

# Child Fatality & Near Fatality Review Board Annual Report



New Jersey | Issued 2017



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# Introduction

The **New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA)**, adopted on July 31, 1997, established the statewide **Child Fatality and Near Fatality Review Board (CFNFRB, N.J.S.A. 9:6-8.88)**. The purpose of the CFNFRB is to ensure a comprehensive case review of child fatalities and near fatalities in order to identify and determine their cause, their relationship to governmental support systems, and methods of prevention. Pursuant to **N.J.S.A. 9:6-8.91**, the CFNFRB established local community-based teams to assist in the review of child fatalities in New Jersey.

These community-based teams are comprised of a variety of professionals who review the circumstances surrounding the tragedy of a child's death to improve services and systems in order to prevent future deaths. Team members include human service professionals from nonprofit and state organizations, physicians, prosecutors, law enforcement officers, pathologists, social workers, and educators. There are four community-based teams to represent three regions of the state; a fifth team includes the State Board, and a sixth team reviews "sudden, unexplained infant deaths" (SUID). In 2016, we added another team which reviews suicide among children in NJ. The teams meet monthly or every other month to review cases in which children have died or almost died in New Jersey.

During our meetings at the State Board level, we review cases in which the child was involved with the New Jersey Division of Child Protection and Permanency (CP&P) either at the time of the incident or within 12 months prior to the incident. We invite the caseworkers and their supervisors to our meeting to gather more information about the case, DCP&P's involvement, and experience working with the family, and their views on what could have been done to have prevented the tragic death. During this time, we explain that the Board is not looking to cast blame for the child's death but instead is looking for ways to improve the responses of systems to prevent such deaths from happening to other children. We look for challenges or barriers to DCP&P doing their work and whether current protocols and procedures should be modified or new resources are needed. We also ask about challenges erected by other systems in which the family was involved such as medical, mental health, substance abuse, law enforcement, and education.

Our goal is to learn from the caseworkers and the materials provided, identify ways to make improvements to the systems, and then suggest recommendations to those systems to address any barriers or challenges that exist. We look for patterns, emerging trends, or problems that repeat over time. For example, the Board recognized that there was an increase in suicides among children and youth which led to the creation of the suicide subcommittee made up of experts from the medical field, law enforcement, child protective services, and the Department of Children and Families to review those specific cases to identify challenges and make recommendations to systems to help educate families on how to reduce the risk of such devastating deaths.

As such, this report includes our recommendations from cases in which children died or nearly died in 2015. We hope these recommendations will be addressed by the entities to which we directed them. Ultimately, we hope that we can successfully prevent unnecessary deaths of children in New Jersey.

Sincerely,

Kathryn McCans, M.D.  
Chairwoman

Judy L. Postmus, Ph.D., ACSW  
Vice-Chairwoman

*All data represented herein was collected during the review process of the 2015 fatalities and near fatalities and analyzed by DCF liaisons to the CFNFRB.*

# Selecting and Reviewing Cases

## The 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, Law Enforcement, and upon request, the Department of Health. 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, law enforcement, educational, mental health, medical, and social service records. The CFNFRB has the authority to subpoena and secure the required materials as necessary.

All relevant documentation is posted in a secure on-line library approximately two (2) weeks before a scheduled meeting for members to review in preparation for discussion.

Some of the possible actions following each case review include: 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.

## Cases are selected for review based on NJ State law. Cases are reviewable when the cause of death is:

- Undetermined
- Substance abuse<sup>1</sup> may have been a contributing factor
- Homicide due to child abuse or neglect
- Child abuse or neglect may have been a contributing factor
- Malnutrition, dehydration, medical neglect or failure to thrive
- Sexual Abuse
- Head trauma, fractures, or blunt force trauma without obvious innocent reason, such as auto accidents
- Suffocation or asphyxia
- Burns without obvious innocent reason, such as auto accident or house fire
- Suicide
- Children whose families were under the supervision of the Division of Child Protection and Permanency (CP&P) at the time of the fatal or near fatal incident or within twelve (12) months immediately preceding the fatal or near fatal incident.
- Drowning
- Motor vehicle accidents in which the child:
  - Had a positive toxicology screen
  - 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)

<sup>1</sup>includes substance use

# Members

The type of case and its geographical location determines which team will review the case. There is a total of six teams: The State CFNFR Board, Northern Community-Based Team, Metropolitan Community-Based Team, Central Community-Based Team, Southern Community-Based Team, and the Sudden Unexpected Infant Death Subcommittee (SUID).

The State Board reviews only those cases that meet criteria in which CP&P was involved at the time of the fatality/near fatality or within the last twelve months; the Teams review all other cases. The SUID Subcommittee reviews all deaths in children under 1 year old whose cause/manner was SUID, Sudden Infant Death Syndrome (SIDS), undetermined, and any others that were sleep related.

## The State CFNFR Board Members:

- **Chair: Kathryn McCans, M.D., F.A.A.P.**, Cooper University Hospital, Division of Pediatric Emergency Medicine
- **Vice Chair: Judy L. Postmus, Ph.D., A.C.S.W.**, Professor/Director, Rutgers University School of Social Work, Center on Violence Against Women and Children
- Cathleen Bennett, Commissioner, Department of Health, Designee: **Lakota Kruse, M.D., M.P.H.**
- Allison Blake, Ph.D., L.S.W., Commissioner, Department of Children and Families, Designee: **Aubrey C. Powers, Assistant Commissioner**, Office of Performance Management and Accountability.
- **Sean F. Dalton, Esq.**, Prosecutor, Gloucester County
- **Andrew L. Falzon, M.D.**, State Medical Examiner
- Col. Rick Fuentes, Superintendent, New Jersey State Police, Designee: **LT Thomas Wiczerak**
- **Martin A. Finkel, D.O., F.A.A.P.**, New Jersey Task Force on Child Abuse and Neglect
- **Manuel Guantez, Psy.D., L.C.A.D.C.**, Vice President, Outpatient and Addiction Services, Rutgers, University Behavioral Healthcare
- Robert Lougy, Attorney General, Office of the Attorney General, Division of Law, Designee: **Thomas Ercolano, Esq.**
- **James A. Louis, Esq.**, Deputy Public Defender, Office of the Law Guardian
- **Lisa von Pier, M.Div.**, Assistant Commissioner, Division of Child Protection and Permanency, Department of Children and Families
- **Karen D. Wells, Psy.D.**, Licensed Clinical Psychologist
- **STAFF: Lisa Kay Hartmann, State Coordinator, Ashley Costello\***, **Amanda Craig**, and **Nicholas Pecht**, DCF Liaisons to CFNFRB

*\* Denotes status as former liaison*

## Members Cont.

### Northern Regional Community-Based Team

(Counties: Bergen ,Hudson, Morris, Passaic, Sussex, Warren)

- **Chair: Paulett Diah, M.D.**, Hackensack University Medical Center (HUMC)
- **Vice Chair: Ruth Borgen, M.D.**, Director, Pediatric Emergency Room, HUMC
- **Frederick DiCarlo, M.D.**, Bergen County Medical Examiner’s Office
- **Danielle Grootenboer, Esq.**, Bergen County Prosecutor’s Office
- **Maria Ojeda**, Division of Child Protection and Permanency
- **Joseph Papisidero, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Sandra Parente**, Division of Child Protection and Permanency
- **Albert Sanz, M.D.**, St. Joseph’s Hospital
- **Sgt. Javier Toro**, Hudson County Prosecutor’s Office
- **Matthew Troiano**, Morris County Prosecutor’s Office

### Metropolitan Regional Community-Based Team

(Counties: Essex, Union)

- **Chair: Monica Weiner, M.D.**, Metro Regional Diagnostic Treatment Center (RDTC)
- **Guadalupe Casillas, Esq.**, Office of the Public Defender, Office of Law Guardian
- **George Ekpo**, Division of Child Protection and Permanency
- **John Esmerado, Esq.**, Union County Prosecutor’s Office
- **Raksha Gajarawala, M.D.**, Pediatric Physician Consultant
- **Gina P. Iosim, Esq.**, Essex County Prosecutor's Office
- **Felicia Okonkwo**, Division of Child Protection and Permanency
- **Donna Pincavage, M.S.W., M.P.A.**, Metro RDTC
- **Carly Ryan, M.A.**, Partnership for Maternal and Child Health of Northern New Jersey

### Central Regional Community-Based Team

(Counties: Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset)

- **Chair: Dr. Gladibel Medina, M.D.**, Dorothy B. Hersh Child Protection Center
- **Peter J. Boser, Esq.**, Monmouth County Prosecutor’s Office
- **Lillian Brennan, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Marisol Garces**, Division of Child Protection and Permanency
- **Carol Ann Giardelli**, Director, Safe Kids New Jersey – Central Jersey Family Health Consortium
- **Det. Matthew Norton**, Mercer County Prosecutor’s Office
- **Joan Pierson**, Division of Child Protection and Permanency
- **Alex Zhang, M.D.**, Middlesex County Medical Examiner’s Office

