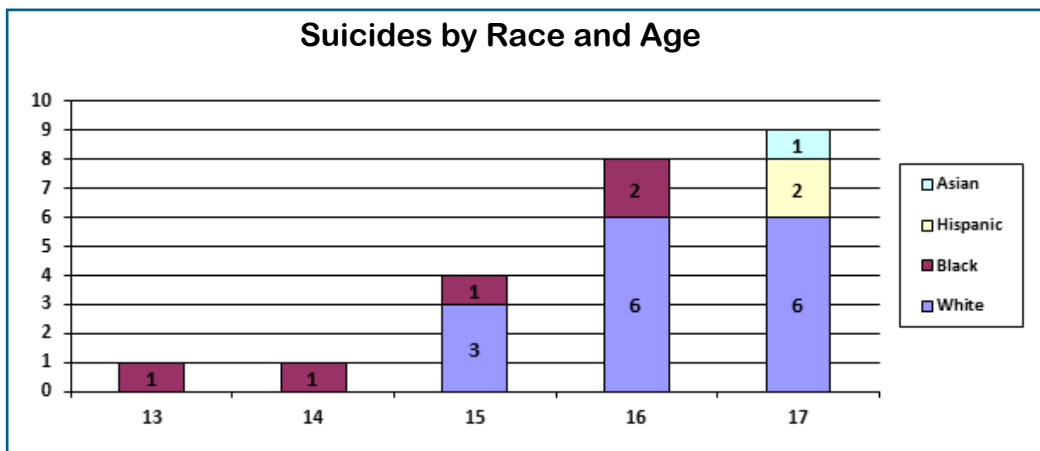
In 2011 there were 23 fatalities by suicide in the under 18 population. This is an increase from previous years.



## Suicides by Race and Age

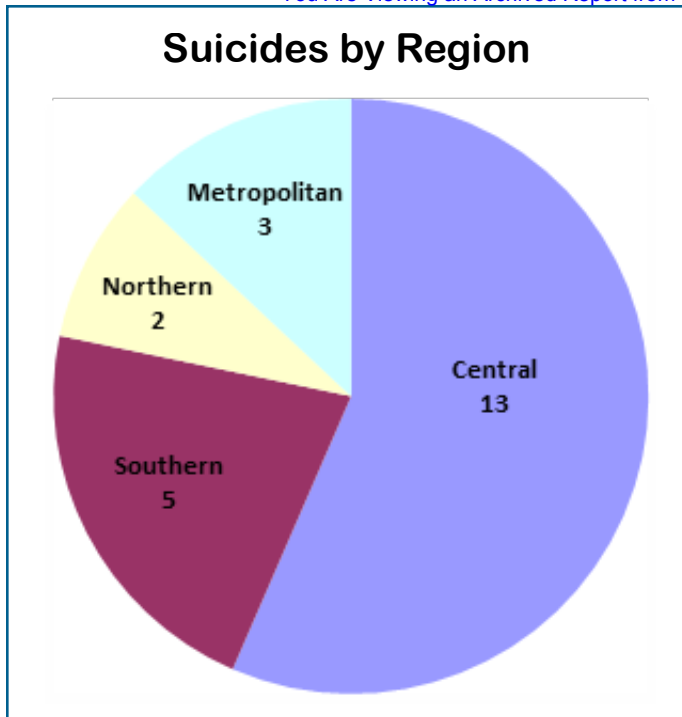
All of the children who committed suicide were between the ages of 13 and 17. The number of 16 year olds doubled that of the number of 15 year olds; and 74% of the victims were 16 or 17 years old.

Of these fatalities, 65% were White, 22% were Black, 9% were Hispanic, and 4% were Asian.



## Suicides by Region

There were a greater number of suicides occurring within the Central Region of New Jersey. Five of the 13 suicides from this region were from Monmouth County. There were three suicides within Essex County and one or two from each of the other 10 counties that experienced a suicide. Four of the five blunt force suicides occurred within the Central Region. Three of these were involving trains and the fourth was involving a semi-truck.



## Suicides by Gender and Method

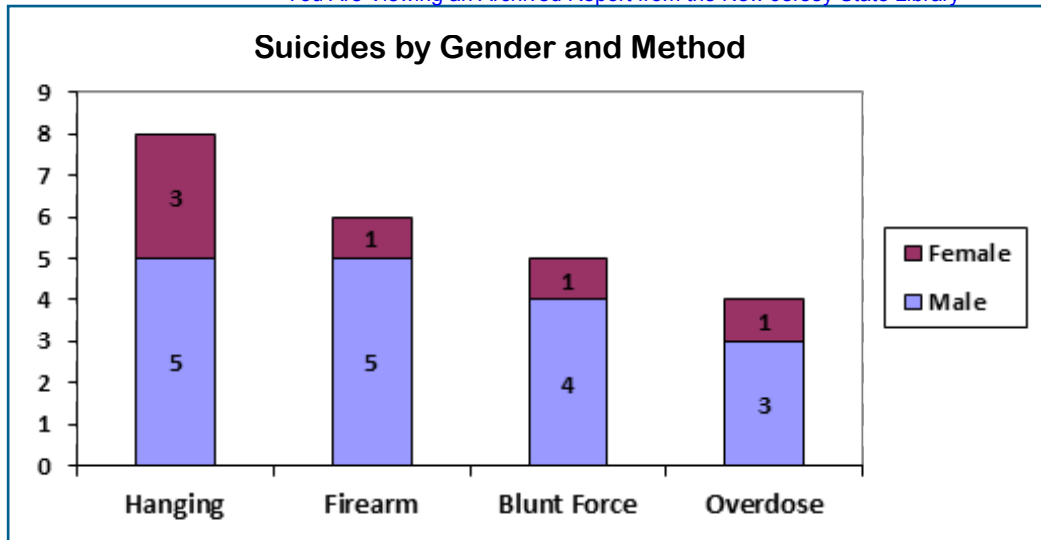
In 74% of the cases, the suicide victim was male, and in 26% of the cases, the victim was female.

In eight (8), or 35% of the cases, the children hung themselves; all were within their own homes. Four (4) or 50% of the hanging victims were also engaged in or exposed to domestic violence. One had a Temporary Restraining Order (TRO) taken against him by his child's mother a few days prior to his suicide. One witnessed domestic violence between his parents, one assaulted his sister, and one had a TRO against her for assault on her great-grandmother.

In six (6), or 26% of the cases, the child utilized a firearm. In four (4) of these cases the firearm belonged to the father, and in two (2) of the cases it is not documented who owned the weapon. In two (2) of the cases the weapon was stored in a secured gun safe, in one (1) case it was stored in an unsecured closet, and in three (3) cases it is not known or documented how the weapon was stored. In four (4) of the cases, the child had experience with firing a weapon and was familiar with gun safety practices. In two (2) of the cases, it is not known or documented if the child was familiar with gun safety.

In five (5), or 22% of the cases, the child was killed by blunt force trauma. Four of these cases involved the children jumping or laying in front of a train. One case involved the child running in front of a semi-truck.

In four (4), or 17% of the cases, the child was killed by taking an overdose of a medication. In all four cases it was prescription and over the counter medications. One was Oxycotin alone; the other three were multiple types. One of the children was prescribed medications for depression. In three of the cases the medications belonged to a family member and were unsecured in the home. In one case, it is not known or documented how the child had access to the pills. None of the four children had a known substance abuse problem.



## Adolescent Risk Factors

The three highest known risk factors for these 23 suicides were: school problems (70%), family conflict (61%), and relationship conflict (52%). Thirteen children, or 57%, experienced four or more risk factors in combination. Ten children, or 43%, experienced three or less of these risk factors in combination. It should be noted that in many cases, these risk factors are not known or documented in any investigation.

**School Problems:** Over half, 70%, of the victims displayed problems in school, including attendance, disciplinary, and academic concerns. One child had reported being bullied in the past. Three (3) children were classified by a Child Study Team.

**Family/Relationships:** In 14, or 61% of the cases family problems were noted prior to the suicide. These problems include severe conflict with and amongst family members as well as family members being absent from the home. In 12, or 52% of the cases relationship troubles with a boyfriend or girlfriend were noted. In five (5), or 22% of the cases domestic violence was an issue; two witnessed it between parents, two engaged in it with family members, and one witnessed it between parents and engaged in it with his baby's mother. In two (2), or 9% of the cases the child was experiencing LGBTQI issues; one girl talked about being in love with a younger girl and another talked about wanting to be a boy. Ten of the victims left a suicide note behind; via social media or other means, some in a text message or on Facebook, and one carved in a chair. Twelve or 52% of the victims had siblings under 18 living with them in the home.

