NEW JERSEY

CHILD FATALITY AND NEAR FATALITY

REVIEW BOARD AND

CITIZEN REVIEW PANEL

June 30, 2005

ANNUAL REPORT

New Jersey Child Fatality and Near Fatality Review Board
and
Citizen Review Panel
2004

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NEW JERSEY CHILD FATALITY AND NEAR FATALITY REVIEW BOARD/ CITIZEN REVIEW PANEL 2004 REPORT

Introduction

This is the sixth annual report of the Child Fatality and Near Fatality Review Board/Citizen Review Panel (CFNFRB). The report includes an overview of the activities and issues raised by the CFNFRB, as well as any actions that were taken to address them.

In August 1990, the Commissioner of the New Jersey Department of Human Services established the Child Death and Critical Incident Review Board by Administrative Order. In January 1991, the Child Death and Critical Incident Review Board began reviewing child fatalities. In December 1992, the status of the Board's authority was changed from a Departmental Administrative Order to State regulations that have the force and effect of law.

The Child Death and Critical Incident Review Board was mandated to review child deaths due to child abuse or neglect in which the family was currently or previously, within 12 months of the incident, receiving services from the Division of Youth and Family Services (DYFS). The Child Death and Critical Incident Review Board concluded its tenure in 1998 with the review of 1997 child deaths and critical incidents. 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, created the Child Fatality and Near Fatality Review Board which replaced the Child Death and Critical Incident Review Board. The Governor officially appointed the members of the CFNFRB in May 1998.

Although the CFNFRB is placed administratively in the Department of Human Services, it is statutorily independent of "any supervision or control by the department" or any of the Department's other "boards or officers."

The scope of incidents that are subject to review has changed to include 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 continues to meet monthly to fulfill this mandate. The principal objective of the CFNFRB 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 child fatalities. According to CCAPTA, the purpose of the CFNFRB 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 CFNFRB, 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; and
- 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.

Pursuant to N.J.S.A. 9:6-8.90, the CFNFRB's mandate requires the identification of fatalities due to unusual circumstances according to the following criteria:

- The cause of death is undetermined;
- Death where substance abuse may have been a contributing factor;
- Homicide, 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; and
- Suicide.

In addition, the CCAPTA mandates the CFNFRB to identify children whose family was under 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. The CFNFRB also examines and identifies approaches to achieve better coordination of efforts regarding child welfare and child protective services cases to promote prevention and the competency of response and investigation of reports of maltreatment.

The CFNFRB is empowered to select cases from among these categories and to conduct a full review.

Finally, CCAPTA requires the CFNFRB to establish regulations to govern its activities. CCAPTA stipulates that the CFNFRB submit an annual report to the Governor and State legislature. The CFNFRB is required to report as follows:

- Trends among unusual fatalities and near fatalities;
- The number of cases reviewed and specific non-identifying information regarding cases of particular significance;
- Risk factors and the governmental support systems available and responsible for support; and
- Recommendations for improving sources of data collection, achieving better coordination and collaboration among State and local agencies, and recommendations for system-wide improvements in services to prevent child fatalities and near fatalities.

This is the second report in which the activities of the CFNFRB are chronicled in a calendar year. The CFNFRB continues to face formidable challenges in setting operational priorities, developing a review protocol for continuity across statewide and regional review, organizational structure, case reviews and with its four Regional Child Fatality and Near Fatality Community-Based Review Teams.

Organizational Issues

Regional Child Fatality and Near Fatality Community-Based Review Teams (Regional Teams)

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 four Regional Teams continue to review cases that were either formerly known to DYFS or were unknown to DYFS at the time of the fatal incident and meet the CCAPTA criteria. The CFNFRB continues to review fatalities that were under DYFS supervision at the time of the fatal incident. The CFNFRB established the following review priorities for the four Regional Teams:

- Deaths due to maltreatment not under DYFS supervision;
- Deaths where the family received services from DYFS within the last 12 months;
- Suspicious deaths; and
- Sudden and unexplained deaths, including Sudden Infant Death Syndrome (SIDS).

Three DYFS professional support staff continue to support the activities of the CFNFRB and its Regional Teams, and another citizen review panel. The CFNFRB Coordinator is responsible for all CFNFRB activities, supervises two professional support staff that each has direct responsibility for two Regional Teams, and the other citizen review panel. Professional support staff obtains the necessary documentation to conduct fatality reviews, record the activities of the CFNFRB and Regional Team meetings by taking minutes, and facilitate communication between the CFNFRB and the Regional Teams. Reports by professional support staff include systemic problems they have identified, and recommendations or requests for assistance and follow-up to the CFNFRB or Regional Teams. The CFNFRB and the Regional Teams also continue to share each other's minutes.

In 2004, the Regional Teams were faced with issues such as staffing, attendance, diversity, membership, and scheduling conflicts. In addition, professional support staff struggled to identify cases, due in part to the narrow case review criteria set forth in the CCAPTA statute, for the Northern and Central Regional Teams to review, and to obtain information on homicide fatalities.

In an effort to address the problem with identifying cases and attendance, the CFNFRB agreed to the request by some of the Regional Teams to meet bi-monthly. This allows professional support staff more time to gather information on fatalities and near fatalities, and should improve attendance because the Regional Teams can meet 6 times instead of 12 times per year. The Southern Regional Team has elected to continue meeting on a monthly schedule while the other Regional Teams Have adopted a bi-monthly meeting schedule. The CFNFRB plans to assess whether the bi-monthly meeting schedule change is producing the outcome it had hoped.

A new professional support staff member was appointed to staff the Southern and Central Regional Teams in January 2004 and by November had lost the professional support staff person. The CFNFRB was unable to identify and appoint members with experience in local law enforcement and prosecution to some of the Regional Teams. However, the CFNFRB has solicited the assistance of the Department of Human Services and the Office of the Attorney General to remedy this problem.

Due to the many other issues faced by the Regional Teams, the issue of diversity was not addressed. The CFNFRB plans to ask the Regional Teams to come up with a plan to actively recruit and achieve a meaningful level of diversity on each of the Regional Teams and report to the CFNFRB.

Because of the organizational/structural changes to the child protection agency, going from 4 Regional Offices to 15 Area Offices, the CFNFRB will need to determine how to incorporate the Area Offices onto the Regional Teams or consider re-aligning the Regional Teams with the Area Offices.

Public Member Appointments/Vacancies

The CFNFRB has 6 Public members that are appointed by the Governor and serve for terms of 3 years. The Law Guardian, Pediatrician and Psychologist have been in "holdover" status since May 2003, the Substance Abuse Expert position has been vacant for 3 years and expired in December 2003, the Prosecutor's Association position has been vacant for 2 year and expired along with the term of the Social Work Educator in May 2004. In effect, the entire public membership is in "holdover" status. This inattention to membership on the CFNFRB, both public and private, speaks directly to the CFNFRB's ability to fulfill its statutorily mandated responsibilities.