# Members Cont.

## Southern Regional Community-Based Team

(Counties: Atlantic, Burlington, Camden, , Cape May, Cumberland, Gloucester, Salem)

- **Chair: Laura Brennan, M.D.**, Rowan University, School of Osteopathic Medicine
- **Mary Alison Albright, Esq.**, Camden County Prosecutor's Office (Retired)
- **Nanette Briggs, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Pamela D'Arcy, Esq.**, Atlantic County Prosecutor's Office
- **Ian Hood, M.D.**, Burlington County Medical Examiner's Office
- **Lt. James Kirschner**, Atlantic County Prosecutor's Office
- **Barbara May, R.N., M.P.H.**, Southern NJ Perinatal Cooperative, Inc.
- **Iris Moore**, Division of Child Protection and Permanency
- **Robert G. Moore**, Division of Child Protection and Permanency
- **Det. Frank Sabella**, Cumberland County Prosecutor's Office
- **Christine Shah, Esq.**, Camden County Prosecutor's Office
- **Sgt. Michael A. Sperry**, Burlington County Prosecutor's Office

## Sudden Unexpected Infant Death Subcommittee

- **Lillian Brennan, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Susan Fiorilla**, Division of Child Protection and Permanency
- **Lakota Kruse, M.D., M.P.H.**, Department of Health
- **Det. Matt Norton**, Mercer County Prosecutor's Office
- **Barbara Ostfeld, Ph.D.**, Program Director, The SIDS Center of New Jersey

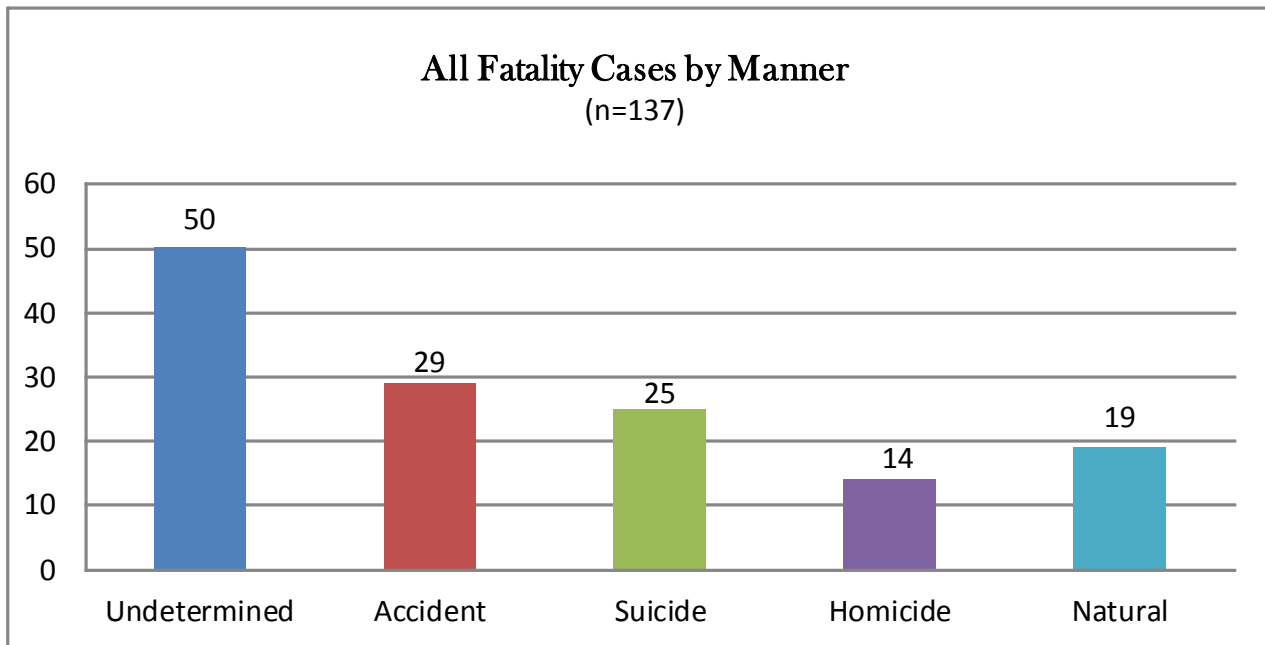
## Suicide Subcommittee

- **Andrew L. Falzon, M.D.**, State Medical Examiner
- **Ruby Goyal-Carkeek**, Children's System of Care
- **Michelle Scott, PhD, MSW**, Monmouth University
- **Maureen Brogan, LPC, DRCC**, Traumatic Loss Coalition
- **Marisol Garces, MSW**, Division of Child Protection and Permanency
- **John Chatlos, Jr., M.D.**, Rutgers UBHC & RWJ Medical School
- **Elizabeth Dahms, MS, RN-BC**, Department of Health
- **Det. Sgt. Michael A. Sperry**, Burlington County Prosecutor's Office
- **Iris Moore**, Division of Child Protection and Permanency
- **Kara Song**, Office of Adolescent Services

*\*Please note that in 2017 there was a consolidation of teams.*

# Statewide

The Fatality and Executive Review Unit of the Department of Children and Families was notified of 291 child fatalities/near fatalities in New Jersey for the 2015 calendar year. Of those 291 cases, 138 met the criteria for review. Of those 138 cases reviewed, one was a near fatality.



Source: Data collected from 2015 Reviews

The leading cause of death in each manner of death is as follows:

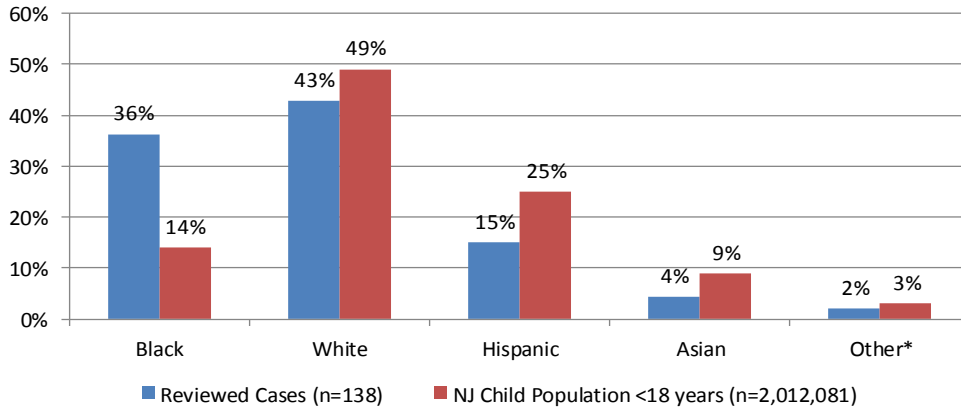
- 88% (44) of the Undetermined cases were sudden unexpected infant death (SUID)/Sleep-Related, followed by one case of acute tramadol intoxication, two cases of hanging, one head injury, one multiple blunt impact injuries and one undetermined.
- 31% (9) of the Accident cases were SUID/Sleep-Related and 41% (12) of the deaths were due to drowning. Other causes included three motor vehicle accident, two drug-related, one hanging, one of blunt force head injuries and one asphyxia.
- 64% (16) of the Suicide cases were caused by hanging, followed by four drug-related, three from blunt trauma, one case with firearms and one case from drowning.
- 29% (4) of the Homicide cases were caused by gunshot wounds, 21% (3) were caused by smoke inhalation, followed by two blunt force trauma, two abusive head trauma, one homicidal violence, one suffocation, one combined strangulation and blunt force trauma.
- 87% (13) of the Natural cases were SUID/Sleep-Related followed by two medical deaths.<sup>2</sup>
- 50% (69) of all reviewed cases were related to SUID and/or the sleeping environment.

<sup>2</sup> Some medical examiners rule the SUIDs natural while some rule them undetermined.