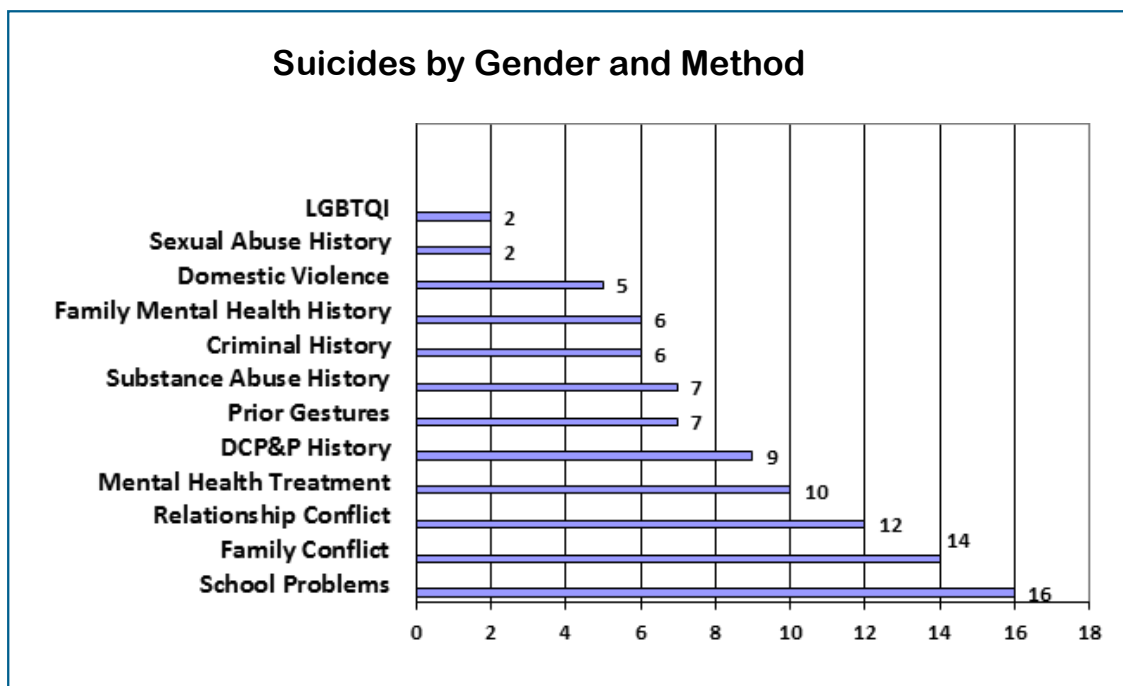
**Mental health:** In ten (10), or 43% of the suicide deaths the victims had a history of mental health diagnoses and treatment. Six (6) or 26% of the victims were engaged in treatment at the time of their death. Thirteen (13) or 57% of the victims had no mental health treatment history. Seven (7) or 30% of the victims made prior suicidal gestures or threats. Six (6) or 26% of the victims had a known family history of mental health diagnosis. Six (6) or 26% of the victims had a history of receiving services from the Division of Children's System of Care. Three (3) of which were open cases at the time of death, and three (3) were closed cases.

**Physical Abuse:** None of the victims had a substantiated history from DCP&P for physical abuse. However, nine (9), or 39% of the cases had previous DCP&P involvement. One (1) case was already open at the time of death, six (6) were closed for greater than one year, and two (2) became open cases at the time of the incident.

Substance Abuse: In seven (7), or 30% of the suicide fatalities, past or current drug or alcohol use was noted. In every one of the cases, marijuana was the drug of choice. Four (4), or 57% of the cases had positive toxicology reports from the autopsies, all of which were for marijuana, and one was in combination with an amphetamine. Ten (10) of the 23 suicide cases had positive toxicology reports, so six (6) of those had no other known substance abuse history.

Juvenile Criminal History: Six (6), or 26% of the victims of suicide had involvement with the juvenile justice system, for charges including possession of alcohol or drugs, harassment, destruction of property, domestic violence, shoplifting, and one child had gang involvement. Two (2) were on probation.

Sexual Abuse: Two (2) or 9% of the victims reported being sexually abused when they were younger. Both of them reported self-mutilation and ongoing suicidal ideation prior to their suicide.

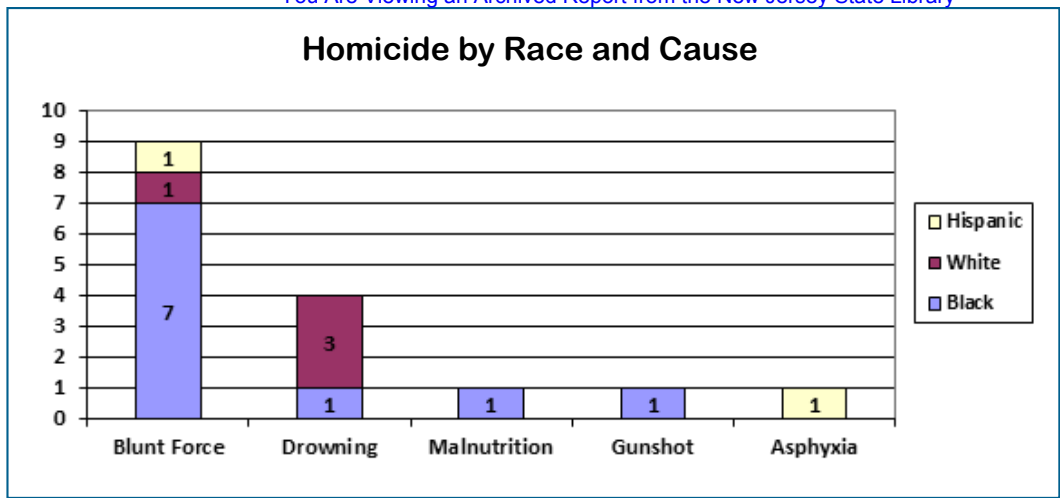


## HOMICIDE DEATHS

The Child Fatality and Near Fatality Review Board reviewed sixteen (16) homicide fatalities that occurred in 2011. Nine (9) victims suffered various fatal blunt force trauma injuries, four (4) victims suffered from drowning, one (1) victim died from severe malnutrition, one (1) victim died from a gunshot wound, and one (1) newborn died of asphyxia due to exposure and without immediate resuscitation when he was born into a toilet and his mother placed him into a plastic bag and tied it shut.

### Race of Homicide Victim

The majority, ten (10) or sixty-three percent (63%), of the homicide victims were Black. Four (4) or twenty-five percent (25%) were White, and two (2) or twelve percent (12%) were Hispanic.



Of the sixteen (16) homicide fatalities reviewed, DCP&P had an active case with two (2) of the families. Nine (9) cases were opened as a result of the child's homicide. Two (2) cases were closed over a year prior to the homicide, and two (2) cases were closed within a year of the fatality. In one (1) case, the family was not known to DCP&P.

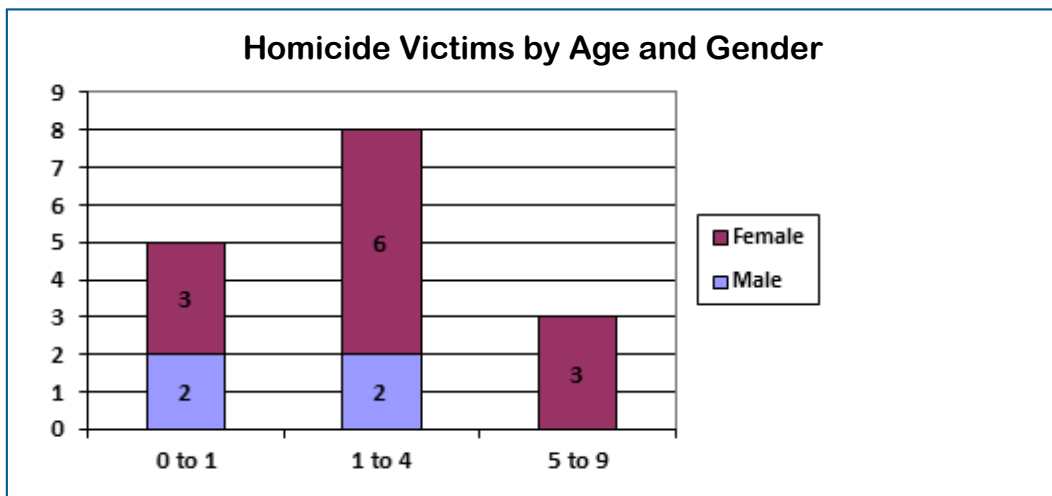
Two (2) of the homicides were not ruled to be related to child abuse and neglect. One of these was the case of an 11 month old victim of a murder-suicide where the mother drowned herself and the child in a tub, but the incident was not reported to DCP&P. The other was a two-year old child who was killed by a gunshot while he was playing with the gun. The remaining fourteen (14) homicides, eighty-eight percent (88%), were ruled to be related to child abuse and neglect and designated as CCAPTA cases.

## Age of Homicide Victim

Five (5) children under a year old were killed as a result of homicide. Eight (8) children ages one (1) to four (4) years old were killed. Three (3) children ages five (5) to nine (9) were killed.

