NJ Child Fatality & Near Fatality Review Board Annual Report

ISSUED 2022

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Introduction

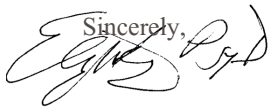
The **New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA)**, adopted on July 31, 1997, established the statewide **Child Fatality and Near Fatality Review Board (CFNFRB), N.J.S.A. 9:6-8.88**. The purpose of the CFNFRB is to ensure a comprehensive case review of child fatalities 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 human services professionals from nonprofit and state organizations, as well as physicians, prosecutors, law enforcement officers, pathologists, social workers, child advocates, and educators. There are three community-based teams to represent different regions of the state; two statewide subcommittees that address specific types of fatalities, Sudden Unexplained Infant Deaths (SUID) and Suicide; and a sixth team comprised of the State Board, which reviews fatalities/near fatalities of children involved with the New Jersey Division of Child Protection and Permanency (DCP&P) either at the time of the incident or within 12 months prior to the incident.

The State Board invites DCP&P staff, including front-line workers, to monthly meetings to gather more information about each case, and to fully understand DCP&P's involvement and their experience working with the family. We always begin the review by asking DCP&P staff for their views on what could have been done to prevent the fatality or near fatality. We explain that the Board is not looking to cast blame, but instead is looking for ways to improve the responses of New Jersey's systems to prevent such incidents from happening to other children. We look for challenges or barriers to DCP&P doing their work, whether current protocols and procedures should be modified, and if new resources are needed. We also ask about challenges erected by other systems in which the family was involved. These systems touch upon a variety of disciplinary fields, including physical health, mental health, substance use, 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. This report includes our recommendations from cases in which children died or nearly died in 2018. We hope these recommendations will be considered by the entities to whom we made them so that we can successfully prevent similar, future tragedies.

Sincerely,

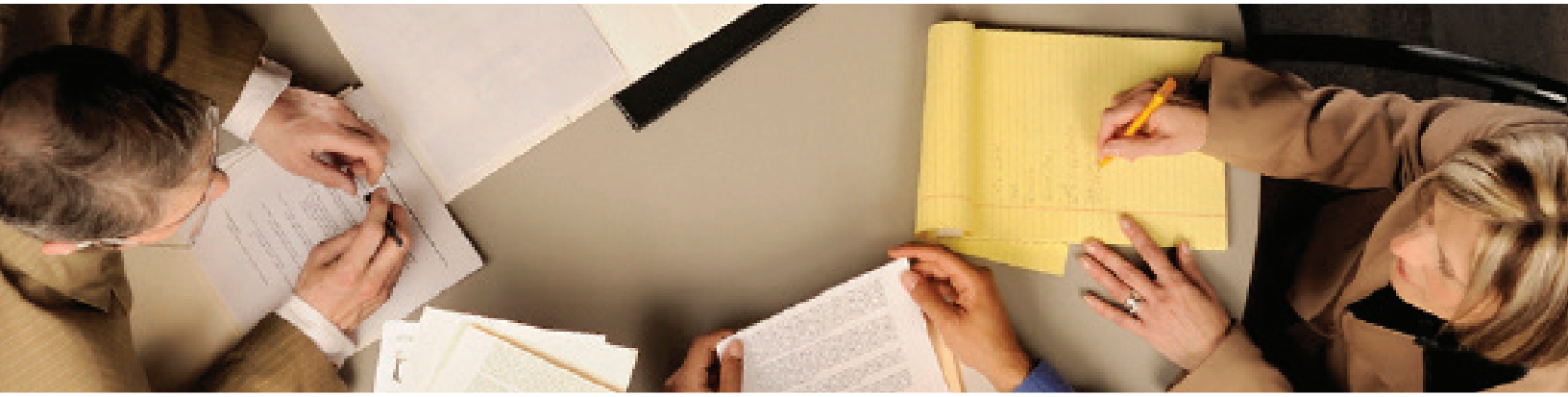


Elayne Weitz, PsyD
Acting Chair

Members

The Child Fatality and Near Fatality Review Board (hereinafter the "Board"), includes a total of six teams, the State CFNFRB, Northern Community-Based Team, Central Community-Based Team, Southern Community-Based Team, Suicide Subcommittee (SSC), and the Sudden Unexplained Infant Death (SUID) Subcommittee. The type of case and its geographical location determines which team will review the case.

The State Board reviews only those cases that meet criteria in which New Jersey's Department of Children and Families (DCF) Division of Child Protection & Permanency (DCP&P) was involved at the time of the fatality or near fatality or within the last twelve months. The regional teams review all other cases that meet the criteria that are not reviewed by the subcommittees. The SUID Subcommittee reviews all deaths in children under one year old whose cause/ manner of death was SUID, Sudden Infant Death Syndrome (SIDS), undetermined, and any others that were sleep related. The Suicide Subcommittee reviews all deaths with the manner of death certified as a suicide.



The State CFNFRB Members:

- **Chair: Kathryn McCans, M.D., F.A.A.P.**, St. Christopher's Hospital for Children
- **Judith Persichilli, RN, BSN, MA, Commissioner**, Department of Health
  Designee: Lakota Kruse, M.D., M.P.H.
- **Christine Norbut Beyer, MSW, Commissioner**, NJ Department of Children and Families
  Designee: Brian Ross
- **Christopher Gramiccioni**, Prosecutor, Monmouth County
- **Andrew L. Falzon, M.D.**, Chief State Medical Examiner
- **DSFC Francis Robina**, New Jersey State Police
  Designee: DSG Joe Brogan
- **Daniel Yale**, New Jersey Task Force on Child Abuse and Neglect
- **Gubir S. Grewal, Attorney General**, Office of the Attorney General, Division of Law
  Designee: Lea De- Guilo, Esq.
- **Lillian Brennan, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Carmen Diaz-Petti, Assistant Commissioner**, NJ DCF Division of Child Protection and Permanency
- **Jennifer Pax, J.D., LCSW, Ph.D.**, Social Work
- **Elayne Weitz, PsyD**, Psychologist

Members Continued

Northern Regional Community-Based Team

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

- **Chair: Paulett Diah, M.D.**, Hackensack Meridian Health
- **Frederick DiCarlo, M.D.**, Southern Regional Medical Examiner's Office
- **Maria Ojeda**, NJ DCF Division of Child Protection and Permanency
- **Yvonne Decicco, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Sandra Parente**, NJ DCF Division of Child Protection and Permanency
- **Captain Javier Toro**, Hudson County Prosecutor's Office
- **Kelly Sandler**, Morris County Prosecutor's Office
- **Andrea Booker**, Partnership of Maternal Child Health of Northern NJ
- **Karen Eigen, M.D.**, Hackensack Meridian Health
- **Amber Rabines**, Partnership of Maternal Child Health of Northern NJ
- **Jennifer Romalin, APN**, Hackensack University Medical Center

Central Regional Community-Based Team

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

- **Chair: Dr. Gladibel Medina, M.D.**, Dorothy B. Hersh Child Protection Center
- **Patricia Soffer, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Carol Ann Giardelli**, Director, Safe Kids New Jersey – Central Jersey Family Health Consortium
- **Captain Matthew Norton**, Mercer County Prosecutor's Office
- **Laura Badilla**, NJ DCF Division of Child Protection and Permanency
- **Lauren Thoma, M.D.**, Middlesex Regional Medical Examiner's Office
  Designee: Francesco Pontoriero
- **Helen Varvi, M.Ed.**, Wellspring Center for Prevention
- **Laura Johnson, MSW**, Temple University
- **Kari Mastro**, Rutgers University School of Nursing