# Statewide

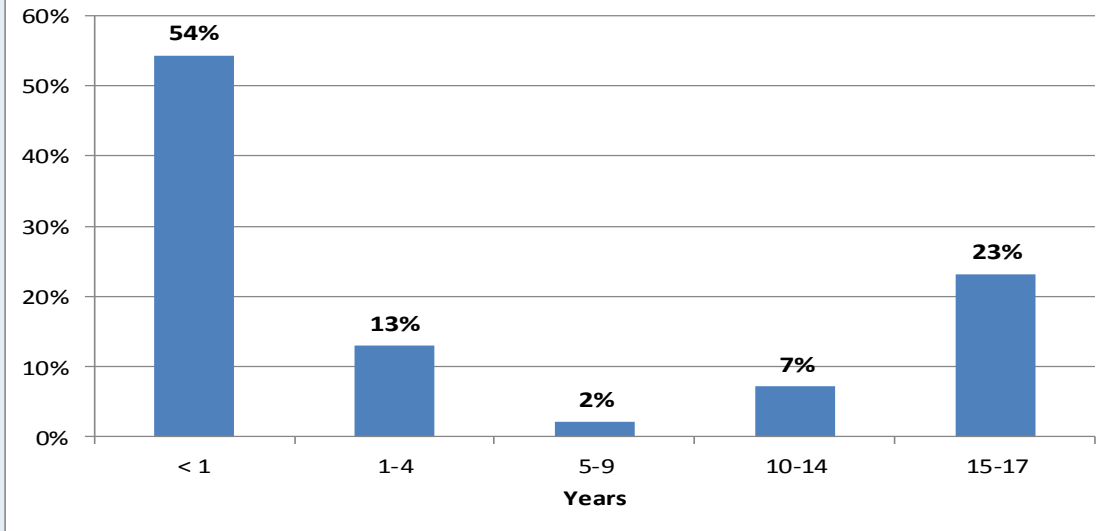
### Race/Ethnicity Comparison of Reviewed Cases to NJ Child Population



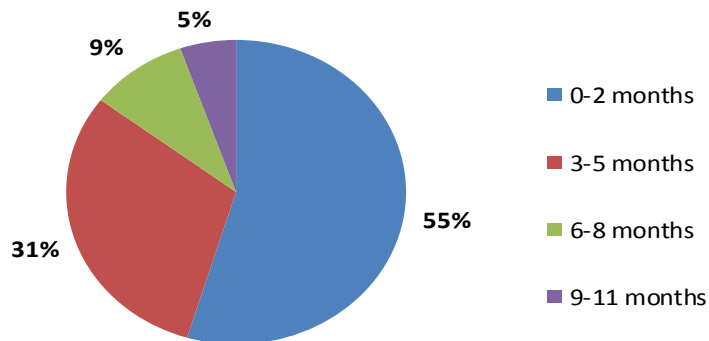
**Gender Distribution**

60% Male  
40% Female

### Age Distribution n=138



### Age Distribution Under 1 Year n=75

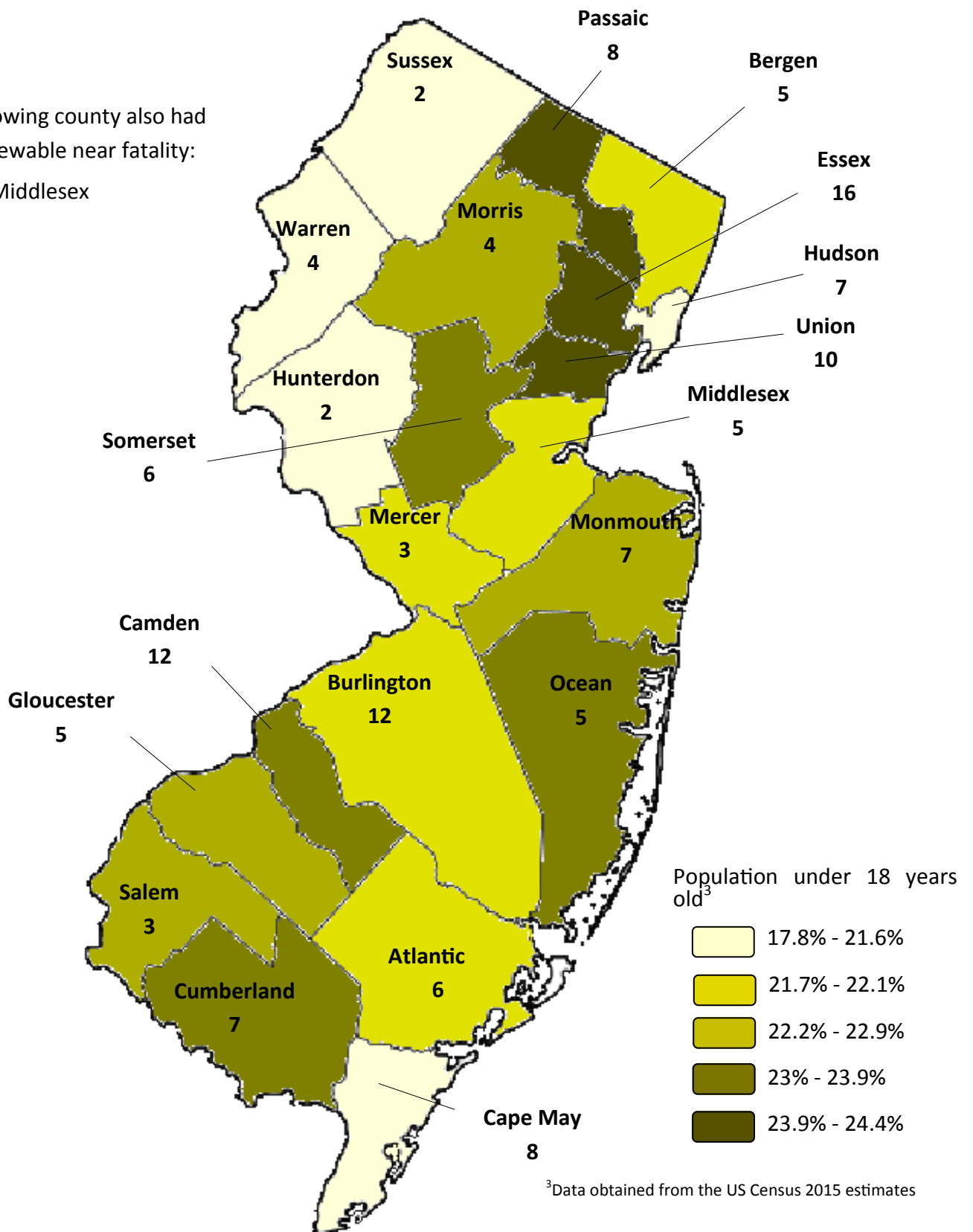


NJ Child Population data obtained from US Census, Population Division, July 1, 2015 estimates

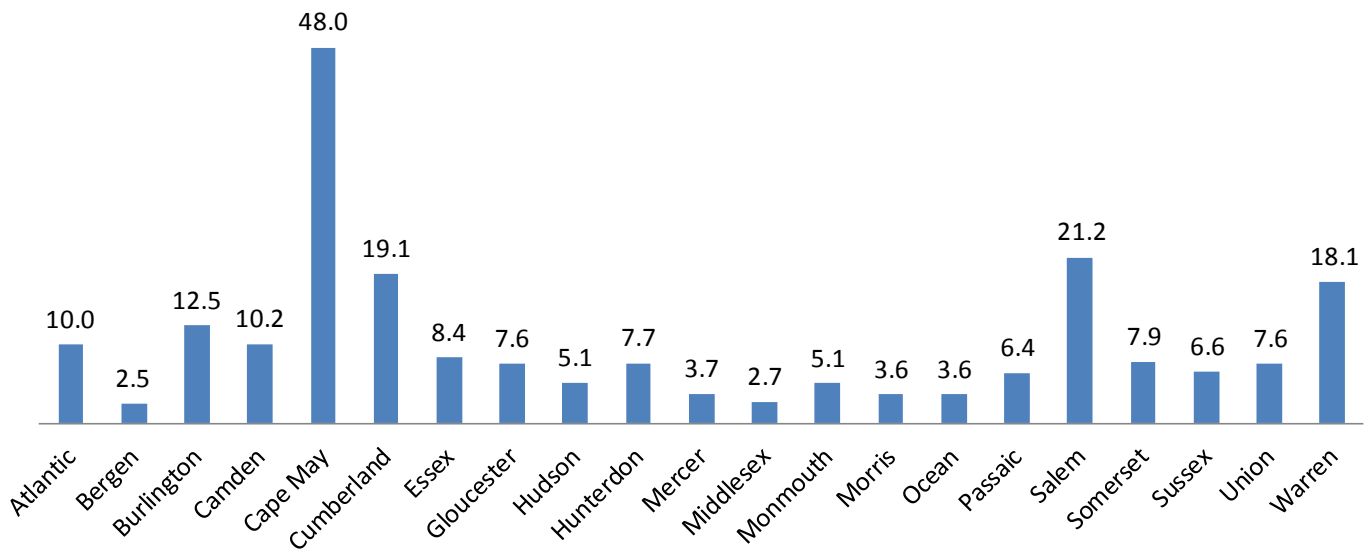
# Reviewed 2015 Fatalities by County of Incident

The following county also had one reviewable near fatality:

Middlesex



## 2015 Reviewed Fatality Rate per 100,000 Children

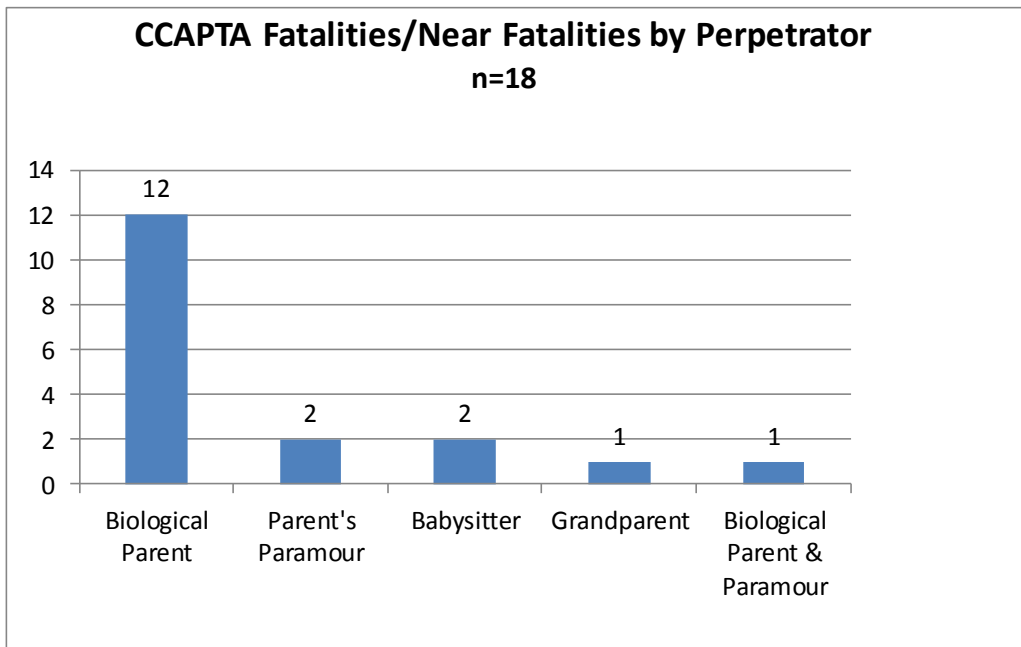


County	Accident	Homicide	Natural	Suicide	Undetermined	County Fatalities	% of NJ Fatalities	< 18 years old	Fatality Rate per 100,000 Children
Atlantic	0	0	1	2	3	6	4%	60,053	10.0
Bergen	2	1	1	1	0	5	4%	201,778	2.5
Burlington	3	1	3	1	4	12	9%	96,348	12.5
Camden	1	1	3	4	3	12	9%	118,023	10.2
Cape May	2	1	0	2	3	8	6%	16,671	48.0
Cumberland	1	1	1	1	3	7	5%	36,625	19.1
Essex	2	3	2	1	8	16	12%	191,384	8.4
Gloucester	3	0	1	1	0	5	4%	65,874	7.6
Hudson	2	1	1	1	2	7	5%	136,991	5.1
Hunterdon	0	0	0	1	1	2	1%	25,976	7.7
Mercer	2	0	1	0	0	3	2%	80,593	3.7
Middlesex	1	0	0	0	4	5	4%	184,157	2.7
Monmouth	1	2	0	3	1	7	5%	138,317	5.1
Morris	0	1	1	1	1	4	3%	109,891	3.6
Ocean	3	0	1	0	1	5	4%	138,349	3.6
Passaic	2	0	0	1	5	8	6%	124,152	6.4
Salem	1	0	1	1	0	3	2%	14,119	21.2
Somerset	1	1	0	1	3	6	4%	76,073	7.9
Sussex	0	0	0	1	1	2	1%	30,315	6.6
Union	1	1	1	2	5	10	7%	131,721	7.6
Warren	1	0	1	0	2	4	3%	22,121	18.1
<b>State Total</b>	<b>29</b>	<b>14</b>	<b>19</b>	<b>25</b>	<b>50</b>	<b>137</b>	<b>100%</b>	<b>1,999,531</b>	<b>6.9</b>

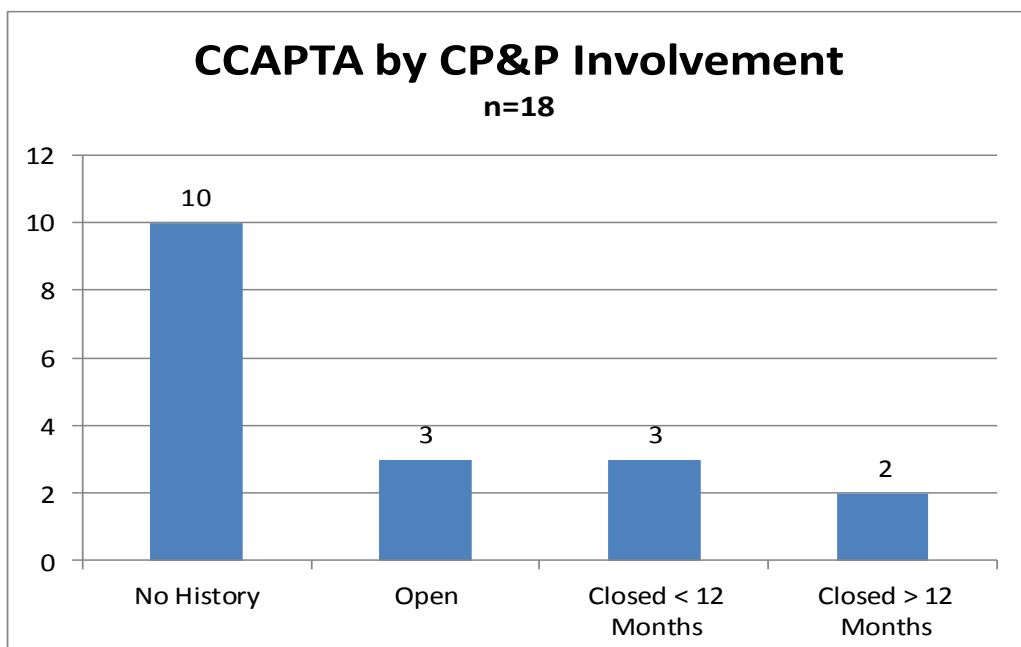
<sup>4</sup>Data obtained from the US Census 2015 estimates

# Comprehensive Child Abuse Prevention & Treatment Act

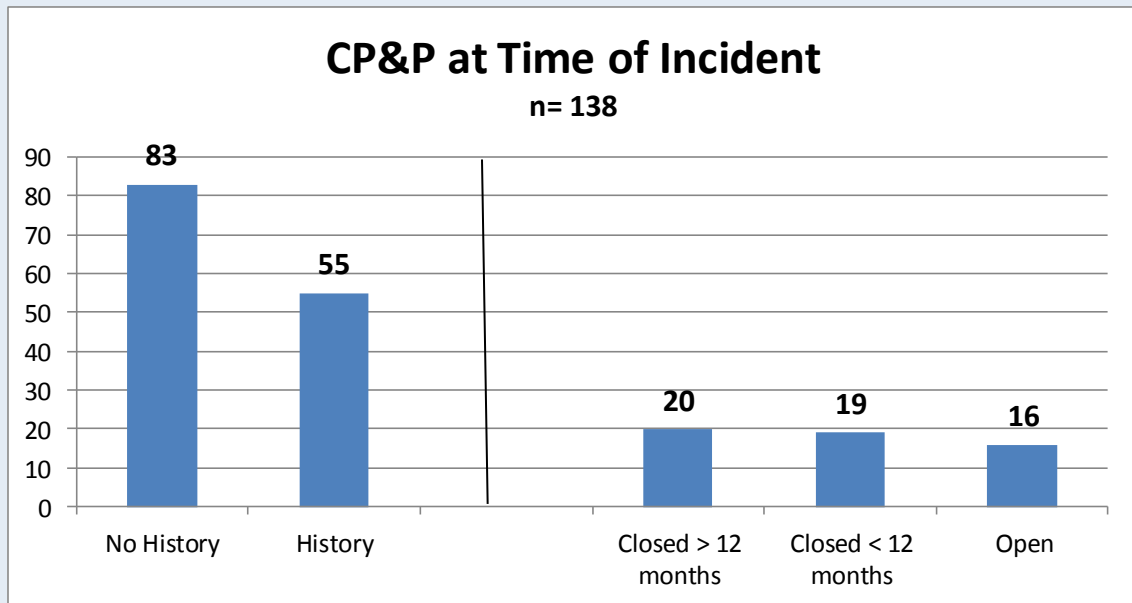
The CFNFRB serves as one of the citizen review panels established by the Comprehensive Child Abuse Prevention and Treatment Act of 1997 (CCAPTA). A case is considered a 'CCAPTA' when a child fatality or near fatality is the result of child abuse or neglect; whether or not the family was involved with CP&P at the time of the incident.



Of the 18 incidents that constitute the 2015 CCAPTA cases, 33% (6) of those children were involved with CP&P at the time of the incident or had been involved with CP&P within the last twelve months.