CFNFRB Member Participation

The CFNFRB has made various attempts since its inception to ensure representation and participation by all public and ex-officio members on the CFNFRB. However, the CFNFRB has been unsuccessful in obtaining consistent representation and participation by the State Police, Prosecutor's Association and Social Work Educator.

The vacancies and lack of attendance by CFNFRB members is of concern in regard to establishing a quorum, but more importantly because it impacts on the CFNFRB's ability to provide a multi disciplinary review of the fatalities and near fatalities.

On September 9, 2004, the CFNFRB Chairman and Vice-Chairman met with the DHS Commissioner to discuss the recommendations of the CFNFRB in its June 30, 2004 annual report, and issues impacting the work of the CFNFRB. The DHS Commissioner agreed to work with the CFNFRB to resolve the lack of representation from the State Police and Prosecutor's Association on the CFNFRB, jurisdictional power of the State Medical Examiner over County Medical Examiners, the problem of information not being shared with the CFNFRB particularly with homicide cases and the lack of representation on the Regional Teams in the area of local law enforcement and the Prosecutor's Office, which fall under the Attorney General's Office.

Near Fatalities

In June 2004, the CFNFRB also adopted the following "Near Fatality" definition: "near fatality means a serious or critical condition, as certified by a physician, in which a child suffers a permanent mental or physical impairment, a life-threatening injury or a condition that creates a probability of death within the foreseeable future." Since DYFS uses the same near fatality definition, the CFNFRB decided to begin reviewing the cases identified as near fatalities by DYFS. The same criteria used to schedule fatality reviews, open DYFS cases at the time of the fatality are reviewed by the CFNFRB and all other fatalities are reviewed by the Regional Teams, will be utilized by professional support staff to schedule near fatality reviews. The review of near fatalities began in September. In 2004, 5 near fatalities were reviewed. One near fatality received the review of a regional team and the CFNFRB. The CFNFRB plans to examine whether to expand its current definition.

Child Fatalities and Near Fatalities Reviewed

Data on child fatalities in New Jersey due to all causes can be obtained from the New Jersey Department of Health and Senior Services, Center for Health Statistics, **@www.state.nj.us/health/chs**.

The CFNFRB continues to utilize child fatality data from the Office of the State Medical Examiner (OSME), and the Division of Youth and Family Services. The CFNFRB prioritizes cases for full review, based upon elements of suspicion related to the cause of death and whether or not the child or the family was known to the Division of Youth and Family Services. Child fatality cases that were suspicious of child abuse or neglect are prioritized as a review category. Cases in this category are further stratified, based upon whether the family is known to the Division of Youth and Family Services (either the child's case was under DYFS supervision at the time of death, or had been open at sometime within the previous twelve months). The CFNFRB continues to review fatalities where the family has an open case with the Division of Youth and Family Services at the time of the fatality, and the Regional Teams review fatalities that were either previously known or unknown to the DYFS.

This is the first report in which part of the analysis of the CFNFRB's child fatality and near fatality data base was completed with the assistance of the DHS Office of Evaluation and Planning. The CFNFRB anticipates this support will continue.

In 2004, the CFNFRB and its Regional Teams reviewed 87 child fatalities and 5 near fatalities. In 2003, 146 fatalities were reviewed. This decrease is due to the reasons noted in the Organizational Issues section. Of the 87 child fatalities reviewed, 3 occurred in 2004, 73 occurred in 2003, 10 in 2002, and 1 in 2001. Of the 5 near fatalities reviewed, 1 occurred in 2004 and 4 in 2003. The following table provides a breakdown of all the fatalities and near fatalities reviewed by the CFNFRB and each Regional Team.

	Fatalities	**Near Fatalities**
Northern Regional Team	**21**	**2**
Metropolitan Regional Team	**21 *(22)**	**1**
Southern Regional Team	**21**	**1**
Central Regional Team	**17**	**1**
CFNFRB	**7**	***(1)**
Total	**87**	**5**

*A near fatality that had been reviewed by the Metropolitan Regional Team was also reviewed by the CFNFRB upon the Regional Teams request. The Central and Metropolitan Regional Teams also reviewed the same fatality. The near fatality and fatality were only counted once.

Of the 87 fatalities and 5 near fatalities reviewed, 9 children were open and receiving services from the Division of Youth and Family Services. Of the 9, 8 were fatalities and 1 was a near fatality. The families of 22 children were previously known to the DYFS, and services to the family had been terminated prior to the fatality. Ten of the 22 fatalities were terminated within twelve months of the fatality and 12 had been closed longer than twelve months. Sixty-one of the children or their families were never known to DYFS. Twenty of the fatalities were substantiated abuse/neglect, 14 were unknown to the DYFS, 4 were open, and 2 had prior involvement at the time of the fatality. Nineteen occurred in 2003 and 1 in 2002.

In 2003, a total of 32 fatalities were substantiated as abuse/neglect; 6 families were open and receiving services from DYFS, 10 were previously known to DYFS and 16 were unknown to DYFS. Twenty four of the 32 substantiated fatalities have been reviewed. Nineteen of the fatalities were reviewed in 2004 and 5 in 2003. The remaining 8 substantiated abuse/neglect fatalities will be reviewed in 2005 unless the mother and/or child tested positive for drugs, and the child subsequently died prematurely, due to low birth weight, or some other medical condition.

In the 2003 annual report, the CFNFRB noted 16 of the 29 substantiated fatalities in 2002 had been reviewed and that it planned to conduct a full review of the 13 remaining fatalities. The CFNFRB was advised by professional support staff of the circumstances surrounding these deaths that were mostly fatalities where either the mother and/or child tested positive for drugs, and/or the child subsequently died prematurely, due to low birth weight, or

some other medical condition. Based on the summary review of each case provided by professional support staff, the CFNFRB decided the remaining fatalities would not require a full review. The CFNFRB plans to look further into the issue of substance exposed infants.

Definitions

The following definitions are nationally recognized by medical examiners and health professionals, and are provided to assure consistent interpretation of data presented in the tables that follow:

CAUSE OF DEATH: Disease or injury or its combination which initiates the sequence of physiological derangement's resulting in death. Examples include: Myocardial Infarction, Acute Bronchopneumonia, Cerebral Vascular Accident.

SUDDEN INFANT DEATH SYNDROME (SIDS): The sudden death of an infant one year or younger which is unexpected and after a thorough postmortem examination including an autopsy, death scene investigation, toxicology, and review of the infant and family's medical history, fails to identify a cause of death.