Suicide Subcommittee

- **Andrew L. Falzon, M.D.**, State Medical Examiner
- **Melinda Carnassale**, NJ DCF Children's System of Care
- **Michelle Scott, PhD**, **MSW,** Monmouth University
- **Maureen Brogan, LPC, ACS, DAAETS,** Traumatic Loss Coalition
- **Marisol Garces, MSW**, NJ DCF Division of Child Protection and Permanency
- **Jennie Blakney, MA. ED.**, Department of Health
- **Captain Michael A. Sperry**, Burlington County Prosecutor's Office
- **Iris Moore**, NJ DCF Division of Child Protection and Permanency
- **Michele Safrin**, Office of Adolescent Services
- **Susan Paredes, Assistant Principal,** Metuchen High School
- **Suzy Azevedo, Principal**, Edgar Middle School
- **Diane Calello, M.D.**, NJ Poison Information and Education System, Rutgers
- **Mary F Beirne, MS, EdD, M.D., DFAPA**, Dept of Children and Families, Rutgers

Members Continued

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
- **Ian Hood, M.D.,** Burlington County Medical Examiner's Office
- **Sgt. Lynn Doughtery,** Atlantic County Prosecutor's Office
- **Barbara May, R.N., M.P.H.,** Southern NJ Perinatal Cooperative, Inc.
- **Iris Moore,** NJ DCF Division of Child Protection and Permanency
- **Det. Frank Sabella,** Cumberland County Prosecutor's Office
- **Christine Shah, Esq.,** Camden County Prosecutor's Office
- **Captain Michael A. Sperry,** Burlington County Prosecutor's Office
- **Jacqueline Forss,** NJ DCF Division of Child Protection and Permanency
- **Sara Plummer, Ph.D., MSW,** School of Social Work, Rutgers
- **John Flammer, Esq.,** Atlantic County Prosecutor's Office

Sudden Unexpected Infant Death Subcommittee

- **Lillian Brennan, Esq.,** Office of the Public Defender, Office of Law Guardian
- **Susan Fiorilla,** NJ DCF Division of Child Protection and Permanency
- **Lakota Kruse, M.D., M.P.H.,** Department of Health
- **Det. Matt Norton,** Mercer County Prosecutor's Office
- **Alissa Sandler,** The SIDS Center of New Jersey
- **Matthew Maguire,** EMS Medical Direction Coordinator Cooper Health
- **Lenore Scott,** NJ DCF Family and Community Partnerships, Early Childhood Services
- **Frederick DiCarlo, MD,** Southern Regional Medical Examiner's Office
- **Kimberly DeNick, MD,** Advocare Pediatrics

Staff

- **Charyl Yarbrough, Director,** NJ DCF Office of Quality
- **Lisa Hartmann, Administrator,** NJ DCF Office of Quality
- **Tamika Young, Administrator,** NJ DCF Office of Quality
- **Amanda Craig, NJ DCF Liaisons to CFNFRB,** NJ DCF Office of Quality
- **Lauren Woods, NJ DCF Liaisons to CFNFRB,** NJ DCF Office of Quality

Selecting and Reviewing Cases

The Review Process

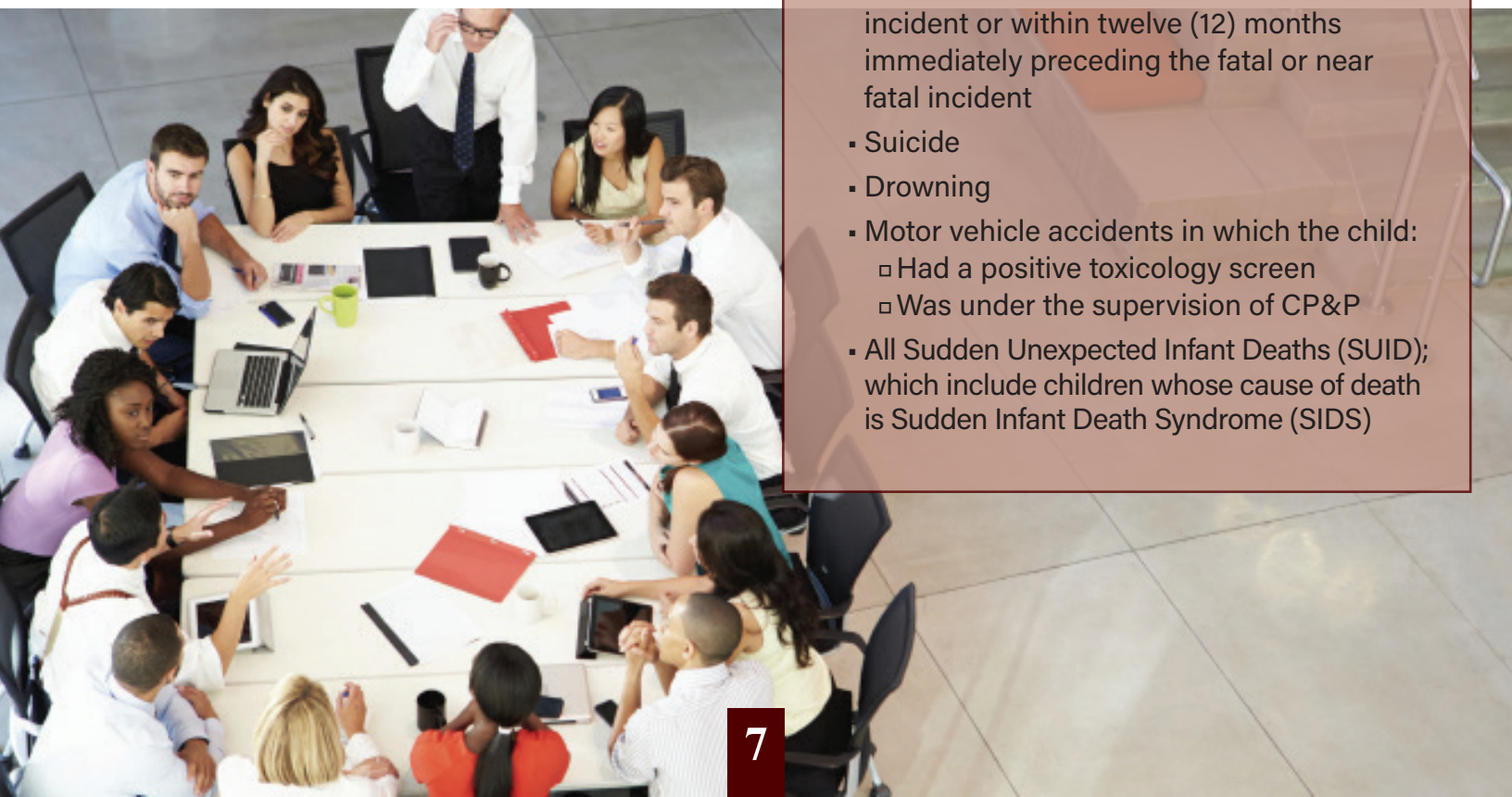
The CFNFRB is notified of child deaths by several sources, including the State Central Registry (SCR), the Office of the State Medical Examiner, Law Enforcement, and upon request, the Department of Health. Once a case is identified for review, DCF's liaison staff is responsible for obtaining all relevant 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 online library approximately two (2) weeks before the scheduled meeting for members to review in preparation for discussion.