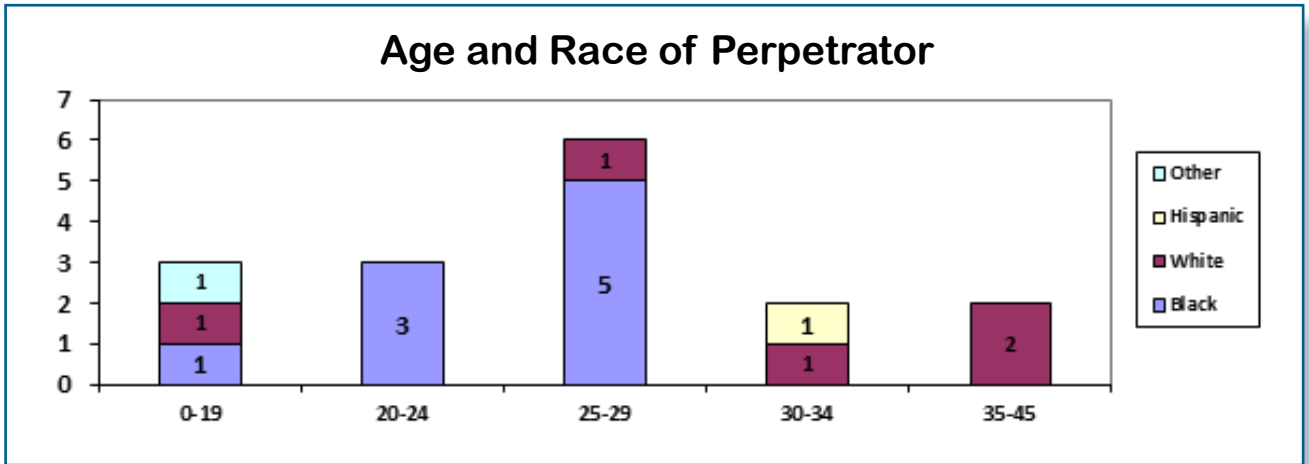
## Gender of Homicide Victim

Of the sixteen (16) homicide fatalities reviewed, four (4), or twenty-five percent (25%), of the victims were male and twelve (12), or seventy-five percent (75%), of the victims were female.

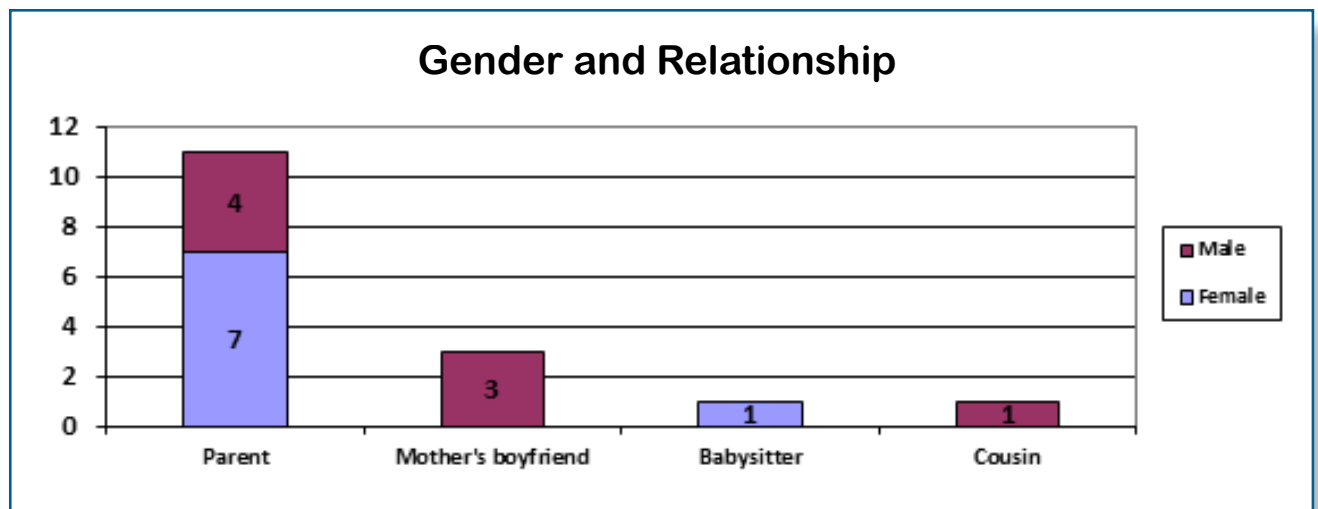


## Risk Factors for Victims of Homicide

The majority of the perpetrators were between the ages of 25 and 29 years old. The youngest perpetrator was an 11 year old child with severe autism. The majority of the perpetrators, fifty-six percent (56%) were Black. Thirty-two percent (32%) were White, and six percent (6%) each were Hispanic and Other.



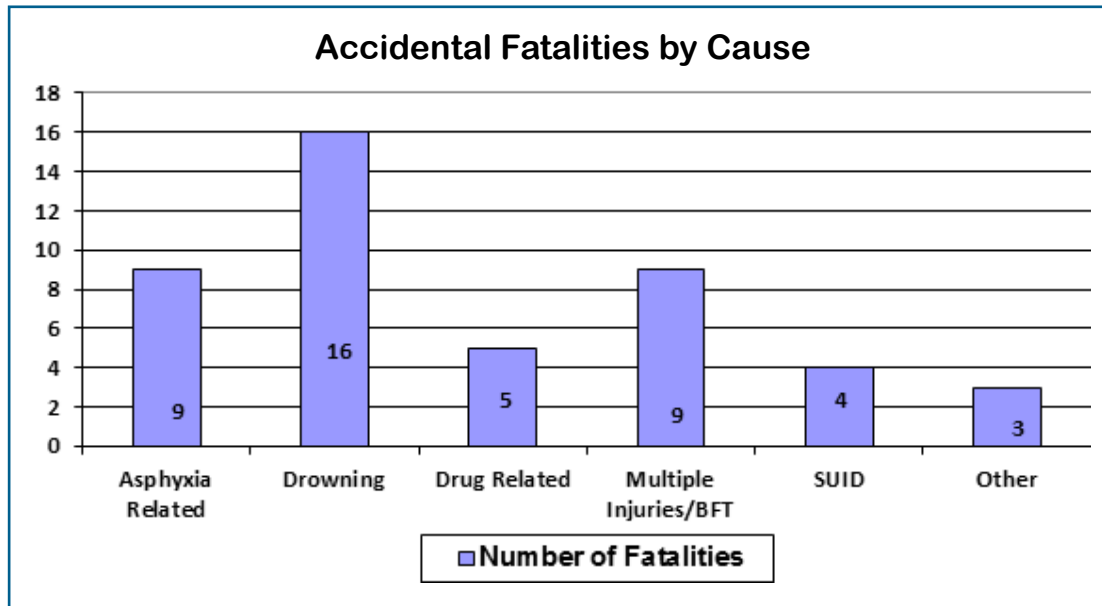
The genders of the perpetrators were evenly split, fifty percent (50%) were male, and fifty percent (50%) were female. The majority, sixty-nine percent (69%) were parents. Nineteen percent (19%) were the boyfriend of the mother, and six percent (6%) each were a cousin or a babysitter.



The records available for review revealed that thirty-eight percent (38%) of the perpetrators had a previous criminal history. Thirty-eight percent (38%) also had a domestic violence history. This included four that were perpetrators, one that was a victim, and one that was engaged as a victim and a perpetrator. Three of them were in current relationships, two were in past relationships, and one involved family members. Thirty-one percent (31%) had a history with DCP&P as a child. Some of the risk factors were not able to be identified based on the records available for review. Also, in four (4) of the cases, a second perpetrator was identified. Two (2) were also parents, one (1) was the mother's boyfriend, and one (1) was a friend of the mother.

# ACCIDENTAL FATALITIES

The CFNFRB reviewed 46 fatalities whose manner of death was certified as accident. The leading cause of accidents was drowning fatalities with 16 instances. There were nine (9) asphyxia related and nine (9) multiple injuries/blunt force trauma fatalities. Five (5) fatalities were drug related, four (4) were deemed SUID, and three (3) were other medically related.



## Asphyxia Related

The CFNFRB reviewed nine (9) cases where children died as a result of accidental asphyxia or hypoxia. A 40 minute old black, Hispanic child died as a result of fetal hypoxia due to maternal cocaine use. The child was born prematurely at 34 weeks gestation. A nine month old white female child died as a result of postural asphyxia. She was found submerged headfirst in a large tub of toys.

A three year old black male died as a result of compressional asphyxia. He was found under the body of his father who died due to atherosclerotic coronary heart disease. A six week old black female died as a result of asphyxia due to obstruction of her nose and mouth by contact with her mother's body (co-sleeping). The child was sleeping in her mother's bed in her mother's arms. A four month old biracial (white/black) female died due to positional asphyxia with co-sleeping in an adult bed. The child was placed to sleep between her mother and father in the parent's bed.