SUDDEN UNEXPLAINED DEATH IN CHILDHOOD (SUDC): The sudden death of a child one year or older which is unexpected and after a thorough postmortem examination including an autopsy, death scene investigation, toxicology and review of the child and family's medical history, fails to identify an adequate cause of death.

MANNER OF DEATH: A classification based on the circumstances bringing about the proximate cause that resulted in a fatal outcome, which include:

NATURAL - If the proximate cause is a natural disease process;

UNDETERMINED – Is used when the information pointing to one manner of death is no more compelling than one or more competing manners of death in thorough consideration of all available information.

ACCIDENTAL - If the agency is an unexpected unforeseen event;

SUICIDE - If the agency was intentionally caused by the decedent. Intent can be implied through the decedent's actions unless it is an altruistic act; and

HOMICIDE - If the event was brought on directly by the actions of another human with express or implied intent to cause a fatal or near fatal outcome; or one that ordinarily results in a fatal outcome or is a felonious action that can be causally related to the fatal outcome.

Cause of Death	
Sudden Infant Death Syndrome (SIDS)	**28**
Hanging	**11**
Undetermined	**11**
Drowning	**7**
Blunt Force Trauma	**6**
Medical Condition	**6**
Drugs	**5**
Asphyxia	**4**
Fire	**4**
Firearm	**3**
Shaken Baby Syndrome	**1**
Pending	**1**
Total	**87**

Manner of Death	
Natural	**34**
Accidental	**19**
Homicide	**9**
Undetermined	**12**
Suicide	**12**
Pending	**1**
Total	**87**

*The "**Manner**" and "**Cause of Death**" were certified by the Medical Examiner.

Child Maltreatment Fatalities

This category of cases includes deaths where the alleged perpetrator of the child maltreatment was the child's caregiver. Maltreatment fatalities can be found throughout the categories under Manner or Cause of Death, but are not categorized separately as maltreatment in other governmental reporting systems. For example, in a drowning death "Drowning" would be the cause and the manner could be categorized as "Accidental" by a Medical Examiner. If there was lack of supervision on the part of a caregiver, the Division of Youth and Family Services would substantiate neglect. Maltreatment includes physical and sexual abuse, physical neglect, and medical neglect. Fatal injuries inflicted upon children by a person other than a caregiver are categorized under homicides. This child maltreatment category may also include infants that were exposed to drugs or alcohol during gestation and tested positive for these drugs at birth. The CFNFRB continues to find that in some of these cases, the Division of Youth and Family Services was able to substantiate neglect by the mother. However, in others, the DYFS did not substantiate neglect because the child was not tested or the toxicology test was negative. In these instances, the death is categorized as a natural death by the Medical Examiner. Of the 87 fatalities reviewed, 20 were substantiated by the DYFS as abuse/neglect. Of the 20, the Medical Examiner certified the Manner of Death "Accidental" in 12 of the fatalities, "Homicide" in 5 and "Undetermined" in 3.

The tables below demonstrate that the children who were victims of child maltreatment were under age 5 and 70% were males. In addition, a relative was the perpetrator in 90% of the child maltreatment fatalities, and specifically the father or the mother in 75% of the fatalities. Almost three-fourths of the families had no DYFS involvement. This does not include the history of the parent/caretaker as a child.

Age of Victim	
Under 1 year	**9**
1-5 years	**11**
Total	**20**

Race of Victim	
Black	**7**
White	**5**
Hispanic	**4**
Interracial	**3**
Arabic	**1**
Total	**20**

Gender of Victim	
Male	**14**
Female	**6**
Total	**20**

CPS History of Victim/Family	
None	**14**
Open case	**4**
Prior Involvement	**2**
Total	**20**

Perpetrator's Relationship to Victim	
Father	**8**
Mother	**7**
Other Relative	**3**
Paramour	**1**
Babysitter	**1**
Total	**20**

Homicide Deaths

The Medical Examiner certified the Manner of Death as "Homicide" in 9 of the fatalities reviewed. In almost half of these fatalities (4) the alleged perpetrator was serving as a caregiver for the child. These 4, are also included in the 20 that were identified as maltreatment. Of the 9 homicides, 8 were male, 6 were black and 6 had no DYFS involvement. The following tables show data on the child homicides reviewed in 2003.

Age of Victim	**Maltreatment**		**Non Maltreatment**
Under 1 year	**(3)**	**3**	**(0)**
1-5 years	**(1)**	**3**	**(2)**
6-12 years	**(0)**	**0**	**(0)**
13-18 years	**(0)**	**3**	**(3)**
Total	**(4)**	**9**	**(5)**

Race of Victim			
Black	**(2)**	**6**	**(4)**
White	**(1)**	**1**	**(0)**
Hispanic	**(1)**	**2**	**(1)**
Unknown	**(0)**	**0**	**(0)**
Total	**(4)**	**9**	**(5)**

Gender of Victim			
Male	**(3)**	**8**	**(5)**
Female	**(1)**	**1**	**(0)**
Total	**(4)**	**9**	**(5)**

CPS History of Victim/Family			
None	**(4)**	**6**	**(2)**
Prior Involvement	**(0)**	**2**	**(2)**
Open Case	**(0)**	**1**	**(1)**
Total	**(4)**	**9**	**(5)**

Suicide Deaths

The Medical Examiner certified the Manner of Death as "Suicide" in 12 of the fatalities reviewed. This category of fatalities includes deaths where the child intentionally caused his death by inflicting injuries or otherwise inducing loss of life. Eleven of the fatalities were due to hanging and 1 involved the child placing a plastic bag over his head. The majority were white male teenagers. A statistical/demographic breakdown of the 12 fatalities by age, race, gender, and CPS history follows. Statewide there were 11 suicide deaths in 2002, 12 in 2003 and 26 in 2004 that were reported to the Medical Examiner.

Age of Victim	
Under 1 year	**0**
1-5 years	**0**
6-12 years	**0**
13-18 years	**12**
Total	**12**

Race of Victim	
White	**8**
Black	**1**
Hispanic	**1**
Korean	**1**
Interracial	**1**
Total	**12**

Gender of Victim	
Male	**8**
Female	**4**
Total	**12**

CPS History of Victim/Family	
None	**9**
Open Case	**1**
Prior Involvement	**2**
Total	**12**

Drowning Deaths

This category of deaths includes fatalities where the child's death resulted from drowning. Some of these fatalities are also categorized as child maltreatment if lack of supervision was substantiated. In 2004, 7 of the fatalities reviewed were due to drowning. Two of the drowning fatalities occurred in a residential pool, 2 in a bathtub, 1 in a bucket, 1 in an ocean/lake, and 1 in a water treatment plant. In 6 of the deaths, the Medical Examiner certified the Manner of death "Accidental", and one as "Undetermined". The DYFS substantiated neglect in two of these drowning deaths.