Some of the possible actions following each case review include recommendations for 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 child's fatality is due to unusual circumstances, such as:

- Undetermined
- Substance abuse
- Homicide due to child abuse or neglect
- Child abuse or neglect
- 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
- Families under the supervision of the DCP&P at the time of the fatal or near fatal incident or within twelve (12) months immediately preceding the fatal or near fatal incident
- Suicide
- 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)



Statewide

The loss of life or near fatal injury of a child due to any cause is a loss to society that is beyond measure. The Board, reviews fatality and near fatality incidents involving children aged 0-17 years known and unknown to New Jersey's child welfare agency. The purpose of the Board includes but is not limited to the following:

- Review child fatalities and near fatalities in New Jersey in order to identify the cause of the incident, the relationship of the incident to governmental support systems, as determined relevant by the Board, and methods of prevention;
- Describe trends and patterns of child fatalities and near fatalities in New Jersey based upon its case reviews and findings;
- Evaluate the response of governmental 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;
- Identify groups at high risk of child abuse and neglect or child fatality, in terms that support the development of responsive public policy; and
- Improve data collection sources by developing protocols for autopsies, death investigations, and the complete recording of the cause of death on the death certificate to make recommendations for system-wide improvements in data collection for the purpose of improved evaluation, potential research and general accuracy of the archive.

The Board was initially established within the Department of Human Services and is now under DCF. The Board is statutorily independent of "any supervision or control by the Department or any board or officer thereof," and DCF's Fatality and Critical Incident Review Unit staff support the Board, including assisting in issuing an annual report.

In 2018, the Board was notified of 309 child fatality and near fatality incidents that occurred in New Jersey. Of the 309 incidents reported, 40 percent (n=124) met the review criteria. See Figure 1. Reviews were completed on all eligible cases and are represented in this annual report.

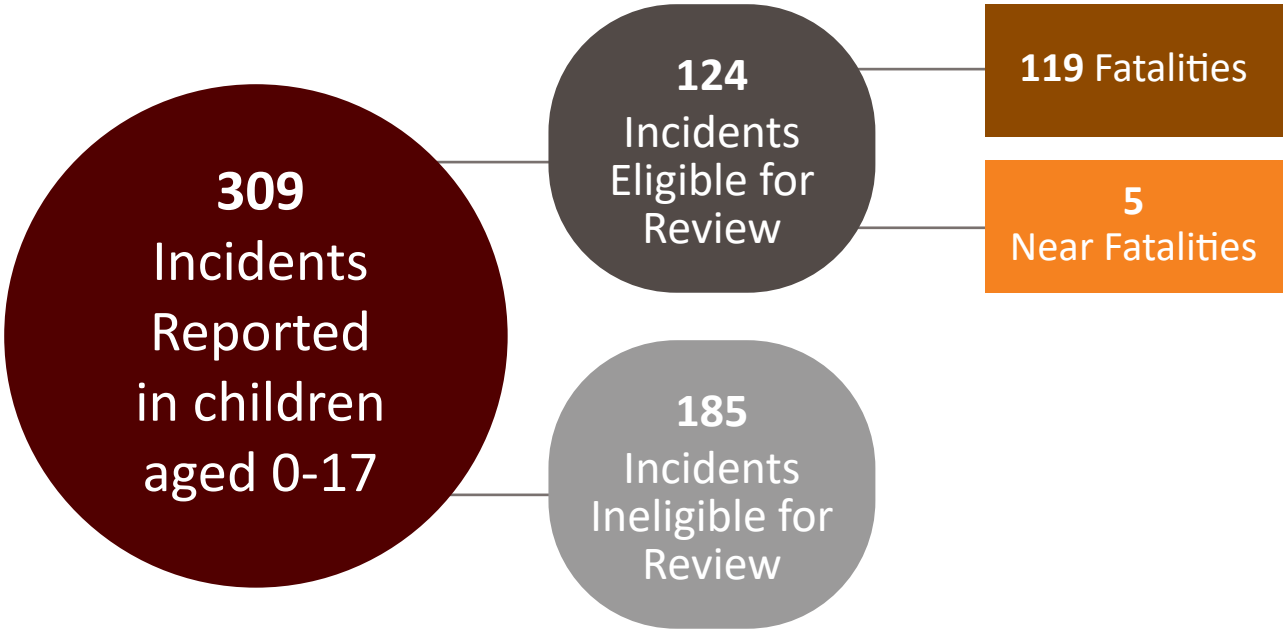


Figure 1: Fatality and near fatality cases reported and reviewed in 2018 by the Child Fatality and Near Fatality Review Board

Statewide

New Jersey is home to over 9.2 million residents and 22%, or almost two million, are under age eighteen. New Jersey is the 11th most populous state in the nation and is also the most densely populated. With New Jersey's 7,504 square miles of land, residents are largely concentrated in urban and suburban areas; while 60% of the state's land is rural, with only 5% of residents living in a rural community. Consequently, there is variation among counties across the state in the proportion of children and youth under age 18, ranging from 17.5% in Cape May County, to 24% in Ocean County. Variation across the state also exists for the number and proportion of child fatalities and near fatalities that occurred in each of New Jersey's 21 counties.[1]

The following counties also had reviewable near fatalities:

Cape May - 1
Essex - 2
Morris - 2

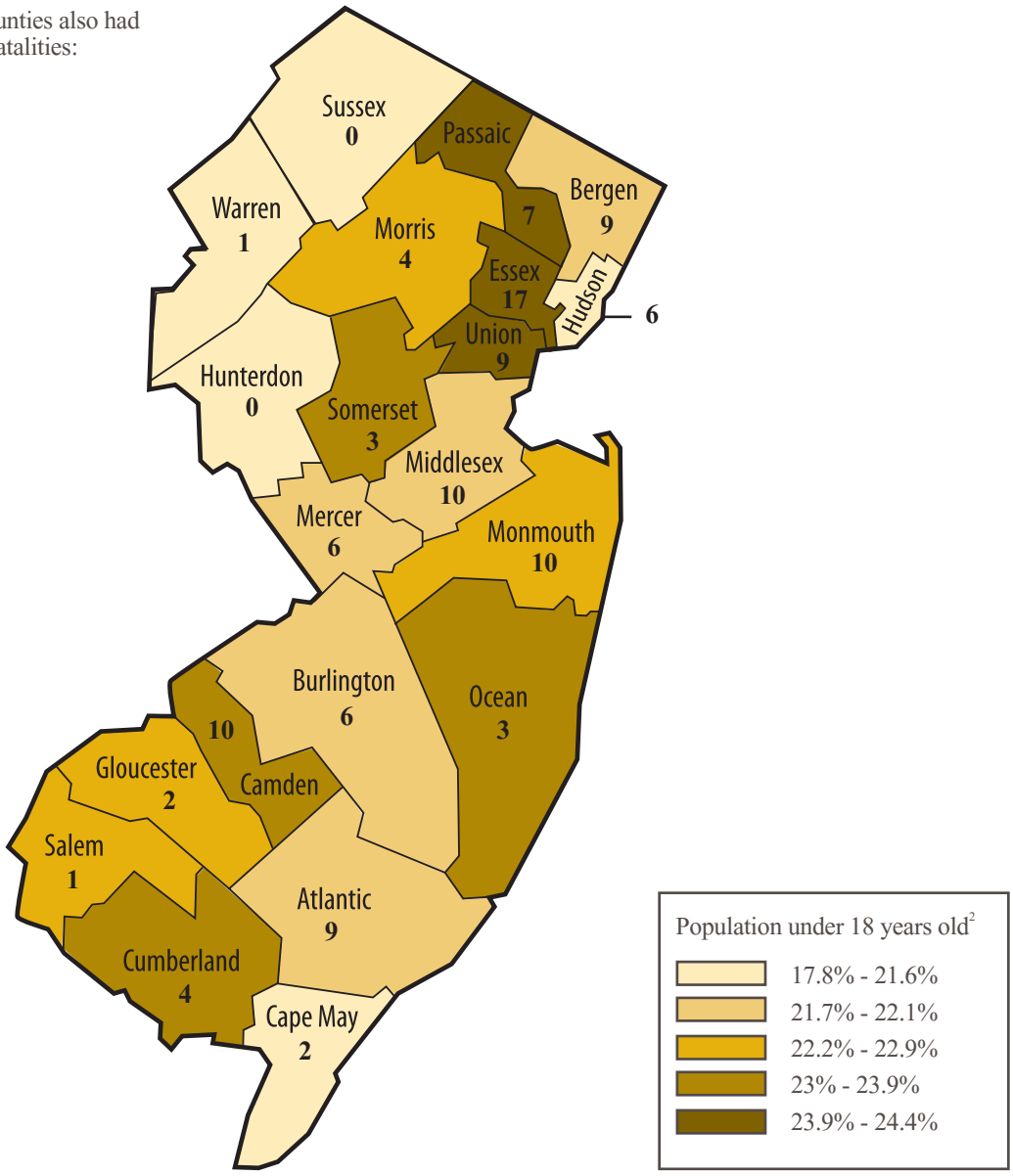


Figure 2: Map of 2018 Reviewed Fatalities with Child Population Shaded

[1] *U.S. Census Bureau. (2022). Quick Facts New Jersey. Retrieved from https://www.census.gov/quickfacts/fact/table/NJ/PST045222*
[2] *U.S. Census Bureau. (2022). Quick Facts New Jersey. Retrieved from https://www.census.gov/quickfacts/fact/table/NJ/PST045222*

Statewide

Since each of New Jersey's counties vary in the number and proportion of children under 18 years old, comparing the rate of fatalities per 100,000 children in the county allows for the ability to compare fatalities across the 21 counties.

In 2018, the rate of fatalities in New Jersey per 100,000 children ranged from zero to 16.1 across counties (see Figure 3). Atlantic County had the highest rate of reviewable fatalities with 16.1 per every 100,000 children residing in the county. The next highest was Cape May at 12.4 reviewable fatalities per every 100,000 children in the county. There were two counties, Hunterdon and Sussex, that did not experience any child fatalities that met the criteria for review.

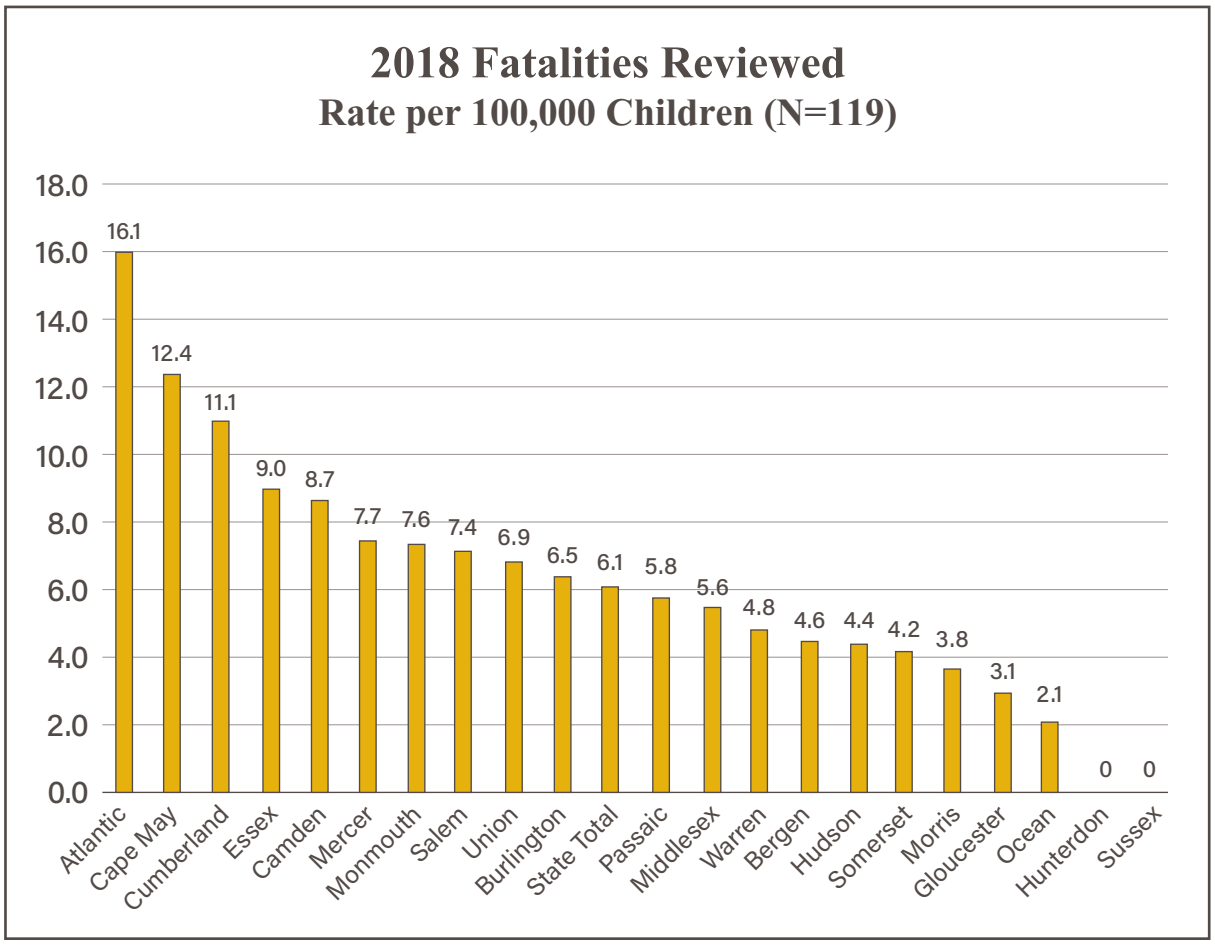


Figure 3: 2018 Fatalities Reviewed Rate per 100,000 Children (n=119)

Statewide

All fatalities are classified according to the cause and manner of death. There are many complexities involved in these classifications, which are determined after an autopsy is performed by the medical examiner's office. It is important to note that an autopsy can be declined, an example being for religious reasons. The cause of death refers to the disease, process, or injury, which eventually lead to death. While the manner of death refers to the injury or disease that leads to death, the manner of death can be classified as natural, undetermined, accidental, suicide, or homicide.

- ***Natural*** – A death resulting from a natural disease process, without the significant influence of any type of injury, drug toxicity, or other significant environmental or other non-natural factor.
- ***Undetermined*** – A death in which there is insufficient information about the circumstances surrounding the death to make a ruling, or in some instances, when the cause of death is unknown.
- ***Accident*** – A non-natural (violent or traumatic) death resulting from an event occurring by chance or unknown causes, with a lack of intention; an unintended and usually sudden, unexpected and unforeseen occurrence.
- ***Suicide*** – A death resulting from the deliberate taking of one's own life voluntarily. Placing oneself in reckless disregard of harm and resulting in a death may also be ruled suicide.
- ***Homicide*** – A death due to another person's actions.

Table 1 outlines all fatalities reviewed in 2018, by county, proportion of state total, and fatality rate. Essex County had the highest number of reviewed fatalities with an undetermined manner of death (n=8), accounting for almost half of their fatalities reviewed.