A four year old white, Hispanic male died as a result of asphyxia due to wedging. The child's crib mattress was placed adjacent to his parent's mattress with pillows placed in the gap. The child was found on top of a pillow with his face pushed against a mattress and pillow. An eight month old white male died as a result of asphyxia due to smothering by mattress in playpen. The child was placed to sleep on his side on a mattress in a playpen. The mattress left a gap or void space around it and the playpen.

The child was found face down, wedged between the mattress and playpen. A two month old black female died as a result of positional asphyxia associated with prone position while sleeping. The child was found unresponsive in the prone position with her face in (and surrounded) by blankets.

A 14 month old black male died as a result of asphyxia by choking due to aspirated food material. The child was left unattended with Swedish fish candy in his pack and play. The child's mother and father were substantiated by DCP&P for neglect.

## **Drug Related**

The CFNFRB reviewed 5 (five) cases where children died as a result of accidental drug-related fatalities. An eight year old white female died from acute Difluoroethane intoxication. The child inhaled fumes from a can of compressed gas typically used to clean computer keyboards.

A 17 year old white male died due to drug toxicity. He tested positive for alcohol and oxycodone. The teenager had a history of cutting, psychiatric hospitalization, substance abuse, and probation. A 16 year old white female died due to the adverse effect of drugs. She tested positive for heroin and oxycodone. The teenager had a history of substance abuse and mental health issues. A 15 year old white male died due to the adverse effect of drugs. He tested positive for anti-anxiety medication, marijuana and oxycodone. The teenager had a history of school truancy, substance abuse, and psychiatric hospitalization.

A 17 year old white male died due to clinical multi-organ failure. The teenager tested positive for opiates and marijuana. The teenager had a prior overdose. He had a history of psychiatric hospitalization, child study team involvement and police involvement.

## **Other – Medically Related**

A 25 week old black male died as a result of an unspecified upper respiratory tract infection with nasal obstruction. Positional asphyxia was listed as a significant condition contributing to the death. The child's father was substantiated by DCP&P for neglect.

Another child died at birth as a result of prematurity complicated by intra uterine pneumonia due to acute chorioamnionitis (inflammation of the fetal membranes). It was complicated by acute and chronic maternal cocaine and opiate abuse. The mother was substantiated for neglect by DCP&P. A three year old black male died from acute esophageal bleeding. The child swallowed a button battery.

## **Drowning Fatalities**

The CFNFRB reviewed 20 drowning fatalities which occurred in 2011. Sixteen (80%) of the drowning fatalities were determined to be accidental in manner; the manner of death was homicide in four (20%) of the drowning fatalities.

In two of the homicide cases, the mother drowned her child in a bathtub and then committed suicide. One of these two fatalities took place in a motel bathroom, and the other took place in the child's home. In one homicide drowning, the child was held underwater by her autistic relative. In the final homicide drowning, the child was thrown into a river by her father while in a car seat.

## Location of Drowning Fatalities

Ten (50%) of the drowning fatalities reviewed occurred in a pool. The majority (70%) of the pool drowning fatalities happened in a residential pool. Only three (30%) occurred in a non-residential, in-ground pool. Two of the non-residential, pool drowning fatalities occurred at a motel pool. In both of these incidents, the pool was not staffed by a lifeguard. In another non-residential, pool drowning, the 17 year old white female was at a campground. The teenager was playing an underwater, breath-holding game when she lost consciousness and drowned. This phenomenon is referred to as “shallow water blackout.”

Of the seven residential pool drowning fatalities, five (71%) took place in an in-ground pool. A one year old Middle Eastern male was able to access the family’s indoor, in-ground pool as one of the doors accessing the pool area did not have a functioning doorknob. A five year old white female was swimming with a sibling when she drowned. In two instances, children were able to exit their homes unsupervised and obtain access to the pool. In one case, a three year old white male was able to get out of the family’s house and into the pool unsupervised. The child had a history of previously getting out of the house unsupervised. In the second case, a one year old black male exited his unlocked house and got into the pool by way of a broken fence gate. A nine year old white female drowned as she was held down by her autistic relative. The children were left in the pool unsupervised by their grandfather. The grandfather was substantiated for child neglect.

Only two (29%) residential pool drowning fatalities occurred in an above-ground pool. In one instance, a five year old white male drowned. The child was with his family at a friend’s house for a BBQ. The child was using a flotation device, and he had a history of swim lessons. In another instance, a one year old black male drowned in a neighbor’s pool. The family was participating in a block party. The child was left unsupervised. A ladder was left near the pool.

Five (25%) of the drowning fatalities reviewed in New Jersey occurred in open water (i.e. lake, river, pond or ocean). A 16 year old black male drowned in a creek. He jumped or fell off a train bridge into the creek. His friends unsuccessfully attempted to rescue him. The child was unable to swim. A 15 year old black male drowned in the ocean. The teenager, who was unable to swim, was with friends. There were no lifeguards on duty. The teenager tested positive for alcohol. A two year old black female drowned in a river in which she was thrown by her father. The fatality was deemed a homicide, and the father was substantiated for child abuse.

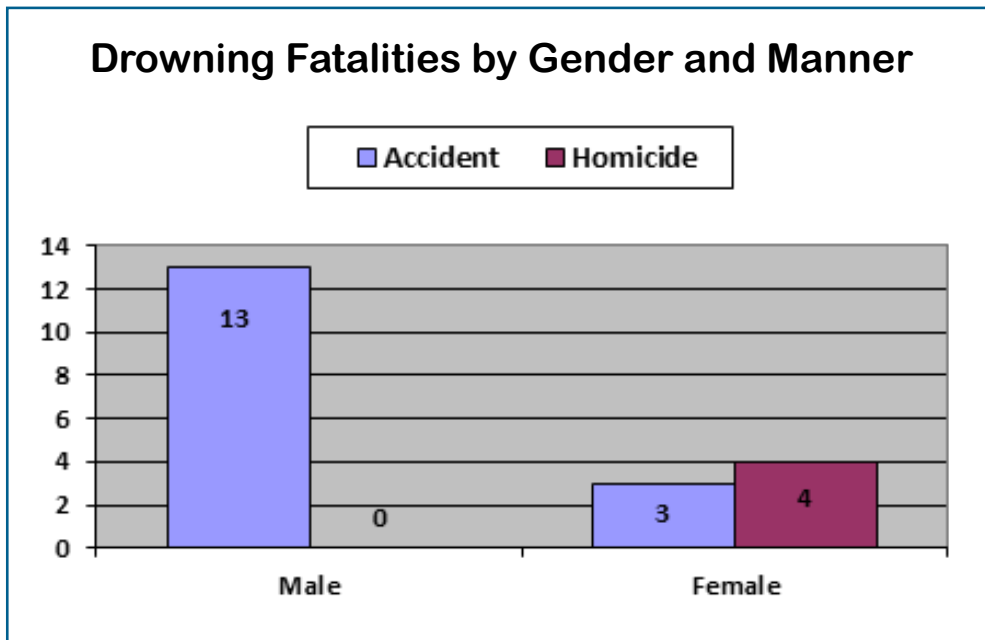
A two year old black male drowned in a lake. The child exited his home and went approximately 100 yards to a nearby lake. The child was described by his mother as nonverbal and autistic. The child had a history of leaving his home and heading for the water. A two year old black, Hispanic male drowned in a manmade lake, which was formerly an old sand mining pit. The lake is on private property, and it is not a designated recreation area. The child was unsupervised by his parents.

Four (20%) of the drowning fatalities occurred in a bathtub. Two of the incidents were deemed accidents, and two were deemed homicides. A 10 month old black male drowned in his home bathtub. His mother left the child briefly to get a towel and use another bathroom. A one year old white, Hispanic male was left unsupervised with another sibling. The child drowned in his family’s home bathtub. In both homicide cases, the white, female children (ages four years and 11 months old) were drowned by their mothers who then committed suicide. One occurred in a home bathtub, and one occurred in a motel bathtub.

In one of the drowning fatalities, a three year old white, Hispanic male drowned in a grease pit. The child was playing outside his family’s business when he fell into the uncovered pit. An employee failed to replace the manhole cover after dumping grease. As a result of this fatality, the city mandated grates be placed over grease pits.

## Gender of Drowning Fatality Victims

With regards to the 16 reviewed accidental drowning fatalities, 13 (81%) of the victims were male. Only three (19%) of the victims were female. With regards to the four homicide drowning fatalities, all four (100%) involved female victims.