All of the drowning deaths were children under age 5. The majority (5) had no DYFS involvement.

Age of Victim	
Under 1 year	**3**
1-5 years	**4**
Total	**7**

Race of Victim	
White	**2**
Black	**2**
Interracial	**2**
Arabic	**1**
Total	**7**

Gender of Victim	
Male	**4**
Female	**3**
Total	**7**

CPS History of Victim/Family	
None	**5**
Prior involvement	**2**
Open	**0**
Total	**7**

Fire Related Deaths

In 2004, 4 of the fatalities reviewed involved fires. The Medical Examiner certified the Manner of Death in 3 of the fatalities as "Accidental" and 1 as "Homicide". The cause of the fire was determined to be electrical in nature in 2 fatalities, a motor vehicle fire in 1, and an intentional house fire by a paramour in 1. The DYFS substantiated neglect in the motor vehicle fire, but did not substantiate abuse/neglect in the intentional house fire because the

paramour who started the fire was not in a caretaker role. The tables below provide some demographics on these children.

Age of Victim	
Under 1 year	**0**
1-5 years	**2**
6-12 years	**1**
13-18 years	**1**
Total	**4**

Race of Victim	
White	**2**
Black	**2**
Total	**4**

Gender of Victim	
Male	**3**
Female	**1**
Total	**4**

CPS History of Victim/Family	
None	**3**
Prior Involvement	**0**
Open Case	**1**
Total	**4**

Training and Education

Safe Sleep Campaign

On March 4, 2004, the CFNFRB wrote to the DHS Commissioner urging the development of a public safety campaign addressing the prevention of infant deaths related to unsafe sleep practices. On April 8, 2004, the DHS Commissioner and the CFNFRB held a press event and launched a safe sleep campaign. The CFNFRB has learned that subsequent to the press event, there has been minimal distribution of the Safe Sleep brochures. However, the DHS Office of Public Affairs will now be partnering with the CFNFRB to increase awareness of this issue.

In 2003, out of 146 fatalities reviewed, 50 Unsafe-Sleep deaths were identified. In 2004, out of 87 fatalities reviewed, the CFNFRB and Regional Teams identified 30 fatalities that involved unsafe sleep practices of infants who were placed on their stomach to sleep, were sleeping together with a caregiver and in some instances another child (aka-bed-sharing/overlay/roll over deaths), etc. Fifteen of the 30 fatalities identified as unsafe sleep involved bed-sharing, 9 involved being placed on the stomach to sleep, 5 involved some other unsafe sleep factor and 1 involved bedding. Some unsafe sleep fatalities involved more than one of these factors. The Medical Examiner certified the cause of death as “SIDS” in 20 of these fatalities, “Undetermined” in 9, and 1 as “Asphyxia.” The Manner of Death was certified as “Natural” in 20 of these fatalities and “Undetermined” in 10.

The CFNFRB has learned that the American Academy of Pediatrics (AAP) recommends placing infants on their back to sleep. The AAP also accepts the placement of an infant on the side if the child will not be placed on its back to sleep. The Sudden Infant Death Syndrome (SIDS) Centers only advocate placing the child on the back to sleep. In order to avoid confusing the public, the AAP and SIDS Centers should meet to resolve whether placing a child on the side to sleep should be recommended.

The CFNFRB and Regional Teams continue to express a need to further educate the public regarding unsafe sleep issues and the dangers posed to infants. The CFNFRB also recommends the DHS, Office of Children's Services, Division of Prevention and Community Partnerships (DPCP), the New Jersey Task Force on Child Abuse and Neglect and the DHSS collaborate with the AAP and SIDS Centers to strategize on how to expand this campaign. DPCP should also involve the Community Collaboratives and Child Welfare Councils in this endeavor.

The table below provides a breakdown of the Unsafe-Sleep deaths. Of the deaths related to Unsafe-Sleep practices, the data show that 60% of all the deaths occurred under 3 months of age and 93% under 6 months of age. In addition, 57% were Black, 53% were male, and 70% (21) were unknown to the DYFS.

Unsafe-Sleep Deaths

Age of Victim	
Under 1 month	**4**
1-3 months	**14**
4-6 months	**10**
7-9 months	**1**
10-12 months	**0**
1 year	**1**
Total	**30**

Race of Victim	
Black	**17**
White	**9**
Hispanic	**3**
Arabic	**1**
Total	**30**

Gender of Victim	
Male	**16**
Female	**14**
Total	**30**

CPS History of Victim/Family	
None	**21**
Prior Involvement	**9**
Open Case	**0**
Total	**30**

The tables that follow provide aggregate data on the fatalities and near fatalities reviewed.

CASE SUMMARIES

Reviewed By:

	Frequency	Percent
Central	18	19.6
Child Fatality & Near Fatality Review Board	7	7.6
Metropolitan	22	23.9
Northern	23	25.0
Southern	22	23.9
Total	92	100.0

Case status at time of fatality/near fatality:

	Frequency	Percent
Closed longer than 12 months	12	13.0
Closed within 12 months	10	10.9
Open	9	9.8
Unknown	61	66.3
Total	92	100.0

Case Findings:

	Frequency	Percent
Substantiated, perpetrator confirmed	20	21.7
Unfounded	1	1.1
Unsubstantiated	3	3.3
N/A	68	73.9
Total	92	100.0

DEMOGRAPHIC DATA

Gender:

	Frequency	Percent	State Percent
Female	35	38.0	51.5
Male	57	62.0	48.5
Total	92	100.0	100.0

Race:

	Frequency	Percent	State Percent
White	29	31.5	72.6
Black	42	45.7	13.6
Hispanic	11	12.0	13.3
Interracial	4	4.3	
Asian	1	1.1	
Unknown	1	1.1	
Other	4	4.3	
Total	92	100.0	

Age at death
Fatality before the age of 1

Age in Months	Frequency	Percent
.00	2	2.2
.36	1	1.1
.46	1	1.1
.53	2	2.2
.59	2	2.2
.69	1	1.1
.79	1	1.1
.92	2	2.2
1.05	1	1.1
1.18	1	1.1
1.32	1	1.1
1.41	1	1.1
1.78	1	1.1
1.97	1	1.1
2.04	1	1.1
2.14	1	1.1
2.40	1	1.1
2.47	1	1.1
2.60	1	1.1
2.63	1	1.1
2.83	1	1.1
2.96	1	1.1
3.06	1	1.1
3.16	1	1.1
3.22	2	2.2
3.26	2	2.2
3.95	1	1.1
4.14	1	1.1
4.31	1	1.1
4.34	1	1.1
4.44	1	1.1
4.67	1	1.1
4.70	1	1.1
4.74	1	1.1
4.80	1	1.1
5.13	1	1.1
5.69	1	1.1
6.05	1	1.1
6.25	1	1.1
6.32	1	1.1
6.74	1	1.1
7.60	1	1.1
10.23	1	1.1
11.35	1	1.1
Total	50	54.3