COUNTY	ACCIDENT	HOMICIDE	NATURAL	SUICIDE	UNDETERMINED	COUNTY FATALITIES	% OF NJ FATALITIES	< 18 YEARS OLD	FATALITY RATE PER 100,000 CHILDREN
ATLANTIC	2	2	0	2	3	9	7.5%	56,006	16.1
BERGEN	2	1	0	4	2	9	7.5%	197,472	4.6
BURLINGTON	2	1	3	0	0	6	5%	92,677	6.5
CAMDEN	2	3	1	2	2	10	8%	115,032	8.7
CAPE MAY	1	0	0	1	0	2	2%	16,187	12.4
CUMBERLAND	1	0	1	1	1	4	3%	36,082	11.1
ESSEX	2	1	3	3	8	17	14%	189,664	9.0
GLOUCESTER	0	0	1	0	1	2	2%	63,725	3.1
HUDSON	0	2	1	0	3	6	5%	137,462	4.4
HUNTERDON	0	0	0	0	0	0	0%	24,181	0
MERCER	1	2	0	1	2	6	5%	78,337	7.7
MIDDLESEX	1	2	3	3	1	10	8%	179,958	5.6
MONMOUTH	2	1	2	1	4	10	8%	131,171	7.6
MORRIS	3	0	1	0	0	4	3%	104,021	3.8
OCEAN	0	0	2	0	1	3	3%	144,531	2.1
PASSAIC	3	0	0	1	3	7	6%	119,937	5.8
SALEM	1	0	0	0	0	1	1%	13,490	7.4
SOMERSET	1	0	0	2	0	3	3%	72,134	4.2
SUSSEX	0	0	0	0	0	0	0%	27,843	0
UNION	2	1	1	2	3	9	7.5%	130,558	6.9
WARREN	0	0	0	0	1	1	1%	20,725	4.8
STATE	26	16	19	23	35	119	100%	1,954,045	6.1

Table 1: Table of 2018 Reviewed Fatalities by County and Manner of Death

Statewide

In 2018, the highest number of child fatalities statewide resulted from an undetermined manner of death (35 children, or 29%) due to a lack of information about the circumstances surrounding the death (see Figures 4 and Table 2 below). For these 35 children with an undetermined manner of death, all but three were under one year of age (n=32) (see Table 2). These findings suggest an opportunity to improve data collection by developing protocols for autopsies, death investigations, and sharing of complete records in deaths of children under 12 months old. Of the child fatality cases reviewed by manner of death, accidents were the second highest with 22%, followed by suicides (19%), natural (16%), and homicide (13%).

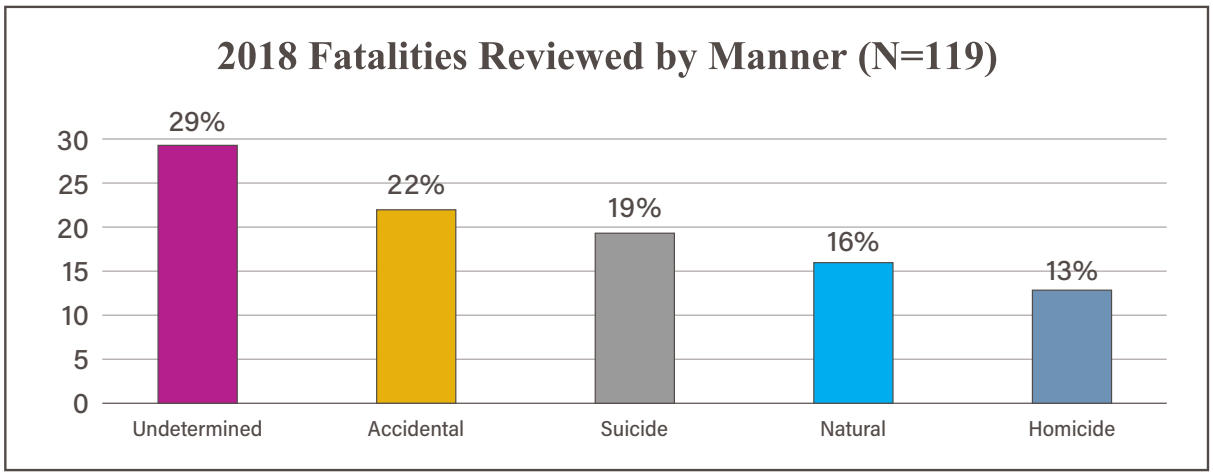


Figure 4: 2018 Fatalities Reviewed by Manner of Death (n=119)

In 2018, half of all fatalities reviewed involved children under 1 year of age, followed by children 15 to 17 years old (16%). Additional findings revealed children were most likely to be male (61%). Black or African American (38%) or White (35%) children accounted for almost three-quarters of cases reviewed (see Table 2).

	UNDETERMINED (N=35)	ACCIDENT (N=26)	SUICIDE (N=23)	NATURAL (N=19)	HOMICIDE (N=16)	TOTAL FATALITIES (N=119)	TOTAL FATALITIES (%)
AGE							
Under 1 year	32	11	0	8	9	60	50%
1 to 4 years	0	8	0	1	5	14	12%
5 to 9 years	1	3	0	5	0	9	8%
10 to 14 years	1	2	9	4	1	17	14%
15 to 17 years	1	2	14	1	1	19	16%
GENDER							
Female	14	9	12	7	4	46	39%
Male	21	17	11	12	12	73	61%
RACE AND ETHNICITY							
Asian	0	1	3	0	0	4	3%
Black or African American	19	8	3	10	5	45	38%
Hispanic or Latino [a]	7	7	6	0	5	25	21%
White	8	10	10	8	6	42	35%
Two or More Races	1	0	1	1	0	3	3%
(a) Hispanic or Latino is defined as any child with Hispanic or Latino ethnicity, regardless of race.							
(b) Two or More Races is defined as any child with more than one race identified.							

Table 2: 2018 Fatalities by age, gender, race, and manner of death (n=119)

Statewide

In 2018, male children ages 0 to 17 accounted for a disproportionate rate of the reviewed child fatalities compared to females. New Jersey's child population is split almost evenly between male (51%) and females (49%). However, the rate of reviewed fatalities for males in New Jersey is 1.5 times higher than the rate for females (7.4 vs 4.9 per 100,000; see Figure 75). For the past four years, males have had a higher mortality rate than females.

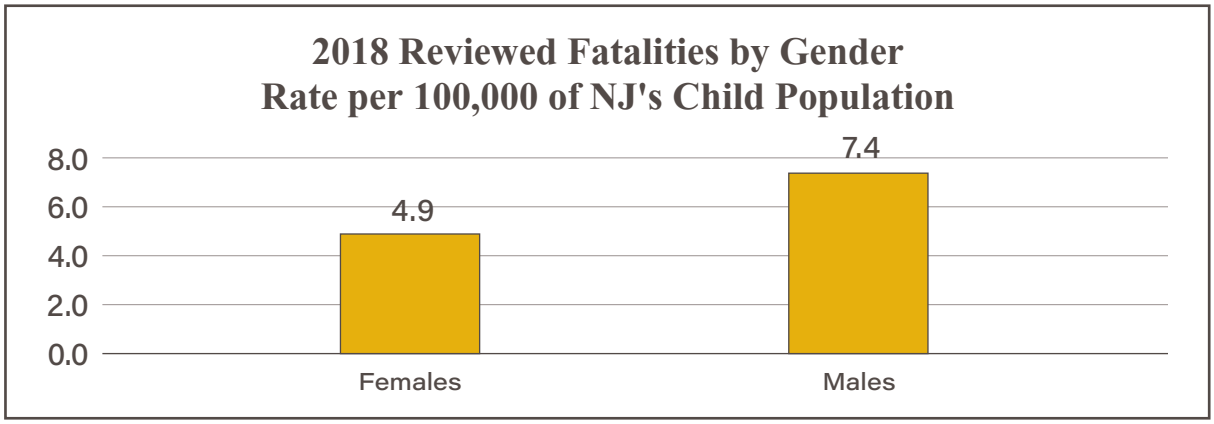


Figure 4: 2018 Fatalities Reviewed by Manner of Death (n=119)

According to the federal Administration for Children and Families 2020 Maltreatment Report, racial disparities also exist in child fatalities. The report concluded nationally "the rate of African-American child fatalities is 3.1 times greater than the rate of white child fatalities, and 3.6 times greater than the rate of Hispanic child fatalities." This disparity can be seen in New Jersey's child fatalities as well. In 2018, the rate of reviewed fatalities for Black children is 16.2 per 100,000. This is 3.5 times greater than the fatality rate for Hispanic (4.7 per 100,000) and White (4.6 per 100,000) children, and 8.5 times greater than Asian (1.9 per 100,000) children (see Figure 6).