## Reasons Why Children Drown

- Weak or no supervision
- Weak or no swimming ability
- Lack of life jacket or other floatation device use
- No or broken barriers (i.e. covers on hot tubs, fencing with self-latching gates surrounding pool, pool alarms, exposed ladders and diving boards, open containers/areas of water within child's reach, unlocked/broken doors accessing pools)
- Youth involved in risky behavior while swimming in water including, but not limited to, the use of drugs and alcohol and swimming in prohibited public areas of water
- Weak or no CPR skills
- Hyperventilating before going underwater or holding breath for long periods of time

## Supervision

Supervision plays an important role in the prevention of child drowning fatalities. Of the 20 drowning fatalities occurring in 2011, five of the caregivers were substantiated for inadequate supervision by DCP&P. In eight additional cases, the CFNFRB noted concerns regarding the caregiver's supervision. Many parents and caregivers often engage in distracting activities while they passively supervise their children in or near water. Some of these activities included talking with someone (in person or on the telephone), leaving the child briefly alone in or near water in order to get something from another room and/or inside the home, leaving child in the care of another sibling or young relative and/or caring for other children.

## Safety Precautions

There are many safety precautions pool owners can utilize in order to minimize drowning incidents. These include, but are not limited to, fences around the perimeter of a pool instead of using the back of the house as a fourth fence side, ladders are removed or stored appropriately when the pool is not in use, self-closing/self-latching gates are in working order, alarms on doors leading directly to pools, pool alarms, and lifeguards.

## Blunt Force Trauma

The CFNFRB reviewed nine (9) fatalities from 2011 in which the manner of death was accident, and the cause was blunt force trauma. Six (6) or sixty-seven percent (67%), of these cases involved motor vehicles, and all six were males between the ages of 15 and 17 years old who tested positive for either marijuana or alcohol, or both. The first case involved three high school football players who died in a motor vehicle accident (MVA). Several MV violations were identified: all three tested positive for marijuana, there were eight students in the SUV, which was a violation of the provisional driver's license, only the driver and two other students were wearing seatbelts, and the driver was text messaging, and driving recklessly. There was a fourth child who also died at the crash, but was not reviewed, as his toxicology was negative for any substances. In another case a teen crashed into a tree and tested positive for marijuana and alcohol. His driver's license had been suspended two months prior to the accident after he was arrested on stolen vehicle charges. In another case a teen was driving a stolen SUV and crashed into a concrete barrier, and tested positive for marijuana. In another case, three high school baseball team members were driving together. One passenger was ejected from the vehicle, resulting in his fatality, after the teen driver was driving recklessly and at excessive speeds, hitting another vehicle. This was also a violation of the provisional driver's license, as he should have had only one other teen in the vehicle. The child who died tested positive for alcohol.

In one (1) case an 11 year old female fell from a Ferris wheel onto a sea shore boardwalk.

In one (1) case a 9 month old female had a television fall onto her.

In one (1) case a 16 year old male was walking on a train track bridge with two friends and was struck by the train. He tested positive for marijuana.

## CHILD PROTECTION AND PERMANENCY (CP&P)

“The Division of Child Protection and Permanency, DCP&P (formerly the Division of Youth and Family Services, DYFS), is New Jersey's child protection and child welfare agency within the Department of Children and Families. Its mission is to ensure the safety, permanency and well-being of children and to support families.

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 all 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 who investigates.”<sup>7</sup>

“The State Central Registry (SCR) is a 24 hour, 365 day a year, state-of-the-art call center. SCR receives approximately 15,000 phone calls each month.”<sup>8</sup> Many of these phone call referrals are forwarded to one of the 47 DCP&P Local Offices for investigation of child abuse and/or neglect or assessment of child welfare needs.

“The Institutional Abuse Investigation Unit (IAIU) is a child protective service unit that investigates allegations of child abuse and neglect in out-of-home settings such as foster homes, residential centers, schools, detention centers, etc. IAIU consists of a Central Administrative Office and four Regional Investigative Offices.”<sup>9</sup>

As of June 2011, approximately 48,450 children were receiving services from DCP&P.<sup>10</sup> The Child Fatality and Near Fatality Review Board (CFNFRB) and its regional teams identified and reviewed a total of 158 fatalities and 12 near fatalities which occurred in 2011.

In thirty-one (18%) of cases reviewed, DCP&P had an open case with the family at the time of the fatality or near fatality, and they were offering some type of family intervention (i.e. child welfare assessment, protective service investigation, or care and supervision).

DCP&P had terminated involvement with nine (5%) of the families within the 12 months preceding the fatality or near fatality. Twenty-six (15%) of the families had a history with DCP&P greater than 12 months prior to the child's fatality or near fatality. In fifty-six (33%) of the cases reviewed, DCP&P responded to a call on or after the date of the child's injury or death.

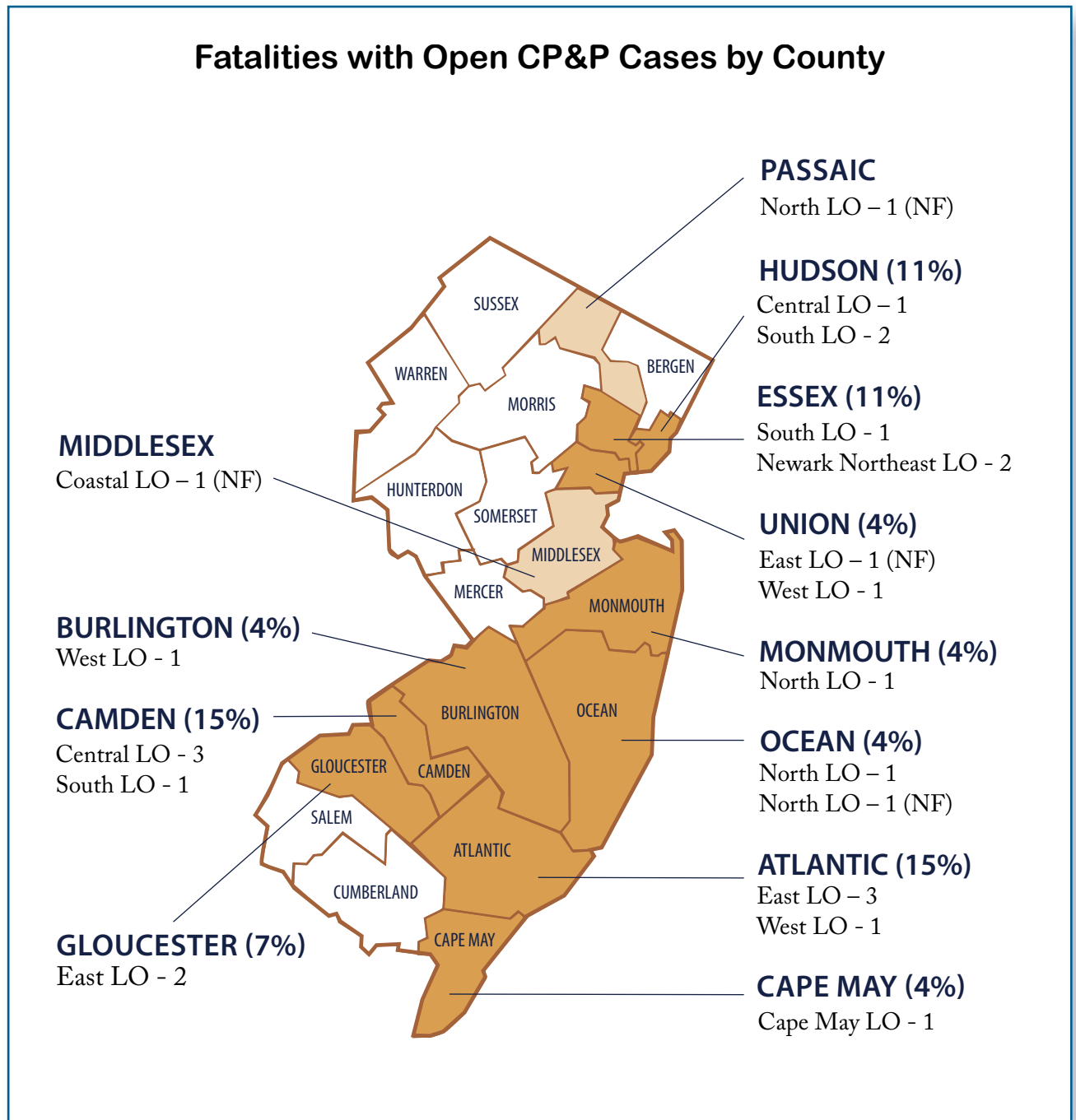
<sup>7</sup> Department of Children and Families. 2013. State of New Jersey. <http://www.state.nj.us/dcf/about/divisions/dcpp/>

<sup>8</sup> Department of Children and Families. Annual Agency Performance Report. New Jersey, 2011. Page 8. [http://www.state.nj.us/dcf/documents/about/AnnualAgencyReport2011\\_110911.pdf](http://www.state.nj.us/dcf/documents/about/AnnualAgencyReport2011_110911.pdf)