Age at death
Fatality after the age of 1

Age in Years	Frequency	Percent
1.00	1	1.1
1.04	1	1.1
1.17	1	1.1
1.19	1	1.1
1.47	1	1.1
1.74	1	1.1
1.80	1	1.1
2.11	1	1.1
2.14	1	1.1
2.27	1	1.1
2.44	1	1.1
2.58	1	1.1
2.63	1	1.1
3.21	1	1.1
4.73	1	1.1
4.77	1	1.1
8.58	1	1.1
12.02	1	1.1
12.99	1	1.1
13.01	1	1.1
13.77	1	1.1
15.17	1	1.1
15.46	1	1.1
15.92	1	1.1
16.26	1	1.1
16.37	1	1.1
16.59	1	1.1
16.99	1	1.1
17.10	1	1.1
17.41	1	1.1
17.68	1	1.1
17.87	1	1.1
17.92	1	1.1
17.98	1	1.1
18.00	1	1.1
18.51	1	1.1
20.00	1	1.1
Total	37	40.2

Age at death	Frequency	Percent
Less than one year	50	54.3
More than one year	37	40.2
N/A (Near Fatalities)	5	5.4
	92	100.0

County of Residence:

County	Frequency	Percent	County % of State Population
Atlantic	2	2.2	3.0
Bergen	4	4.3	10.5
Burlington	3	3.3	5.0
Camden	10	10.9	6.1
Cape May	3	3.3	1.2
Cumberland	4	4.3	1.7
Essex	18	19.6	9.4
Gloucester	2	2.2	3.0
Hudson	3	3.3	7.2
Mercer	4	4.3	4.2
Middlesex	2	2.2	8.9
Monmouth	11	12.0	7.3
Morris	2	2.2	5.6
Ocean	4	4.3	6.1
Passaic	8	8.7	5.8
Sussex	1	1.1	1.7
Union	9	9.8	6.2
Missing	1	1.1	
Unknown	1	1.1	
Total	92	100.0	

Immediate Cause of Death:

Cause of Death	Frequency	Percent
SIDS	28	30.4
Hanging	11	12.0
Undetermined	11	12.0
Drowning	7	7.6
Blunt Force Trauma	6	6.5
Medical Condition	6	6.5
Drugs	5	5.4
Asphyxia	4	4.3
Fire	4	4.3
Firearm	3	3.3
Shaken Baby Syndrome	1	1.1
Pending	1	1.1
N/A (Near Fatalities)	5	5.4
Total	92	100.0

As a Consequence of:

Consequence	Frequency	Percent
Hanging	6	6.5
Inflicted Injuries	3	3.3
Fire	2	2.1
Drowning	2	2.1
Left Unattended in Car	2	2.1
Bed Sharing	2	1.1
Fall	1	1.1
Shaking	1	1.1
Smoke Inhalation	1	1.1
Ingestion of Heroin/Alcohol	1	1.1
Prenatal Drug Use	1	1.1
Motor Vehicle Accident	1	1.1
Motor Vehicle Fire	1	1.1
Cerebral Edema	1	1.1
Poison	1	1.1
Asphyxiation/Plastic Bag Over Head	1	1.1
Submerged in Bucket/Cleaning Fluid	1	1.1
Left Unattended in Bath Tub	1	1.1
Undetermined	1	1.1
N/A	62	67.4
Total	92	100.0

Manner of Death:

	Frequency	Percent
Accidental	19	20.7
Homicide	9	9.8
Natural	34	37.0
Suicide	12	13.0
Undetermined	12	13.0
N/A (Near Fatalities)	5	5.4
Pending	1	1.1
Total	92	100.0

Unsafe Sleep:

	Frequency	Percent
No	62	67.4
Yes	30	32.6
Total	92	100.0

Suicide:

	Frequency	Percent
No	80	87.0
Yes	12	13.0
Total	92	100.0

Suicide Factors:

	Frequency	Percent
Asphyxia	1	1.1
Hanging	11	12.0
N/A	80	87.0
Total	92	100.0

Homicide:

	Frequency	Percent
No	83	90.2
Yes	9	9.8
Total	92	100.0

Homicide Factors:

	Frequency	Percent
Fire	1	1.1
Gun	3	3.3
Asphyxia	1	1.1
Maltreatment	4	4.3
N/A	83	90.2
Total	92	100.0

Drowning:

	Frequency	Percent
No	85	92.4
Yes	7	7.6
Total	92	100.0

Drowning Factors:

	Frequency	Percent
Bathtub	2	2.2
Bucket	1	1.1
Residential pool	2	2.2
Ocean/Lake	1	1.1
Water Treatment Plant	1	1.1
N/A	85	92.4
Total	92	100.0

Fire:

	Frequency	Percent
Yes	4	4.3
No	88	95.7
Total	92	100.0

Fire Cause:

	Frequency	Percent
Faulty electrical wiring	2	2.2
Mother's paramour	1	1.1
Vehicle fire	1	1.1
N/A	88	95.7
Total	92	100.0

MVA:

	Frequency	Percent
No	89	96.7
Yes	3	3.3
Total	92	100.0

MVA Cause:

	Frequency	Percent
Father lost control of car	1	1.1
Fire	1	1.1
Run over by neighbor	1	1.1
N/A	89	96.7
Total	92	100.0

Family History of Domestic Violence (DV):

	Frequency	Percent
Yes	1	1.1
No	15	16.3
Unknown	76	82.6
Total	92	100.0

Substance Abuse:

	Frequency	Percent
Yes	9	9.8
No	14	15.2
Unknown	69	75.0
Total	92	100.0

Alleged Perpetrator:

	Frequency	Percent
Daycare/Babysitter	1	1.1
Father	8	8.7
Mother	7	7.6
Other Relative	3	3.3
Husband/paramour	1	1.1
N/A	72	78.3
Total	92	100.0

DV Involved in Death:

	Frequency	Percent
No	92	100.0
Total	92	100.0

Was there disagreement with the cause of death:

	Frequency	Percent
No	81	88.0
Yes	6	6.5
Undetermined	5	5.4
Total	92	100.0

To what degree was the death preventable:

	Frequency	Percent
Definitely Could Have Been Prevented	23	25.0
Probably Could Have Been Prevented	18	19.6
Probably Not	40	43.5
Undetermined	6	6.5
N/A (Near Fatalities)	5	5.4
Total	92	100.0

Division of Youth and Family Services

Medical Director

In November 2004, the Division of Youth and Family Services announced the appointment of a Medical Director. The Medical Director will be responsible for the development, implementation and evaluation of health initiatives and policies that will meet the needs of children and families who are served by DYFS. The CFNFRB extended an invitation to the DYFS Medical Director who attended the CFNFRB's December meeting. The CFNFRB anticipates regular attendance by the DYFS Medical Director to the CFNFRB meetings will not only enhance the reviews by the CFNFRB, but assist the Medical Director with the charge to meet the health needs of children served by DYFS. The DYFS Medical Director is not a voting member.