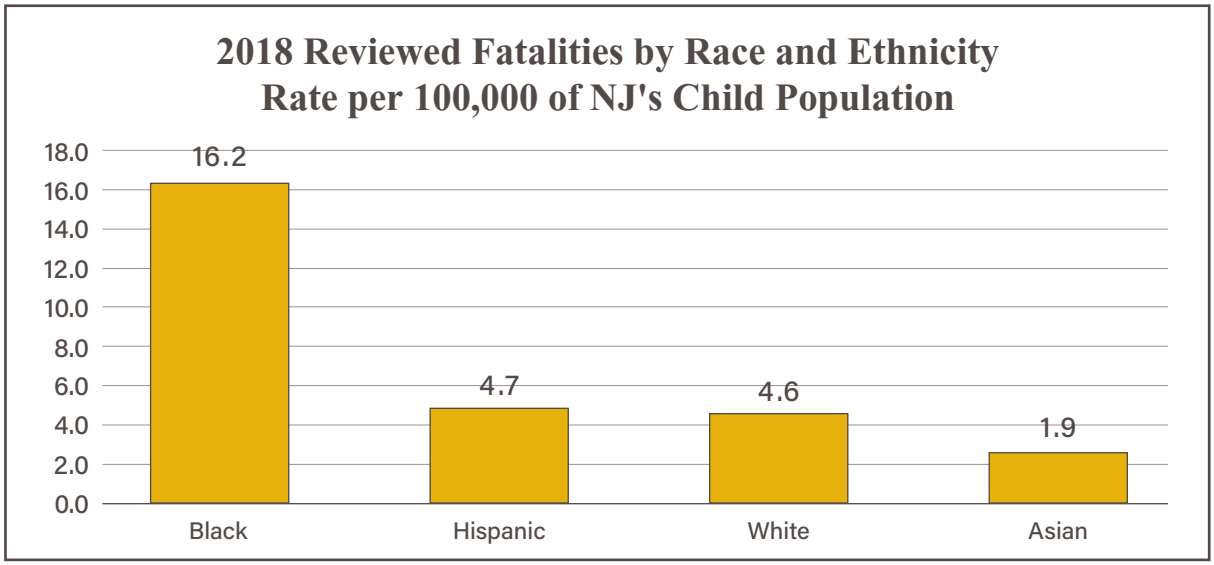


Figure 6: Reviewed Fatalities by Race and Ethnicity, Rate per 100,000 of NJ Child Population

[3]*The Annie E. Casey Foundation (2022). KIDS COUNT Data Center, Retrieved from: https://datacenter.kidscount.org*
[4]*U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.*

Division of Child Protection and Permanency

DCF's DCP&P is New Jersey's child protection and child welfare agency. Its mission is to ensure the safety, permanency, and well-being of children and support families. DCP&P is responsible for investigating allegations of child abuse and neglect, and if necessary, arranging for the child's protection and the family's treatment. The Child Abuse Hotline (State Central Registry) receives and prioritizes reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the DCP&P Local Office to investigate. See Appendix A for infographic "What happens after the child abuse hotline is called."

The Board reviews fatalities and near fatalities involving children both known and unknown to DCP&P. Reviews conducted by the Board include a broader spectrum of incidents viewed through the lens of social impact and the concern over the safety and protection of children, strengthening families, and improving the delivery of child protection services. The activities of the Board are a component in the state's plan to transform its child welfare system. The Board also examines the roles played by other agencies and systems relevant to child fatalities and near fatalities, such as law enforcement, prosecutors, and health care providers, and makes recommendations regarding findings at both state and local levels.

In 2018, the families of 63 children (51% of the fatalities/near fatalities) had no prior involvement with DCP&P. Additional findings revealed:

- 26 (21%) of the families had an open case with DCP&P at the time of the incident;
- 21 (17%) of the families had cases that were closed with DCP&P ***less than*** 12 months at the time of the incident; and
- 14 (11%) of the families had cases that were closed with DCP&P ***more than*** 12 months at the time of the incident.

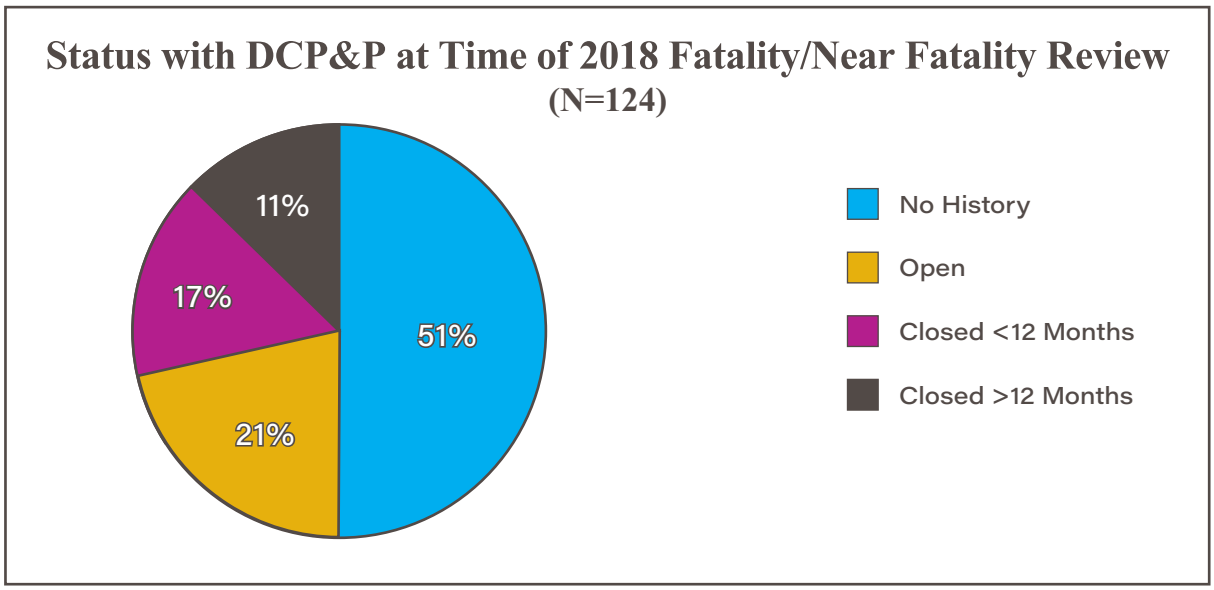


Figure 7: Status with DCP&P at Time of 2018 Fatality/Near Fatality Review (n=124)

NJ Comprehensive Child Abuse Prevention and Treatment Act

Key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), which provides funding and guidance to states in support of prevention, assessment, investigation, prosecution and treatment activities. CAPTA also provides grants for demonstration programs and projects. The adoption of New Jersey's Comprehensive Child Abuse Prevention and Treatment Act (NJ CCAPTA) ensured the state's compliance with federal CAPTA legislation and created the CFNFRB. NJ CCAPTA allows DCP&P to identify and release certain information regarding a child's death or near death that was determined to be the result of abuse or neglect; whether or not the family was involved with DCP&P at the time of the incident.

Child abuse and/or neglect can result from acts of omission or commission (or both) on the part of the parent or caregiver. Sometimes a single incident will be sufficient to indicate that a child is abused or neglected. Other situations may exist where the child abuse or neglect is the cumulative result of a pattern of behavior or conditions that together constitute child abuse or neglect.

In 2018, 23 of the child fatality or near fatality incidents reviewed were identified by DCP&P to have resulted from abuse and/or neglect and met the NJ CCAPTA determination.