<sup>9</sup> Department of Children and Families. 2013. State of New Jersey. <http://www.nj.gov/dcf/about/divisions/iaiu/>

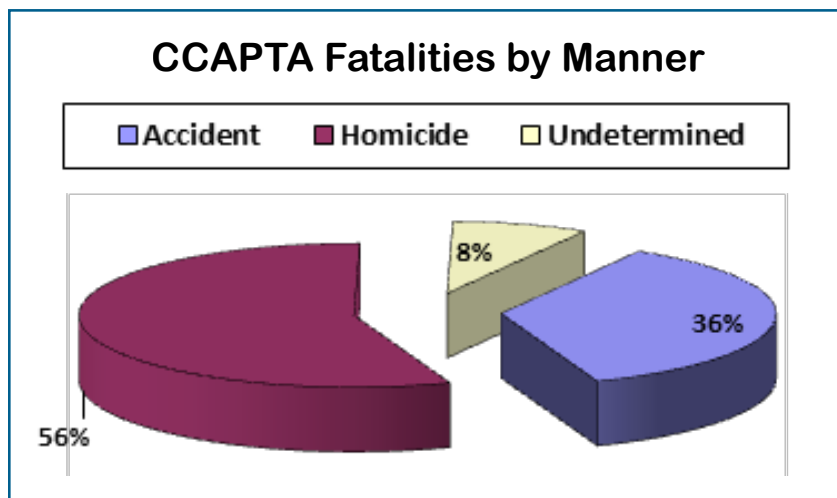
Forty-eight (28%) of the cases reviewed had no DCP&P involvement prior to the child's injury or death. These cases include fatalities which were either not reported to SCR (36) or were reported, but did not rise to the level of complete a child protection services (CPS) investigation or a child welfare service (CWS) assessment (12).

In 2011 the CFNFRB found a higher incidence of fatalities with open DCP&P cases in Mercer County with five (19%) fatalities.



## CCAPTA Fatalities by Manner

Of the 25 CCAPTA fatalities reviewed, homicide was determined to be the leading manner of death with fourteen (56%) incidents followed by accident with nine (36%) incidents. Two (8%) cases reviewed were certified undetermined.



## CCAPTA Fatalities by Cause

Multiple injuries, including blunt impact injuries and severe non-accidental head trauma was the leading cause of death for the CCAPTA fatalities reviewed with eleven (44%) cases total. The manner of death in ten of these cases was homicide; one of these fatalities was certified as undetermined.

There were six (24%) CCAPTA fatalities involving a child who drowned. Four were accidents and two were homicides. One child died as a result of homicidal violence including being submerged in water. Six (24%) fatalities were a result of asphyxia, hypoxia or SUID. Five of these fatalities were ruled accidents, and one was certified a homicide. In the homicide case, the child died as a result of asphyxia due to exposure without receiving immediate resuscitation. The child was delivered into a toilet and found wrapped inside a tied plastic bag.

In one (4%) case, a child died as a result of a methadone drug overdose. This fatality was certified as undetermined. In one (4%) case, a child died as a result of severe malnutrition and medical negligence. This fatality was ruled a homicide.

Three (25%) children were severely injured due to blunt force impact. Two children were involved in motor vehicle accidents. In one case, the child's father tested positive for alcohol. In the other case, the child's father purposely hit another vehicle in an attempt to injure his family. The child's father died as a result. In both cases, the father was substantiated. In another case, the child was thrown from a vehicle by her mother.

Three (25%) children nearly drowned. Two children nearly drowned in a bathtub due to inadequate supervision. In both cases, the child's father was substantiated for neglect. In another case, the child nearly drowned in a koi pond. The mother was substantiated for neglect, inadequate supervision.

In one (8%) CCAPTA near fatality case, the child experienced liver failure and seizures. The child's mother was substantiated for neglect.

## CCAPTA Substantiated Perpetrators

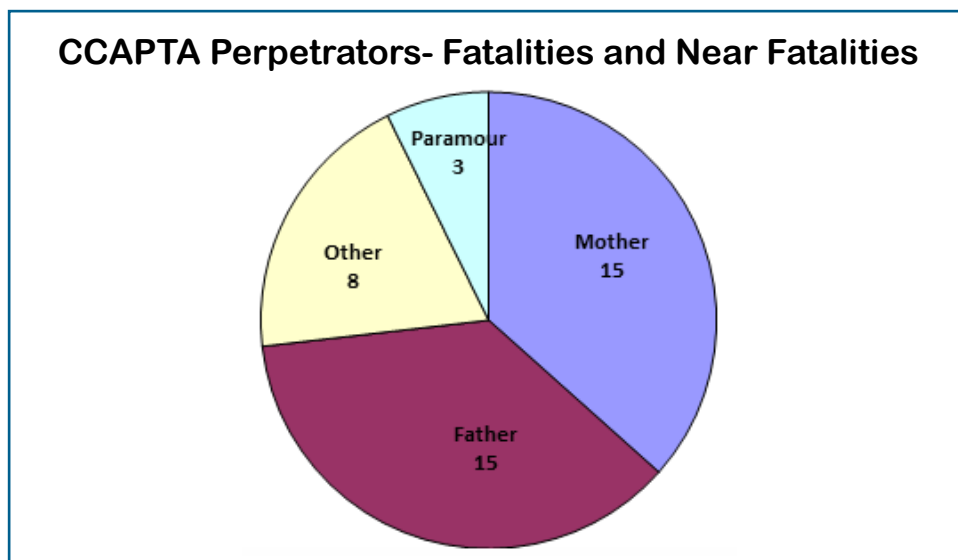
The CFNFRB found that in the 37 CCAPTA fatalities and near fatality cases there were a total of 41 substantiated perpetrators. Thirty (73%) of the 41 substantiated perpetrators were parents. The mother accounted for fifteen of the substantiations; the father was also substantiated in fifteen instances. In three cases, both the mother and father were substantiated as perpetrators in their child's fatality or near fatality.

The mother's paramour was involved as a perpetrator in three (8%) of the cases. In all three cases, the children suffered blunt impact trauma resulting in their deaths.

Relatives were perpetrators in two (5%) cases. In both cases, the children drowned. In one case, the maternal grandfather was substantiated due to lack of supervision. In another case, the maternal aunt was substantiated due to lack of supervision. The child exited the home and drowned in the family's pool.

In four (11%) cases, there was an unknown perpetrator. In two cases, the children died. A child died as a result of morphine drug overdose, and a child suffered a subdural hematoma due to blunt force trauma of head. In two cases, the children received severe, near fatal injuries due to non-accidental trauma. In all four cases, the medical examiner, law enforcement and/or DCP&P were unable to determine who inflicted these injuries to the children.

Two (5%) babysitters were substantiated for abuse. One child died as a result of blunt head trauma, and one child died of SUID associated with positional asphyxia.



## CFNFRB FUTURE PRACTICE

The CFNFRB has historically made annual recommendations. The CFNFRB recognizes that this practice causes a delay in the distribution of recommendations that are unequivocally deemed as important to current practice for any discipline. As a result, the CFNFRB plans to issue interim recommendations in the hope that they can offer strategies in 'real-time' that change current practices which could prevent child fatalities and near fatalities. Consistent with the CFNFRB's practice, these recommendations will be made based on the facts of a case or cases but will not identify for the public any child or family.

## RECOMMENDATIONS THAT CONTINUE FROM PRIOR ANNUAL REPORTS

The CFNFRB has identified a number of key recommendations that have yet to be addressed and remain areas of concern. The CFNFRB continues to feel strongly that the implementation of these recommendations would provide substantive change to current practices that result in on-going harm and risk that lead to fatal and near-fatal acts.

### DEPARTMENT OF LAW AND PUBLIC SAFETY

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#### *Office of the Attorney General - Appointment of State Medical Examiner*

During its 14 years in existence, the CFNFRB has observed inconsistencies in the practices of different County Medical Examiner offices. Without an appointment of a State Medical Examiner, no uniform forensic investigatory practices can be enforced, which creates a disservice to the citizens of New Jersey by impacting the quality and value of autopsies and death scene investigations throughout the State. The "Revised State Medical Examiner Act" was introduced on January 10, 2012 to address this matter.

The CFNFRB commends the progress, by consensus and not mandate, that has occurred within the Office of the State Medical Examiner under its current leadership. However, the CFNFRB continues to strongly recommend that a permanent State Medical Examiner be appointed with the authority to ensure policies and procedures are consistent throughout all of the medical examiner offices and with the recommendations of the National Association of Medical Examiners (NAME).

## OFFICE OF THE ATTORNEY GENERAL AND THE DEPARTMENT OF CHILDREN AND FAMILIES

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### *Multi-Disciplinary Investigation Protocol*

The Child Fatality Multi-Disciplinary Investigation Protocol is currently being developed by Gloucester County Prosecutor, Sean Dalton, with collaboration from multiple agencies including the Department of Children and Families (DCF). It outlines the expectations, roles, and responsibilities of each agency involved in a child fatality investigation; and it strives to provide clarity where roles may be unclear.