# Division of Child Protection and Permanency (CP&P)



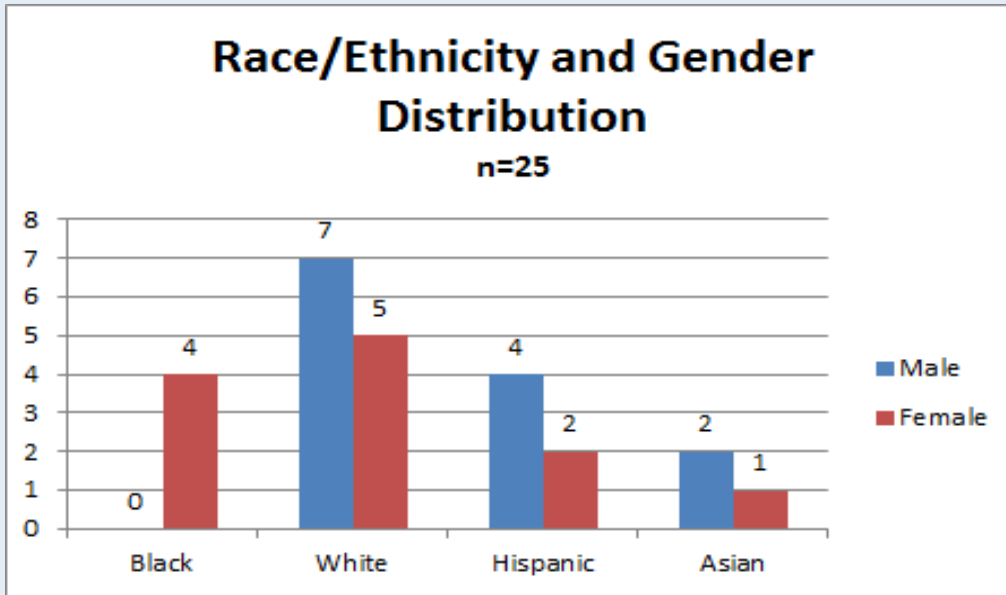
Source: Data collected through 2015 reviews

'History' includes all children who had ever been involved with CP&P regardless of timeframe.

CP&P investigates all reported allegations of child abuse and neglect. The mission is to ensure the safety, permanency, and well-being of children and to support families.

- 12% (16) of the cases reviewed were open with CP&P at the time of the incident.
- Of the 138 children reviewed, 40% (55) of them had, at some point in their life, been involved with CP&P.

# Suicide

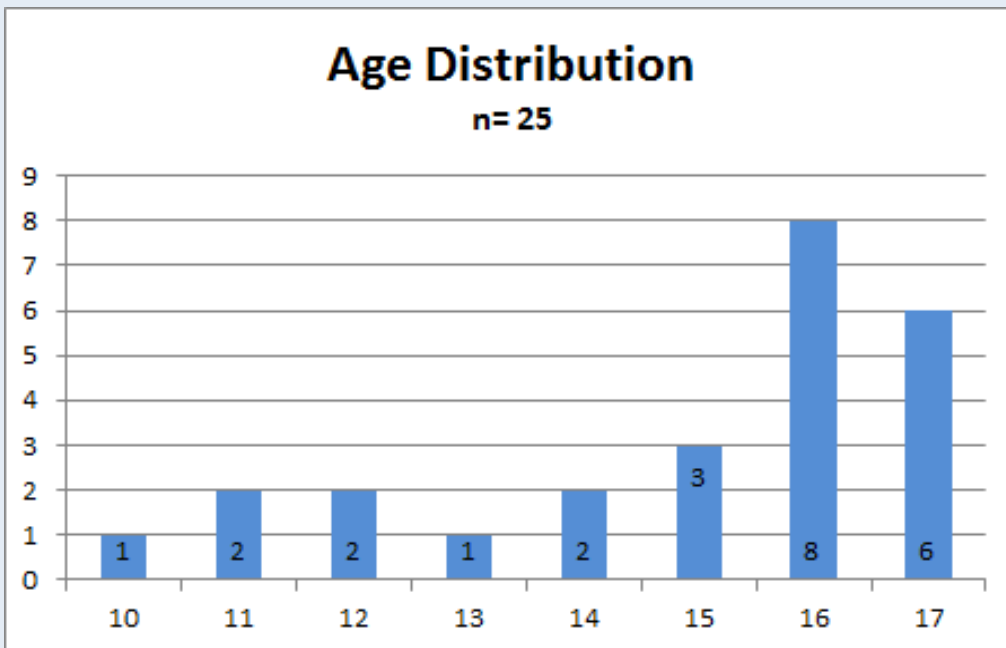


## Method

64% (16) of the suicides were completed by hanging.

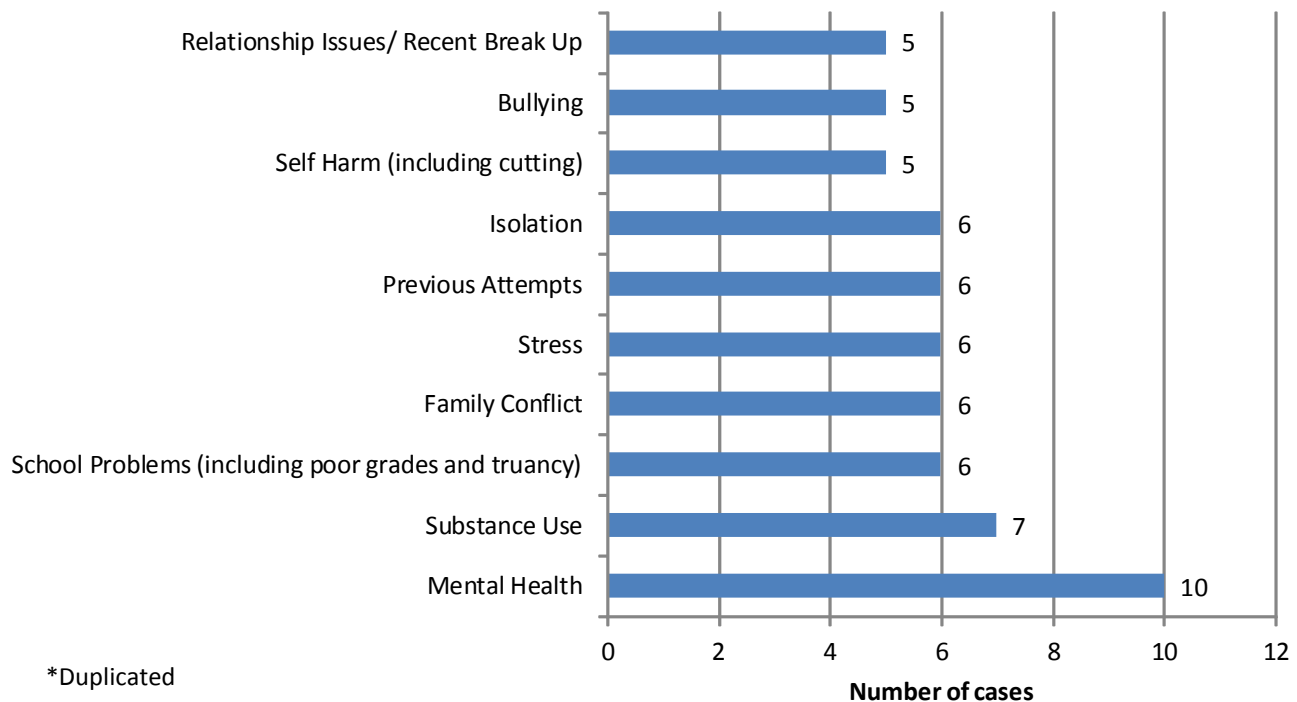
16% (4) were completed by drug overdose.

The remaining methods (5) included use of a firearm, blunt force trauma and drowning.