CFNFRB Staff

The CFNFRB consists of volunteer members and as such the CFNFRB's ability to function effectively depends on its professional support staff. The three (3) professional support staff assigned to the CFNFRB and its 4 Regional Community-Based Teams perform a variety of essential functions to support its activities. In addition to attending national conferences relative to child fatality and citizen review panels, the CFNFRB would also like to become involved in national child fatality efforts. The Maternal Child Health (MCH) Center for Child Death Review is involved in a federal effort to implement a web-based child fatality review database. The CFNFRB would like to become involved in this effort that is currently being piloted. For these and various other reasons, the CFNFRB is requesting additional staff or that the duties of the existing professional support staff be limited to the CFNFRB activities.

Information Needs

The CFNFRB has continually expressed its support for DYFS to acquire a Statewide Automated Child Welfare System (SACWIS). In 2004, CGI-AMS was awarded the Implementation Vendor contract to transfer a SACWIS program from another state and modify it to meet New Jersey's needs. The SACWIS system developed by CGI-AMS for Wisconsin became the basis for the NJ SPRIT application, a comprehensive intake, assessment, case management and fiscal system for DYFS.

In March 2004, CGI-AMS established a joint DYFS-contractor worksite at Carnegie Center in Princeton and Requirement Validation Sessions (RVSs) commenced with DYFS field staff participation to validate the requirements in the RFP and the capacity of the Wisconsin SACWIS to meet these requirements.

Joint Application Development Sessions (JADs) for Release 1 (Intake) began with field staff participation in April - May 2004. These sessions reviewed the functionality, screens and drop-down values and identified necessary modifications to meet New Jersey requirements. CGI-AMS revised the system based on information gathered in the JAD sessions and from August to September 2004, unit testing, system testing and user acceptance testing of Release 1 of the NJ SPIRIT application was conducted

Pilot offices were identified (Mercer and Ocean) for Release 1 and training of staff in these offices and State Central Registry (SCR) staff began in September 2004. On December 1, 2004, Release 1 of the NJ SPIRIT application was implemented statewide.

In September - December 2004, JAD sessions for Release 2 were held for investigation, fiscal and resource management. During this period, DYFS began operation of a data bridge developed by CGI-AMS to move data between the current SIS system and the NJ SPIRIT application. The objective of this effort was to avoid the need to perform duplicative data entry and look-ups in both systems.

Decision-Making

The CFNFRB continues to identify concerns regarding DYFS' case practice statewide. Between 2001 and 2003, DYFS developed components of a Structured Decision Making Model that was implemented statewide in the fall of 2001.

In April 2004, DYFS began a phased implementation of a new case management system for child protective services and child welfare services. The development of the New Jersey SDM system was initiated in 2003 with the assistance of the Children's Research Center (CRC). In July 2004, DYFS implemented the safety, risk and ongoing services component of the SDM case management system. At the same time, staff in all regions began to record findings in an expanded management information system, which included a web SDM application. Information regarding the screening of referrals, response times and completion of safety and risk assessments can be viewed by authorized users at the Safe Measures website.

The Safety assessment is used by workers during child protective service (CPS) investigations and child welfare assessments (CWA) to identify child safety factors and provide immediate service intervention to protect children. If one or more safety factors are identified and can be appropriately addressed through in-home intervention the child may be maintained safely in the home. When an in-home Safety plan cannot be developed the child(ren) is considered unsafe and removed from the home.

A Family Risk Assessment is completed at the end of each investigation to estimate the family's risk of future abuse or neglect and to guide the Division's decision on whether to open a case for ongoing service. This assessment classifies each family into one of four risk levels (low, moderate, high or very high) based on the likelihood they will become involved in a subsequent abuse or neglect incident. Research in other jurisdictions has shown that high risk families are more likely than low risk to have another incident of child maltreatment. The Family Risk Assessment results are used to guide service intervention, establish frequency of contact with the family (Minimum Visitation Requirements) and to monitor family progress in reducing risk in the family home.

The risk level determined provides workers with a case opening recommendation. It is recommended that cases are opened for all High and Very High risk families, regardless of the investigation finding. Moderate risk cases may be opened and low risk cases may be closed at the end of the investigation. Once opened, risk level is used to guide the frequency of worker intervention whereby families at greatest risk receive more intensive intervention.

The Reunification Assessment is used to determine if homes from which children were removed meet risk, visitation, and safety requirements prior to returning children home.

Strengths and Needs assessments are completed on all CPS referrals. The assessment findings are used to guide service provision and target specific needs of the family. Services provided are meant to increase safety and reduce risk of subsequent harm to the child. These assessments are critical in ensuring that families receive appropriate and adequate services to meet the educational, physical and mental health needs to increase the safety of the child and reduce the risk of maltreatment.

CRC has been conducting case reviews in local offices throughout the state to assess how well SDM tools are being used. CRC provides feedback to the individual office for improvement.

Child Welfare Reform Initiatives to Improve Case Practice

As the Child Welfare Reform Plan is implemented there have been many changes in DYFS that enhance case practice. The following captures some of those changes:

In 2004, DYFS began to restructure the agency moving from a regionally based to a county based operation. The four Regional Offices were disbanded and sixteen Area Offices were created statewide. On October 1, 2004, DYFS restructured the Intake

operations of Local Offices by designating caseworkers as Investigators for protective service, Assessors for child welfare referrals and Permanency Workers for on-going cases. Under this new structure, dedicated Investigators provide a workforce of staff trained to respond to reports of abuse/neglect in 24 hours and complete investigations within 60 days. Assessors have 45 days to complete the child welfare assessment.

In addition to restructuring local offices, on July 1, 2004 NJ opened a Statewide Central Registry (SCR), a toll free telephone hotline for citizens to report suspected child abuse or neglect. Calls are answered 24 hours a day, 365 days a year. SCR is staffed by specially trained workers using an allegations based system.

In 2004, DYFS focused on reducing and equalizing caseload sizes. An additional 332 case carrying positions were allocated to DYFS, Impact Teams were created and a contract was made with Social Work PRN. The additional staffing, Impact Teams and Social Work PRN staff were used to reduce and equalize caseloads statewide.