The review found that families of 11 (48%) of the child fatalities or near fatalities, had no prior involvement with DCP&P. Additional findings revealed:

- 7 families had an ***open*** case with DCP&P at the time of the incident;
- 3 families had cases that were closed with DCP&P ***less than*** 12 months at the time of the incident; and
- 2 families had cases that were closed with DCP&P ***more than*** 12 months at the time of the incident

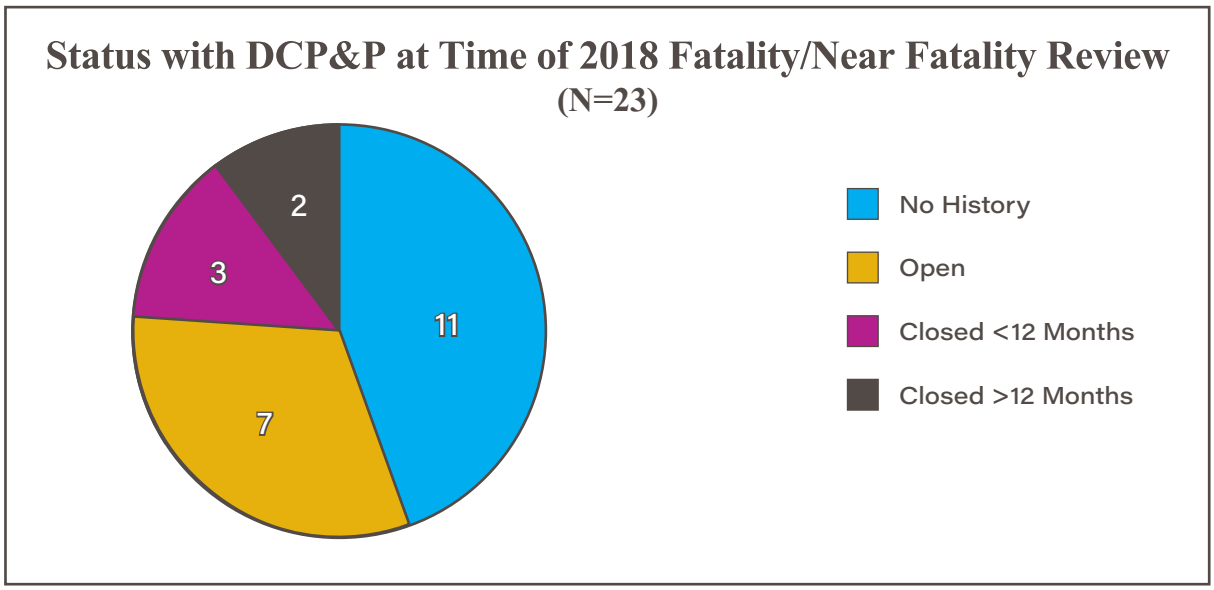


Figure 8: 2018 NJ CCAPTA Fatality/Near Fatality by DCP&P Involvement (n=23)

NJ Comprehensive Child Abuse Prevention and Treatment Act

NJ CCAPTA law allows DCP&P to identify and release certain information regarding a child fatality or near fatality that was the result of abuse and/or neglect, including information on the alleged perpetrator and relationship to the victim. A perpetrator of child abuse or neglect must be the child's parent, guardian, caregiver, temporary caregiver, institutional caregiver, or anyone responsible for the care, custody, or oversight of the child.

As previously stated, in 2018, 23 child fatality or near fatality incidents reviewed were investigated by DCP&P and determined to have resulted from abuse and/or neglect.

The review found that parents were responsible for 20 of 23 abuse and/or neglect incidents that resulted in the deaths or nears deaths of their child, as outlined in Figure 9 below. Other caregivers (babysitter (n=2) and aunt (n=1)) were responsible for three of the 23 abuse/neglect incidents that resulted in the deaths or near death of a child (see Figure 11).

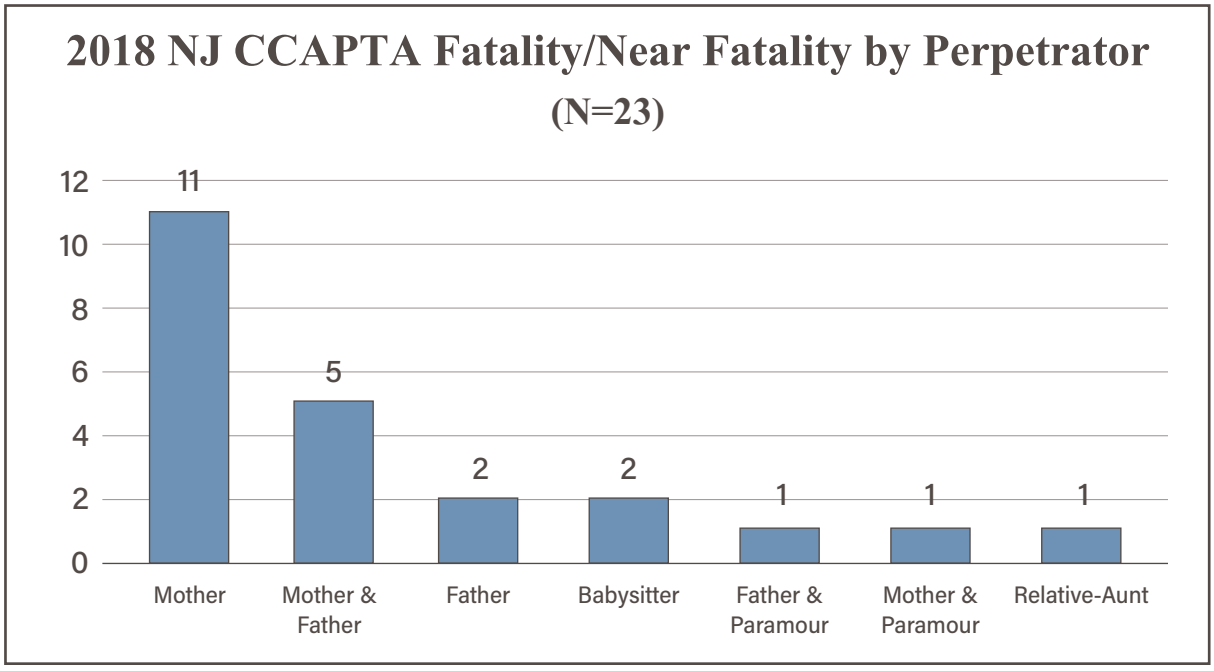


Figure 9: 2018 NJ CCAPTA Fatality/Near Fatality by Perpetrator (n=23)

Sudden Unexpected and Sleep Related Infant Deaths

According to the Center for Disease Control (CDC), Sudden Unexplained 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 an investigation. Approximately 3,400 babies in the United States die suddenly and unexpectedly each year. Parents or caregivers do not usually see these deaths as they happen making it difficult to get a clear description of the circumstances surrounding the death, which are necessary for determining the cause and manner. Unfortunately, different practices in investigating and reporting SUID can affect the ability to reliably monitor SUID trends and risk factors. On behalf of the Board, DCF's Fatality and Critical Incident Review Unit participates in the CDCs Division of Reproductive Health SUID monitoring program working to improve data quality on SUID cases. This effort leads to a better understanding of circumstances that may increase the risk of SUIDs.

In 2018, 60 fatality cases reviewed involved children under 1 year of age and 47 of those deaths met the CDC criteria for review by the Board's SUID subcommittee. Thirteen cases did not meet the CDCs criteria, which included 9 homicides, 2 accidental deaths, 1 natural, and 1 undetermined death (see Figure 10).