**Suicidal Warning Signs:** Talking about wanting to die • Looking for a way to kill themselves • Feeling hopeless or having no reason to live • Talking about feeling trapped or in unbearable pain • Extreme mood swings; sudden changes in personality • Talking about being a burden to others • Increasing use of alcohol or drugs • Acting anxious or agitated; behaving recklessly • Sleeping too little or too much • Withdrawing or isolating themselves • Showing rage or talking about seeking revenge • Running away from home Sources: National Prevention Suicide Lifeline, National Alliance for Mental Illness

## Suicide Risk Factors (as identified during case review) \*



### Teen Suicide Risk Factors: A recent or serious loss

- A psychiatric disorder, particularly a mood disorder like depression, or a trauma-and stress-related disorder
- Prior suicide attempts increase risk for another suicide attempt
- Alcohol and other substance use disorders, as well as getting into a lot of trouble, having disciplinary problems, engaging in a lot of high-risk behaviors
- Struggling with sexual orientation in an environment that is not respectful or accepting of that orientation
- A family history of suicide is something that can be really significant and concerning, as is a history of domestic violence, child abuse or neglect
- Lack of social support
- Bullying We know that being a victim of bullying is a risk factor, but there's also some evidence that kids who are bullies may be at increased risk for suicidal behavior
- Access to lethal means, like firearms and pills
- Stigma associated with asking for help
- Barriers to accessing services
- Cultural and religious beliefs that suicide is a noble way to resolve a personal dilemma

Source: Child Mind Institute

**If in a crisis, youth between 10 and 24 years old can call or text 2nd Floor Youth Helpline at 888-222-2228 and visit their website [www.2ndfloor.org](http://www.2ndfloor.org)**

**OR**

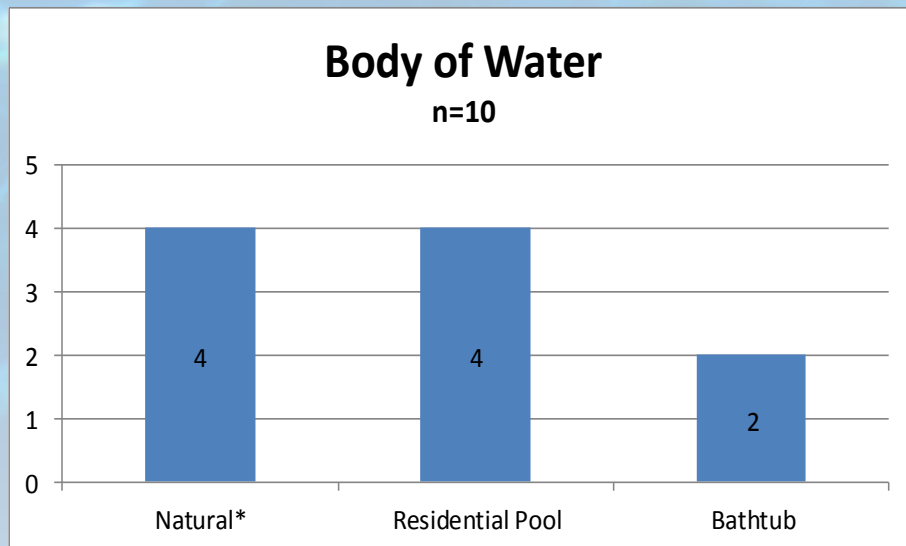
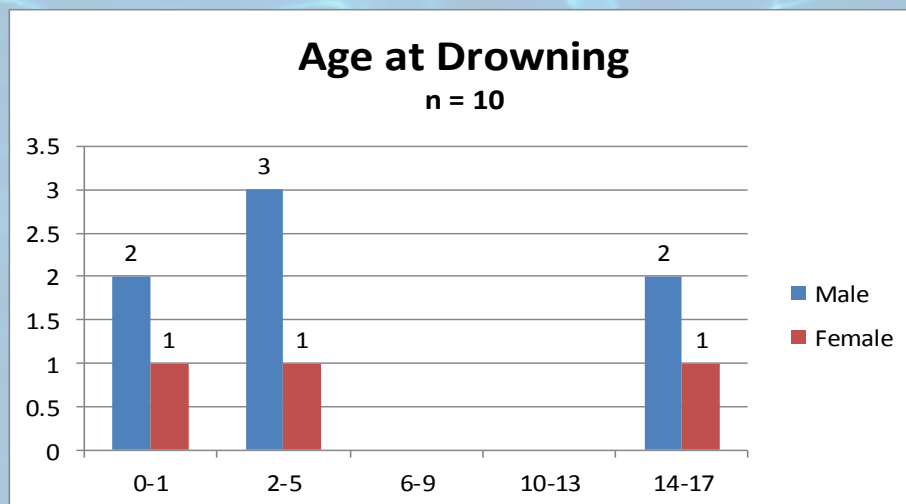
**People of any age can call the NJ Suicide Prevention Hope Line at 1-855-654-6735, text at [njhope-line@ubhc.rutgers.edu](mailto:njhope-line@ubhc.rutgers.edu), or visit their website [www.njhopeline.com](http://www.njhopeline.com)**

Additional resources include:

- PerformCare (provides linkage to various services for children):  
1-877-652-7624  
[www.performcarenj.org](http://www.performcarenj.org)
- Mobile Response and Crisis Screening: 1-877-652-2764
- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

# Drowning

There were no drownings for the age groups 6-9 and 10-13.



\*Natural includes lake, river, and ocean

All four children who drowned in a residential pool were between one and two years old.

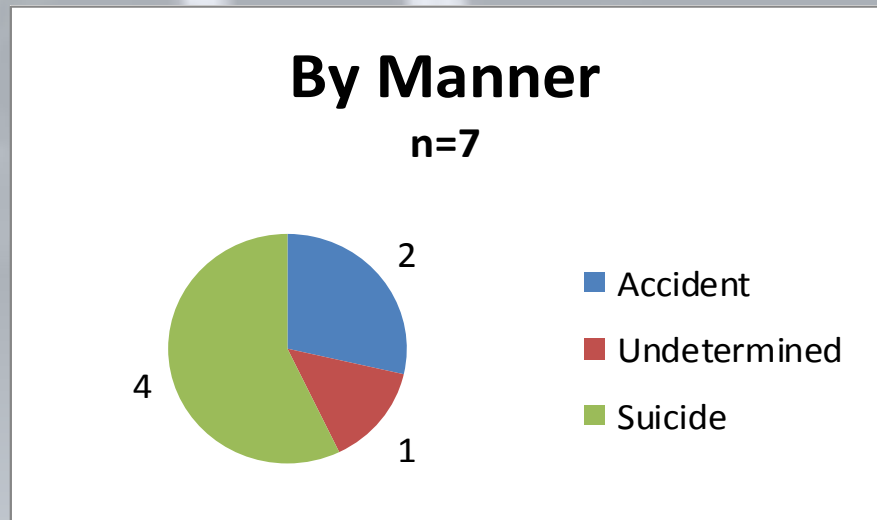
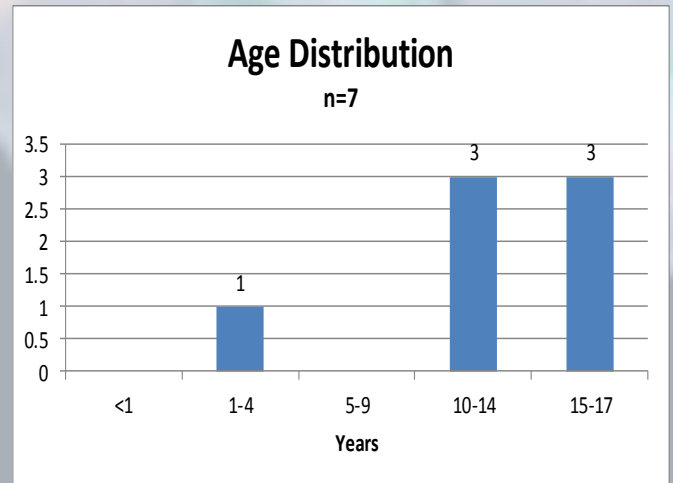
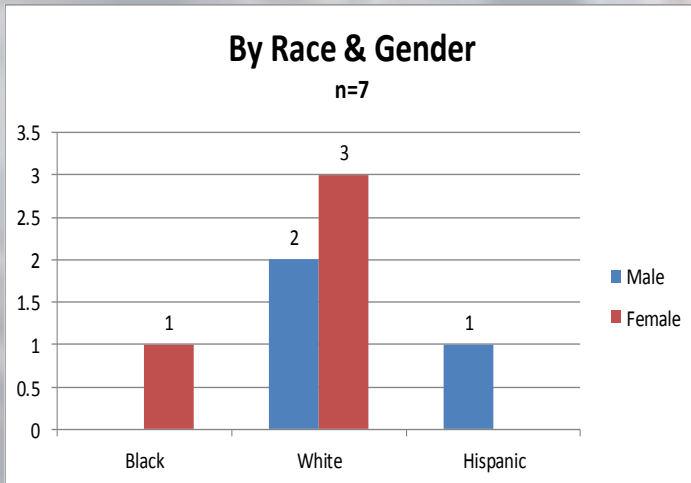
## Pool Safety<sup>5</sup>:

- ◆ Never leave children in or near water unattended; stay within an arm's length of small children in water to protect against rapid drowning.
- ◆ Warn children to never swim at a pool or beach alone or without a lifeguard.
- ◆ Train children to swim at an early age.
- ◆ Teach children that swimming in open water is far different than swimming in a pool.
- ◆ Be certain only qualified and undistracted adults are entrusted with supervising children in water.
- ◆ Always empty inflatable pools, buckets, pails, and bathtubs after each use.
- ◆ Personal flotation devices do not guarantee water safety.