Psychiatric Risk Indicators

In July 2003, the CFNFRB wrote to the Commissioner of the Department of Human Services expressing concern over a lack of recognition of risk indicators associated with the mental health of the primary caregiver of the child and the inability of the case manager to readily access an expert opinion. The CFNFRB made the following recommendations:

- DYFS to provide training to all case managers and supervisory staff on recognizing psychiatric indicators of risk
- DYFS to establish a psychiatric consultant in each of the DYFS regions to assist DYFS staff in identifying risk and developing meaningful interventions
- DYFS to establish a protocol to prioritize cases for limited psychological and psychiatric support hours
- DHSS and DYFS to reactivate the SCAN (Suspected Child Abuse and Neglect) Teams in hospitals and the Regional Child Abuse Diagnostic Centers

Former Commissioner Gwendolyn L. Harris responded to the CFNFRB's recommendations in January 2004. Commissioner Harris provided that the SDM Risk Assessment tool (developed with Children's Research Center) addresses psychiatric risk indicators. All DYFS staff involved in the investigation and assessment of clients have been trained in the use of SDM. Regarding the CFNFRB's recommendation for DYFS to establish a psychiatric consultant, Commissioner Harris responded that the Regional Diagnostic Treatment Centers already provide this service. The third recommendation, for DYFS to establish a protocol to prioritize cases for limited psychological and psychiatric support hours is also addressed through the use of SDM tools. Regarding the recommendation to re-activate SCAN Teams, there has been no progress made on this

subject. DYFS will be revisiting this initiative with the newly hired Medical Director for the Office of Children's Services.

Quality Assurance Feedback Loop

DYFS continues to review and assess the quality assurance processes used in an effort to improve case practice statewide. In 2004, DYFS' infrastructure was modified and sixteen Area Offices were created to replace the four Regional Offices and additional Local Offices were created. The Area Office structure includes a Continuous Quality Improvement (CQI) position and each Local Office has a Case Practice Specialist (CPS). The Local Office CPSs maintain regular contact with CPSs in the Central Office CPS unit.

All critical incident reports (child death, serious abuse or neglect cases) are referred to the Case Practice Unit in Central Office. The Case Practice Unit reviews these incidents and follow-up with Local Offices to ensure corrective action recommendations are implemented. These corrective actions consist of policy clarification, in-service trainings, and recommendations for community in-service trainings. The Case Practice Unit also tracks case practice patterns and trends and elevates this information to management.

The DYFS CQI unit also works in collaboration with the Case Practice Unit and Local Office staff. Staff from the DYFS CQI unit conducted case reviews in a number of Local Offices and provided feedback to staff and management regarding case practice matters.

In 2005, it is expected that the Area Office CQI staff will work closely with the Office of Children's Services CQI Director to develop CQI processes and protocols.

Keeping Children and Families Safe Act of 2003

The President signed the Keeping Children and Families Safe Act of 2003, Public Law 108-36 into law on June 25, 2003. In part, the law reauthorizes and amends the Child Abuse Prevention and Treatment Act through FY 2008. The amendments revised the citizen review panel requirements by:

- requiring each citizen review panel to examine the *practices* (in addition to policies and procedures) of State and local agencies to evaluate the extent to which the agencies are effectively discharging their child protection responsibilities (section 106(c)(4)(A));
- requiring each panel to provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community (section 106(c)(4)(C)); and
- requiring each panel to make recommendations to the State and public on improving the child protection services system at the State and local levels. The appropriate

State agency is to respond to the panel and State and local child protective services agencies in writing no later than six months after the panel recommendations are submitted. The State agency's response must include a description of whether or how the State will incorporate the recommendations of the panel (where appropriate) to make measurable progress in improving the State and local CPS systems (section 106(c)(6)).

Public Outreach

The CFNFRB and the other two citizen review panels took testimony from conference participants during the New Jersey Task Force on Child Abuse and Neglect Annual Conference on September 10, 2004. The testimony was taped and provided an opportunity for the public to comment on the areas currently under review by the panels and/or suggest ideas on other areas the panels should explore. Since the CFNFRB and the citizen review panels do not have dedicated funding to support any undertakings relating to its charge, the CFNFRB coordinator is exploring the use of DYFS funds to pay for the tapes to be transcribed.

State Response Report

The CFNFRB reviewed the December 30, 2003 "Official State Response to Citizen Review Panels' Recommendations". The CFNFRB finds that while the report addressed the specific recommendations that were made by the CFNFRB, some of the responses lacked clarity on how the recommendations will be implemented and who would be responsible for following up with the CFNFRB's recommendations. The CFNFRB would like to see the next State Response Report clearly specify whether the recommendations will or will not be implemented. For recommendations that will be implemented, the report should indicate what agency or office will be responsible.

The New Jersey Department of Human Services (DHS) takes the lead in preparing the States' response to the recommendations of the Citizen Review Panels. The recommendations of the citizen review panels were released on June 30, 2004. The State response was due on December 30, 2004. The CFNFRB learned that the DHS requested a 30 day extension to complete the report. The CFNFRB plans to review and discuss the response report upon receipt to determine any next steps.

Medical Examiner System

The CFNFRB has noted on numerous occasions in the past that the New Jersey county-based medical examiner system is fragmented and functions at varying levels of efficiency and responsiveness with reporting delays and inconsistent application of established protocols. Legislation has been introduced this past year (Assembly Bill No. 2817) addressing this issue. It is supported by the CFNFRB.

The CFNFRB continues to recommend the immediate need to address these issues and supports an Executive Order by the Governor to give the Office of the State Medical

Examiner necessary additional authority to improve County Medical Examiner offices. The additional resources necessary to implement these changes should also be supported.

The Death Scene Investigation Subcommittee of the Sudden Child Death Autopsy Protocol Committee, chaired by the State Medical Examiner, has developed an investigative protocol for evaluation of child deaths under the age of three. The protocol consists of three sections for utilization by the medical examiner including sections for Emergency Medical Services, Medical Examiner offices and the SIDS Resource Center of New Jersey. This approach will provide a very extensive understanding of the circumstances involved in these types of cases.

Department of Health and Senior Services (DHSS)

Database

The CFNFRB continues to note the fragmented manner in which child fatalities are reviewed and how data is collected. Numerous entities are involved in parallel review of child fatalities. These entities include, but are not limited to, the New Jersey SIDS Center, New Jersey Fetal Infant Mortality Review, New Jersey Maternal Mortality Review, internal hospital mortality/morbidity reviews, and the Child Fatality and Near Fatality Review Board. Additionally, the Department of Health and Senior Services collects death certificate data and the Office of the State Medical Examiner collects autopsy data. To address this issue, the Department of Health and Senior Services and DHS, supported by the CFNFRB, applied for, and received, a grant from the Maternal and Child Health Bureau to improve coordination of mortality/morbidity reviews in New Jersey.