The CFNFRB continues to recommend that the Office of the Attorney General issue a directive mandating the Child Fatality Multi-Disciplinary Investigation Protocol be approved and implemented with the multiple agencies involved in a child death investigation; including emergency medical services, law enforcement, Medical Examiner's Office, hospitals, and the Division of Child Protection and Permanency (DCP&P).

## DEPARTMENT OF CHILDREN AND FAMILIES

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### *Child Protection and Permanency – Risk Reassessment*

The CFNFRB has observed that DCP&P's risk assessment and reassessment tool has not been consistently implemented, with particular concerns in cases where an override exists without the use of the tool to inform that decision. The CFNFRB is aware that DCP&P is currently evaluating the appropriateness of the tool, and the effectiveness of its implementation. The CFNFRB believes that a systematic, consistent, protocol should be created as a standard to determine how to make decisions when risk has been mitigated. During the interim period of the Division's evaluation, all cases where risk is lowered should be documented with the current available tools. There should also be a mechanism where multiple referrals, regardless of outcome, create an elevated degree of risk, which cannot be overridden without dynamic and clear guidelines.

## OUTCOMES OF PAST CASE REVIEWS AND/OR FORMER RECOMMENDATIONS

## NEW JERSEY HOSPITAL ORGANIZATION

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### *Reporting to DCF*

The CFNFRB commends the response received from a hospital organization which revised their policy and procedure regarding reporting child abuse and neglect to reflect a requirement that complex cases be subjected to a case conference involving clinical leadership from the treating unit, behavioral health leadership and risk management. The CFNFRB had raised concerns that a child who suffered from depression with psychotic features, was removed from the behavioral health unit Against Medical Advice and no report to DCP&P was made regarding the safety of the child.

## DEPARTMENT OF EDUCATION

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### *Suicide Prevention and Response*

The CFNFRB commends the Department of Education (DOE) on its youth suicide prevention and response efforts. The DOE supported the development and dissemination of *Managing Sudden Traumatic Loss in the Schools: New Jersey Adolescent Suicide Prevention Project*<sup>11</sup>. In addition to disseminating the manual, the DOE followed up with a five-part video series for administrators, crisis teams and faculties, as well as for the preparation of students for funeral services.

The DOE also developed the concept for and originally funded the establishment of the current county-based Traumatic Loss Coalitions for Youth<sup>12</sup>. The coalitions, now funded by DCF, function as primary sources of ongoing support to schools with trainings, technical support and incident response.

As per N.J.A.C. 18A:6-113, Core Curriculum Content Standards (CCCS) in Comprehensive Health and Physical Education appropriately include the subject of suicide (or intentional injury) prevention in elementary, middle and high school curriculums.

The CCCS can be found at <http://www.state.nj.us/education/cccs/standards/2/index.html>.

In addition to the DOE's efforts, New Jersey has many resources for suicide awareness and prevention. Although the following list is by no means exhaustive, it does highlight some of these resources available to the public.

- **DCF Adolescent Suicide Report**  
[http://www.nj.gov/dcf/families/csc/prevention/documents/AdolSuicideRpt\\_6\\_1\\_12.pdf](http://www.nj.gov/dcf/families/csc/prevention/documents/AdolSuicideRpt_6_1_12.pdf)
- **DCF NJ Youth Suicide Prevention Plan 2011-2014**  
<http://www.nj.gov/dcf/families/csc/prevention/documents/preventionplan.pdf>
- **NJ Traumatic Loss Coalition**  
<http://ubhc.umdnj.edu/brti/tlc/>
- **NJ Youth Suicide Prevention Advisory Council**  
<http://www.nj.gov/dcf/families/csc/prevention/>
- **GLSEN (Central Jersey Chapter)**  
<http://chapters.glsen.org/cgi-bin/iowa/centralnj/home.html>
- **2nd Floor**  
<http://www.2ndfloor.org/>
- **NJ Hopeline**  
<http://www.state.nj.us/humanservices/news/press/2013/approved/20130508.html>
- **Jersey Voice**  
<http://www.jerseyvoice.net/>

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<sup>11</sup> Underwood, M & Dunne-Maxim, K. (revised 1997). *Managing Sudden Traumatic Loss in the Schools: New Jersey Adolescent Suicide Prevention Project*. NJ Departments of Education, Human Services, and Health and Senior Services and UMDNJ – University Behavioral HealthCare.

<sup>12</sup> Rutgers University Behavioral Health Care/Behavioral Research and Training Institute. (2011). *Traumatic Loss Coalition for Youth Program*. <http://ubhc.rutgers.edu/brti/tlc>

The CFNFRB strongly encourages schools to utilize the resources and guidance made available by the New Jersey State Department of Education. The CFNFRB further encourages individual Boards of Education at the local level to identify mechanisms within schools for easy and anonymous reporting when students are concerned about their peers.

## DEPARTMENT OF CHILDREN AND FAMILIES AND DEPARTMENT OF HUMAN SERVICES

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### *Guidelines of Expert Evaluations*

During the past year, DCF and the Department of Human Services (DHS) have adopted recommendations from the Ad Hoc Task Force on Mental Health Evaluations, which was previously suggested by the CFNFRB. These guidelines have been appended to all existing contracts for mental health providers working with both departments. The CFNFRB understands it is DCF's intention to provide opportunities for contracted clinicians to understand the expectations and to contribute to their implementation. The written expectations will increase accountability and are a direct result of systemic issues wherein contracted providers have not provided an adequate product (i.e. evaluations, reports or assessments) for court purposes. Common errors included the failure to request, receive, or review documents necessary to formulate a clinical diagnosis, treatment plan or a statement about the treatment necessary to mitigate current or future risk. It is the CFNFRB's concern that the failure to consider this critical information leads to faulty assessment and identification of risk. The CFNFRB looks forward to the full implementation of these guidelines.

## DEPARTMENT OF CHILDREN AND FAMILIES

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### *Reviewing State Child Abuse Hotline Calls*

The CFNFRB was concerned that all relevant information gathered by screeners at the State's Child Abuse Hotline, the State Central Registry (SCR), needed to be communicated clearly to the investigator responsible for the field response. In 2011, the CFNFRB strongly recommended that immediate action be taken allowing Local Office staff at DCP&P access to review hotline calls to assist them with their investigations/assessments. The CFNFRB understands this will allow additional information to be available to the field response and investigation that may not have been included in the written documentation of the call. The CFNFRB is pleased that the technology to allow investigators to listen to calls was developed and made effective in July 2013.

### *Four Tier Model of Child Abuse Findings*

The CFNFRB is pleased to recognize a new Four Tier Model of child abuse findings, which was made effective on April 1, 2013 by DCP&P. The former two tier model of findings, of either "substantiated" or "unfounded", has been replaced by a four tier model of either "substantiated", "established", "not established", or "unfounded". The CFNFRB notes that this will allow for improved consistency of investigative findings.

### *Public Service Announcement on Water Safety*

The CFNFRB is pleased that in July 2013 the New Jersey Department of Children and Families (DCF) launched a partnership with the private sector to provide a public safety education effort which reminds adults never to leave a child unattended around water. The campaign includes a public service announcement made by the Commissioner of DCF as well as available free resources <sup>13</sup>.

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<sup>13</sup> Department of Children and Families (2013). Child Safety Campaigns: Not Even for a Second.  
<http://www.nj.gov/dcf/families/safety/water/>

*Administrative Office Of The Courts – Judiciary Relationship with CFNFRB*

As a result of the CFNFRB's prior recommendation that the Judiciary provide better access to information regarding the court involvement of families who have experienced a child fatality or near fatality, the Administrative Office of the Courts (AOC) issued a statewide directive permitting the CFNFRB access to recordings of court proceedings involving such cases. This review will enhance the CFNFRB's understanding of the courts' decision-making process in specific cases, as well as provide the CFNFRB with broader knowledge of the context in which courts make child welfare decisions. The CFNFRB appreciates the AOC's partnership and further recommends that the AOC provide education and training to the Judiciary to enhance its knowledge and understanding of the circumstances which pose an increased risk of harm to children which may result in a child fatality or near fatality.

**CURRENT RECOMMENDATIONS**

**DEPARTMENT OF CHILDREN AND FAMILIES**

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*Domestic Violence Joint Task Force*

The CFNFRB recognizes that a multidisciplinary joint task force was recently established by the DCF Commissioner; including members representing the court system as well as the Domestic Violence Fatality and Near Fatality Review Board. The intended purpose of the task force was to clarify what information domestic violence reports should include, the protocol for sharing with DCP&P, and the role of the domestic violence liaison within the DCP&P local offices. The CFNFRB supports the creation of this joint task force and requests periodic reports on their work.