<sup>5</sup><http://nj.gov/dcf/families/safety/water/>



# Substance Use



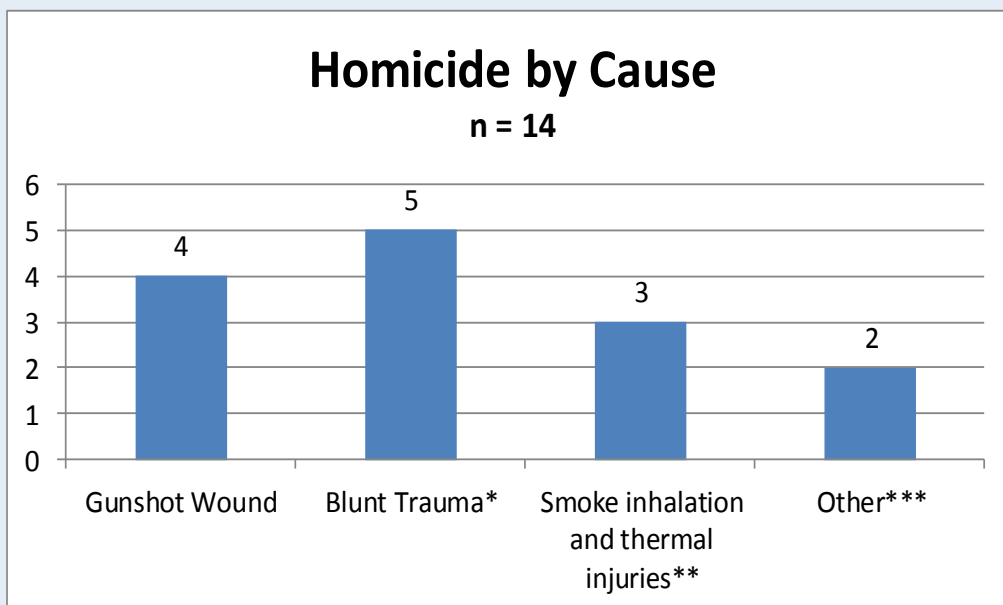
Call PerformCare at  
877-652-7624 to access  
child behavioral  
healthcare and other  
services OR  
Call the NJ Mental Health  
Cares hotline at  
866-202-4357 for  
referrals to services

**Warning Signs:** • Changes in mood • Academic/school problems • Changing friends and a reluctance to have parents/family get to know the new friends • A "nothing matters" attitude • Finding substances (drug or alcohol) in youth's belongings • Physical or mental changes (memory lapses, poor concentration, lack of coordination, slurred speech, etc.)

Warning signs indicate that there may be a problem —not that there definitely is a problem. Speak with the youth to get a better understanding of the situation and have the youth screened for substance use by a professional. If formal intervention is necessary, local substance abuse professionals should be contacted. If there is no clear evidence of substance use/abuse, consider working with your primary care physician or a mental health professional to address the child's behaviors and needs.

Source: <http://youth.gov/youth-topics/substance-abuse/warning-signs-adolescent-substance-abuse>

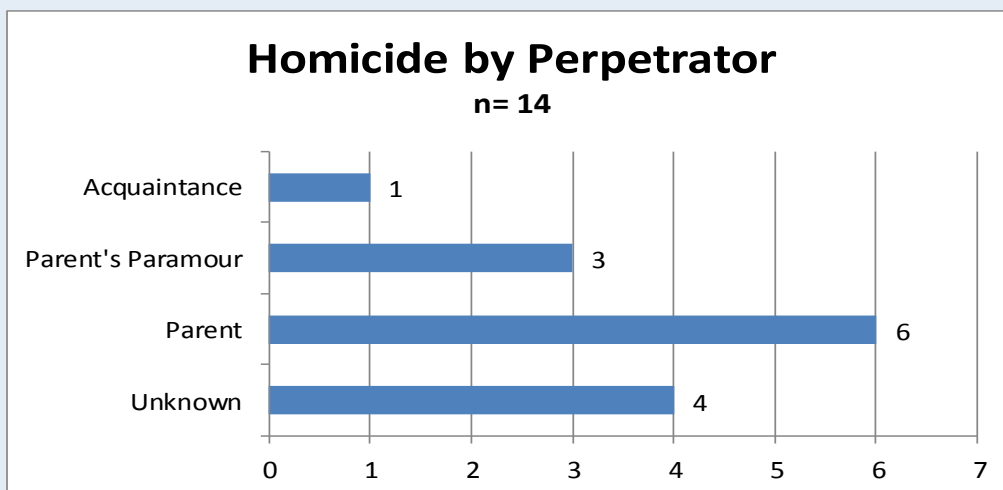
# Homicide



\* One of the cases involving blunt trauma had a combined cause of strangulation.

\*\* Two of the children who suffered from smoke inhalation and thermal injuries were a sibling group and a gunshot wound also contributed to their deaths.

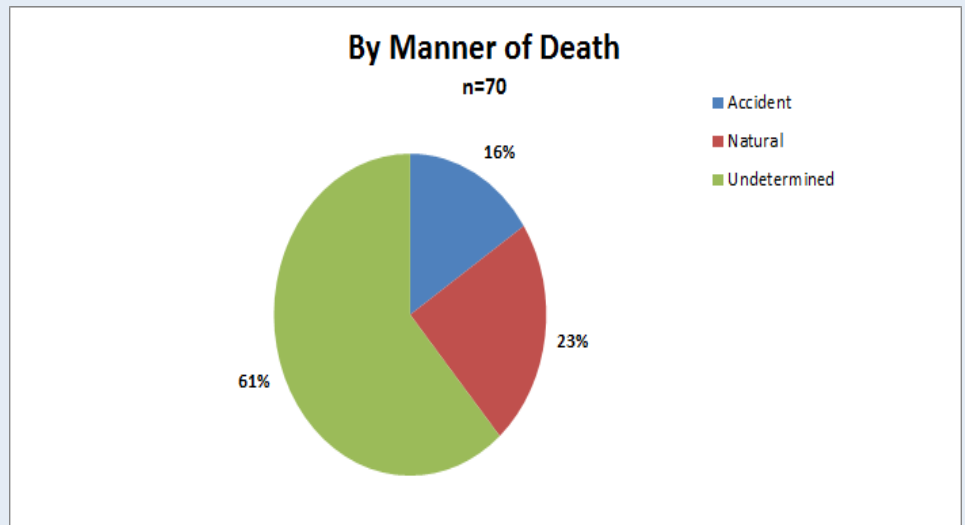
\*\*\* Other causes includes homicidal violence of undetermined etiology and suffocation.



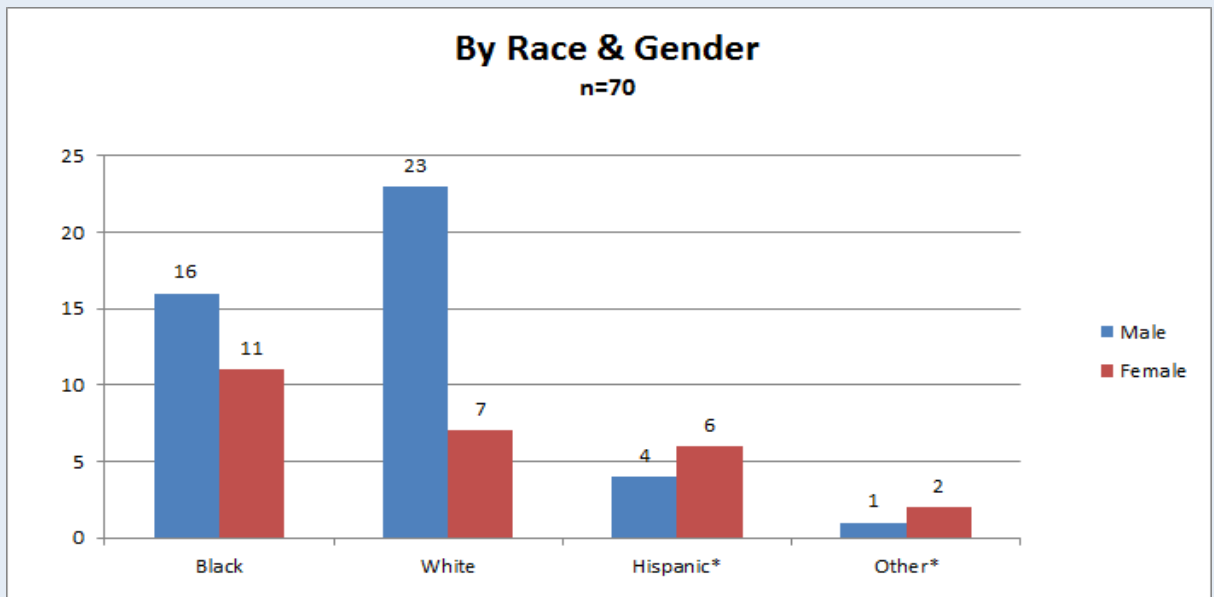
- ◆ The four children who died by gunshot wound were between the ages of 15 and 17.
- ◆ Four of the homicide victims were female.