Because of significant start-up delays, not all grant funds were expended during the project period. The NJ Mortality/Morbidity Review Project grant received a one-year no-cost extension, which ends May 31, 2005. Work to establish the comprehensive mortality/morbidity review data information system will continue through the Family Health Initiative at the Southern NJ Perinatal Cooperative.

On March 16, 2005, an invitational summit will be held entitled “Benchmarking Progress: Outcomes of Mortality/Morbidity Review Processes" at the Doral Forrestal Conference Center in Princeton, NJ.

Citizen Review Panel Rules and Regulations

The CFNFRB and the other two citizen review panels provided feedback on rules and regulations that were drafted to come into compliance with the New Jersey Child Abuse Prevention and Treatment Act. The rules and regulations will govern the functioning of the citizen review panels and are currently in the process of being promulgated.

Citizen Review Panels Training

The CFNFRB learned of a National Citizen Review Panel conference being sponsored by the University of Kentucky Training Resource Center. The New Jersey Task Force on Child Abuse and Neglect is exploring if it can use existing funds to support sponsoring 2 members and/or professional support staff to attend the training.

Office of Child Advocate (OCA):

In December 2004, the OCA released a child fatality report on the deaths of 12 children it reviewed. The report acknowledges the existence of the CFNFRB, but OCA did not involve the CFNFRB at any point during its review of the cases or development of the report. The CFNFRB concurs with the OCA and the need to "align our efforts". The CFNFRB has outreached to OCA to talk about collaboration in the future.

Progress on Previous Recommendations

- The CFNFRB recommended that the Office of the Attorney General (AG) seek to amend N.J.S.A. 52:17B-78 et seq. (State Medical Examiner Act) giving the State Medical Examiner supervising authority over County Medical Examiner (CME) offices. Recognizing the delays inherent in revising state statute, the AG through the Division of Criminal Justice could seek an Executive Order from the Governor to give the OSME additional powers over CME offices, and the resources to effect such change.

  Board Comment: No response or progress has been made in this area.

- The adoption of Rules and Regulations for the CFNFRB and citizen review panels consistent with Federal and State legislation should occur.

  Board Comment: Progress has been made in this area with a draft of the rules and regulations prepared for discussion and adoption by the CFNFRB.

- It is recommended that an agreement between the CFNFRB, DHSS and DHS be implemented for a one year contract for the development, implementation and utilization of a joint infant, child and maternal fatality database.

  Board Comment: Progress has been made in this area and a working database is ready for discussion and adoption by the CFNFRB.

- The CFNFRB will endeavor to diversify the Regional Teams and make appointments that would make the Regional Teams broadly representative of the community.

Board Comment: No progress has been made in this area since the appointments require specific designations by state government or practitioners necessary for appointment do not reflect the diverse communities they serve.

- The Board recommends that the Governor complete the public membership appointments to the CFNFRB and consider appointments that would make the CFNFRB broadly representative of the community.

  Board Comment: No response or progress was made in this area. The Board has not had a representative of the Prosecutors' Association or the State Police at its meeting for the entire year.

- The CFNFRB will arrange a meeting with representatives of the Office the Attorney General to resolve the lack of attendance and representation by the State Police and Prosecutor's Association.

  Board Comment: No response or progress has been made in this area.

- The CFNFRB should collaborate with research universities to investigate the causes and prediction of preventable fatalities.

  Board Comment: No progress has been made in this area.

- The CFNFRB and Regional Teams will review all child fatalities due to child maltreatment.

  Board Comment: Significant improvement has been made in this area.

- The CFNFRB will define and review a sample of near fatality cases.

  Board Comment: Progress has been made in this area and review has begun.

- A public outreach session will be convened between the three citizen review panels in September 2004 at the Ninth New Jersey Conference on Child Abuse and Neglect.

  Board Comment: This was accomplished.

- The CFNFRB will establish an ad hoc work group with the Department of Law and Public Safety to better integrate child fatality review and investigative practices and procedures.

- State Response Report

Board Comment: No progress has been made in this area. The State response to the June 30, 2004 annual report was signed on June 16, 2005 according to DHS representatives. At the time the CFNFRB released its June 30, 2005 annual report, it had not received the State response and therefore those comments are not included in this report.

Goals and Recommendations - 2004

- The CFNFRB again recommends for the fifth consecutive year that the Office of the Attorney General (AG) seek to amend N.J.S.A. 52:17B-78 et seq. (State Medical Examiner Act) giving the Office of the State Medical Examiner (OSME) supervising authority over County Medical Examiner (CME) offices. Recognizing the delays inherent in revising state statute, the AG through the Division of Criminal Justice could seek an Executive Order from the Governor to give the OSME additional powers over CME offices, and the resources to effect such change. The CFNFRB is aware that bills are pending in the legislature to support this recommendation.
- The CFNFRB will endeavor to diversify the Regional Teams and make appointments that would make the Regional Teams broadly representative of the community. At this point in time, the Board and Regional Teams need to establish a plan to achieve ethnic and racial diversity.
- The CFNFRB will continue to promote and endorse public awareness campaigns about situations of high risk to children which could lead to death such as Unsafe Sleep practices, SIDS, water hazards, and home risk prevention such as fire and infant safety awareness.
- The CFNFRB is requesting additional staff or that current staff be relieved of duties not relating to the Board so it may achieve its goal of reviewing fatalities and near fatalities in a calendar year and become more involved in national child fatality efforts. The DYFS Assistant Commissioner should address this staffing inquiry.
- The CFNFRB seeks to increase the efficacy of criminal and civil investigations and prosecutions. Areas to be addressed in these discussions include “perpetrator unknown” cases of substantiated maltreatment, death scene investigation, autopsy protocols and release of homicide discovery information.
- The CFNFRB recommends that DHS establish a funding stream to support the activities of the Board and Panels.
- The CFNFRB will review the DYFS Survey analysis by the Task Force Citizen Review Panel and extrapolate policy recommendations pertinent to child fatality review.
- The CFNFRB is especially interested in SDM risk findings relative to fatality and near fatality in 2004 and 2005 reviews, and rates of recidivism would be an important analysis for the CFNFRB since suspicious death invariably is the unintended but real result of poor assessment of risk.
- Risk level should be included in future reviews as a measure of prediction for child and near fatality review.

- The CFNFRB recommends that the Office of the Child Advocate collaborate on their findings prior to issuing annual reports on child fatality since these parallel efforts are counterproductive to establishing initiatives that benefit at risk children.

CFNFRB Regional Team Rosters

- **Central**
- **Metropolitan**
- **Northern**
- **Southern**

Central Regional Community-Based Review Team
2004

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Susan Hodgson, M.D., Co-Chairperson, Medical Co-Director
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Frederick DiCarlo, M.D.
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