*Task Force on Child Abuse and Neglect – Domestic Violence Batterers Intervention*

The CFNFRB recognizes that the NJ Task Force on Child Abuse and Neglect has created a batterer accountability work group to develop recommendations for a protocol for the Prosecutor's Offices concerning the co-occurrence of domestic violence and child abuse. The CFNFRB recommends that this group review the batterer programs of other states to inform their recommendations for the implementation and evaluation of treatment programs for batterers.

*Division of Child Protection and Permanency (DCP&P) – Clinical Consultants*

The CFNFRB acknowledges that DCF has made available to Local Office staff through contracts a Clinical Consultant, whose role is to consult with staff when there are questions/concerns about a child's mental health status, treatment, diagnosis or needs. The CFNFRB recommends the role of the Clinical Consultant be standardized to provide for better consistency statewide. Furthermore, the CFNFRB recommends that DCF create performance standards for use when evaluating the effectiveness of the service. The CFNFRB has commended DCF in the past for the successes and accomplishments of the Child Health Units and would suggest that model be examined for this process.

## *Division of Children's System of Care (CSOC) – Extended Hospitalization Services*

The CFNFRB acknowledges that the CSOC has a range of services available through contracted agencies to meet the needs of children and youth with mental/behavioral health needs. The CFNFRB is concerned about the availability of services for extended assessments/hospitalizations for youth whose behaviors necessitate treatment in a secure facility. The CFNFRB therefore recommends expanding the availability of inpatient psychiatric intermediate care facilities, and creating other means of admissions to these services, aside from a referral by a Children's Crisis Intervention Services (CCIS) unit.

### *Reporting To DCP&P*

The CFNFRB recommends that the CSOC contact the DCP&P in cases where a child has severe mental health issues and has either voluntarily terminated or is non-compliant with their CSOC treatment services, whereby placing them at high risk. The CFNFRB acknowledges that services provided through the CSOC to children, youth and families are done so on a voluntary basis. However, in limited circumstances, the failure or non-compliance of families to address the mental/behavioral health needs of the child/youth may contribute to increased risk and may warrant child welfare involvement.

## **DEPARTMENT OF EDUCATION**

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### *Home-Schooling*

The CFNFRB recommends that the DOE review the specific requirements for children with severe emotional disabilities who are removed from school by their parents to be home-schooled and are no longer under the supervision of the local school district. The CFNFRB has remained concerned that this subset of youth may not be receiving adequate school instruction specific to their emotional/behavioral needs.

### *Safe Sleep Education*

The CFNFRB recommends that the DOE revise middle and secondary health curricula to include Healthy Infant Sleep education as outlined by the American Academy of Pediatrics. Not only will this teach the parents of tomorrow how they can minimize the risk of SIDS and other sleep-related infant deaths but it will also educate current care providers (be they older siblings or babysitters) whose knowledge may help inform the community at large of these simple preventative practices.

## **DEPARTMENT OF LAW AND PUBLIC SAFETY**

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### *Office of State Medical Examiner – Suspected Suicide Death Investigation Tool*

The CFNFRB has observed that in the cases of suicide fatalities, there is often little information gathered regarding the potential risk factors, mental health history, medication history, and even on the storage/security of firearms. This presents a gap in knowledge about any preventative information regarding suicides, which in turn limits the CFNFRB's ability to complete a thorough and meaningful review and the ability to make more specific recommendations on this type of fatality. Therefore, the CFNFRB recommends the Office of the Medical Examiner create a standard form and protocol of its use to be disseminated to all local Medical Examiners for use in all suicide fatalities. The CFNFRB notes a similar tool and process exists for the investigation around a Sudden Unexplained Infant Death Investigation.

### *Pediatric Expertise*

It is the understanding of the CFNFRB that any person practicing as a medical examiner within the State of New Jersey is required to obtain a minimum of 20 continuing medical education (CME) credits every two years. It is also the understanding of the CFNFRB that the Assistant State Medical Examiner reviews and approves each of these credits. The CFNFRB recommends that the Medical Examiner's Office requires that five (5) of these 20 mandated credits become allocated within the pediatric sphere to address the evolution of pediatric care and ensure medical professionals are current in practice and standards specific to pediatric medicine.

### *Skeletal Surveys*

The CFNFRB encourages proper x-rays be completed on all children, and recommends that all of the New Jersey Medical Examiner Offices comply with the American College of Radiology standards for skeletal surveys.

## **NEW JERSEY HOSPITAL ASSOCIATION AND DEPARTMENT OF HUMAN SERVICES**

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### *Out of State Hospital Services*

The CFNFRB has observed that there are occasions where ill children are sent to hospitals out of state, despite adequate services being available within state. This presents a potential burden on the families involved and has a significant fiscal effect on NJ hospitals. The CFNFRB recommends that the NJ Hospital Association and the Department of Human Services examine this practice and recommend that services are prioritized to be within state.

## **DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF HEALTH**

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### *Perinatal Risk Assessment Form*

The CFNFRB recommends that the standardized Perinatal Risk Assessment (PRA) form be created and used at all Federally Qualified Health Care Centers for their first encounter with a pregnant woman. The CFNFRB hopes that wide spread use of this standardized PRA would identify risks, such as domestic violence and substance abuse, and that those identified cases could be referred for services. The CFNFRB also hopes that this information would be reviewed by the DHS and shared with the Medicaid Managed Care Organizations.

## **DEPARTMENT OF HEALTH**

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### *New Mother Visiting Nurse Program*

The CFNFRB recognizes the benefit of having a universal visiting nurse program for all new mothers. This prevention initiative has been shown to be the best intervention to reduce inflicted trauma in new born babies, especially as it relates to educating mothers about crying and frustration.

## NEW JERSEY AMERICAN ACADEMY OF PEDIATRICS (NJAAP)

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### *Public Service Announcement on Small Magnetic Toys and Batteries*

The CFNFRB is concerned about the small magnetic toys, known as “Buckyballs”, which can stick together inside a child and cause serious harm, including perforations to the intestines, if ingested. The CFNFRB is also concerned about injury regarding small batteries. Thus, the CFNFRB recommends that the AAP consider making a Public Service Announcement (PSA) regarding these concerns.

## NEW JERSEY HOSPITAL ASSOCIATION AND NEW JERSEY COUNCIL OF TEACHING HOSPITALS

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### *Sudden Unexpected Infant Death (SUID) - Newborn-Related Education*

The CFNFRB recommends that model legislation be developed in association with the New Jersey Hospital Association and the New Jersey Council of Teaching Hospitals requiring parents to have training in safe sleep practices before leaving the hospital with a newborn.

The CFNFRB further recommends that new parent training include, as outlined by the American Academy of Pediatrics, the following critical information and is updated regularly:

- Healthy sleeping environments, such as a crib with a tight fitting mattress and without bumpers, blankets, pillows, toys or any other object within;
- The “Back is Best” campaign - Infants should always be placed on their backs to sleep, every time they sleep;
- The risks and dangers of co-sleeping or bed-sharing;
- The benefits of supervised “Tummy Time”;
- The risks of infant tobacco smoke exposure;
- The benefits of breastfeeding and of offering the infant a pacifier;
- The benefits of obtaining proper recommended immunizations and well-visits;
- Strategies for coping with infant crying and new parent feelings of frustration.

This legislation should pertain to all birthing hospitals in New Jersey, requiring that such educational efforts be adequately presented to all parents prior to infant discharge. A formal notation of such activity should be placed in the permanent medical record of both mother and child.

The CFNFRB will continue to partner with the New Jersey Chapter of the American Academy of Pediatrics to continue to advocate the discussion of these issues with parents at their newborn’s pediatric and other medical visits on an ongoing, repetitive basis.

## *SUID Prevention*

The CFNFRB strongly feels that with the timely education of vulnerable families by trained professionals many of New Jersey's sudden infant deaths would be potentially preventable. In 2011 the CFNFRB and/or the SUID Subcommittee reviewed 62 cases of SUID or sleep-related sudden deaths; of these 47 (or 75.8%) were deemed preventable if safe and healthy sleep practices and environments had been utilized.

As 13% of the 2011 SUID cases reviewed had late or no prenatal care (as opposed to a statewide level of only 3.6% ) the CFNFRB recommends that New Jersey birthing hospitals implement (or improve the implementation of) protocols ensuring that all women identified as having late or no prenatal care receive a social work consultation. During this social work consultation, the social worker should provide safe sleep education as noted above. The social worker should also refer the mother to a home visiting program for an initial home visit and assessment. Home visitors should also reinforce safe sleep education and ensure that the family has a crib or other suitable safe sleep space (pack-n-play or bassinette). A free crib (or a referral to another agency for a free crib) will be provided to parents in financial need.

The CFNFRB recommends the recommendations on safe and healthy sleeping be discussed at the Early Learning Commission and incorporated as one of the objectives of the NJ Council for Young Children.