# Sudden Unexpected & Sleep-Related Death in Children Under 12 Months Old

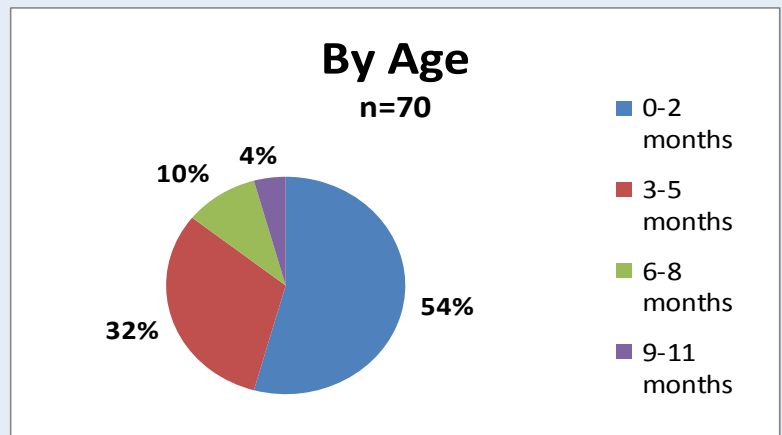
According to the CDC, Sudden unexpected infant death (SUID) is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before investigation.



\*Includes Black & White Hispanic;  
\*\*Includes two Asian & one Bi-racial (Black/White)

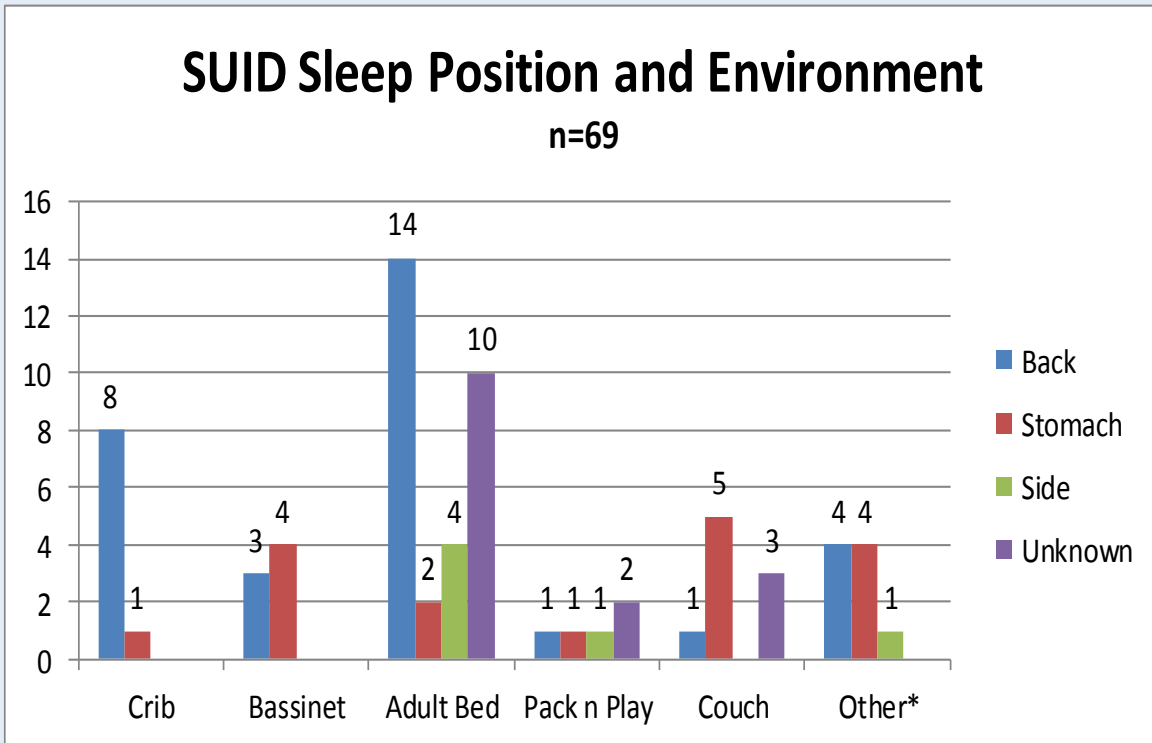


<https://www.babyboxuniversity.com/>



## Sudden Unexpected & Sleep Related Cont.

Sleep-related infant deaths are those where the sleep environment was likely to have contributed to the death, including those ruled SIDS, SUID, suffocation, and other causes.



\*Includes 1 air mattress, 2 recliners, 1 swing, 1 bedside co-sleeper, 1 stroller, 2 floor, and 1 car seat

59% (41/69) of the children were sharing a sleep surface with another person.

99% (69) of the fatalities reviewed by the SUID Subcommittee were related to sleep and/or the sleep environment.

### Guidelines for Safe Sleep<sup>6</sup>:

- ◆ Bare is Best: Place baby on the back to sleep in a crib free from objects (i.e. toys, stuffed animals, and blankets)
- ◆ Place baby on a firm sleep surface
- ◆ Place baby in the same room with you but not the same bed
- ◆ Limit baby's exposure to smoke (cigarette, cigar, illegal substances)
- ◆ Consider breastfeeding
- ◆ Bring baby to the pediatrician for all well-visits
- ◆ Practice supervised, awake 'tummy time'
- ◆ Avoid overheating
- ◆ Avoid products such as wedges, positioners, and bumpers

# Recommendations

Please note that any responses received from the recipients of these recommendations will be published in the 2018 Child Fatality & Near Fatality Review Board Annual Report. If there are no responses received that will be noted as well.

## Water Safety

To: The Department of Children and Families

DCF water safety public education materials (i.e. brochures, posters) should explicitly include bathtub safety, as currently the materials are focused on drownings in pools/open water.

## Multi-Disciplinary

To: The Department of Children and Families

Law Enforcement

As advocated in “Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities,” prevention may be aided by real-time, cross-jurisdictional information sharing. The Board therefore recommends the same and further recommends that CP&P consider revising their standard collateral forms to include Likert scales and other evidence-based survey methods to improve the quality of information transmitted. The Board further recommends that CP&P consider the feasibility of sharing information electronically, while continuing to maintain the confidentiality of the children and families it serves.

The Board recommends that all New Jersey counties adopt the Child Fatality Multi-Disciplinary Investigation Protocol and, as modelled by Gloucester County, hold annual meetings where local police, the prosecutor’s office, the medical examiner’s office, emergency medical services, and CP&P can come together to clarify their separate and shared responsibilities. This will ensure that all parties know how to proceed when investigating a child fatality, while simultaneously fostering relationships between the different offices’ personnel.

## Health Insurance

To: NJ Department of Banking and Insurance

Health insurers should cover routine medical care based on best practices, as recommended by leaders in the medical field, like the American Academy of Pediatrics (AAP). For example, the 30 month well visit is recommended by the AAP, but is often not covered by health insurers so therefore this recommendation is rarely followed. This recommendation is based on a case reviewed in which, had the child been seen by a pediatrician at the 30 month well visit, risk may have been identified and the outcome may have been different.

## Substance Use

To: Treatment Providers

The results of drug screens should be communicated in an expedited manner to those making decisions with regards to treatment plans and services, including CP&P workers, psychological evaluators and the courts.

# Recommendations

## SUID Prevention

To: Hospitals & Pediatricians

Hospital staff and social workers should develop protocols for referring at-risk families to Home Visiting programs prior to discharge of a newborn.

Electronic patient education material incorporated into electronic medical records and hospital discharge information should be regularly updated to include new guidelines and language especially related to safe infant sleep messages.

Pediatricians must stay informed with regards to the AAP's current safe sleep recommendations and ensure that they have the most up-to-date safe sleep information to share with their patients' caregivers.

These recommendations are in light of the fact that 99% of the SUID fatalities reviewed in 2015 were related to the sleep environment.

## Suicide Prevention

To: Department of Education

The CFNFRB recommends that both public and non-public schools integrate effective and proven suicide prevention programs into the curricula and services currently provided. It is also recommended that such programs promote resilience and positive youth development and provide information on warning signs and available community resources. Programs should monitor outcomes, as evidence-based programs are considered to be best practice. This recommendation reiterates a similar recommendation made in last year's report. Special consideration should be made with regards to nonpublic schools and their suicide prevention education programs. 16% of NJ children that completed suicide in 2015 attended nonpublic schools.

Schools should explore evidence-based disciplinary practices that are protective of all students. Out-of-school suspension, as a disciplinary measure, does not address the child's behavior, and negatively impacts the child's well-being by isolating the child, a well-known risk factor for suicide.