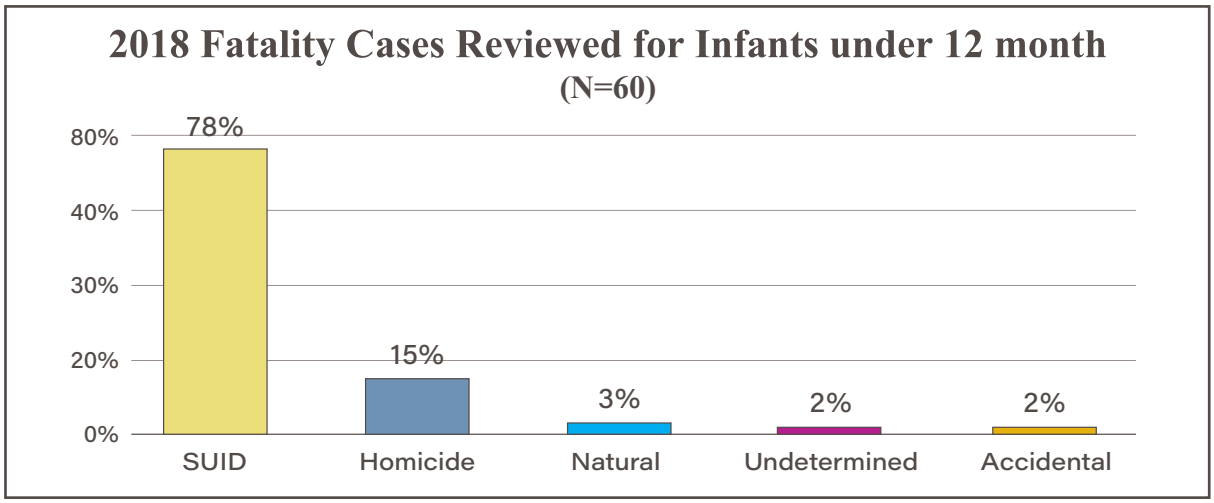


Figure 10: 2018 Fatality Cases Reviewed for Infants under 12 Months (n=60)

As displayed in Figure 11, the manner of death for the 47 SUID cases reviewed by the SUID Subcommittee in 2018, the majority (66%) were undetermined, followed by accidental (19%) and natural (15%).

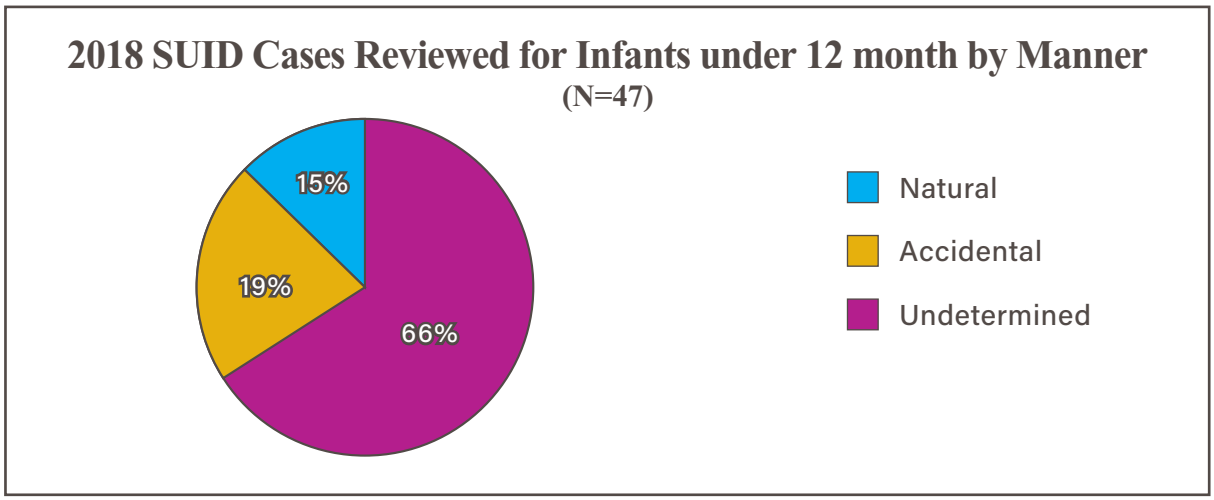


Figure 11: 2018 SUID Cases Reviewed for Infants under 12 Months by Manner (n=47)

[5]*Centers for Disease Control (2022). About SIDS and SUID. Retrieved from: https://www.cdc.gov/sids/about/index.htm*

Sudden Unexpected and Sleep Related Infant Deaths

The CDC further categorizes SUIDs to include SIDS, accidental suffocation in a sleep environment, and other deaths from unknown causes. These deaths often happen while the infant is asleep or in the infant's sleep area.

Although SIDS rates have declined, significant racial and ethnic differences involving these deaths continue. This trend was present in cases reviewed by the Board, in which Black males represented the highest number of SUID fatalities, and Black infants died as a result of SUID three times more than white infants, as outlined in Figure 12 below.

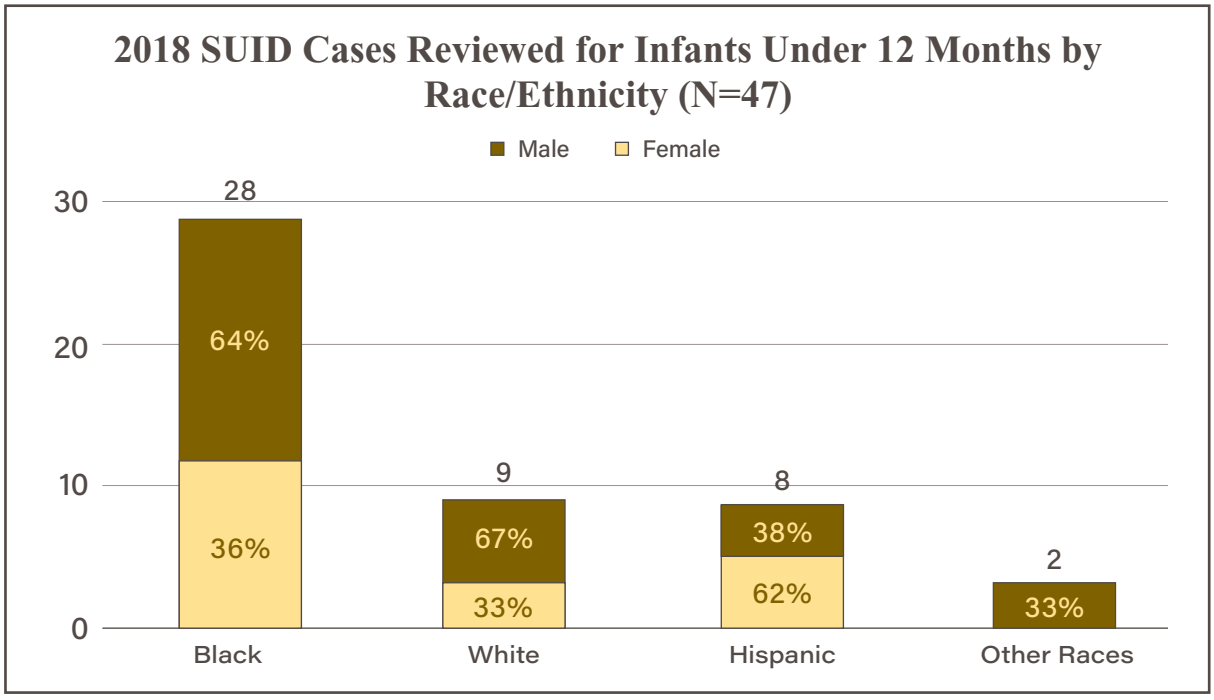


Figure 12: 2018 SUID Cases Reviewed for Infants Under 12 Months by Race/Ethnicity (n=47)

Age is also a risk factor identified with SUID, occurring more in newborns, and declining as infants approach 12 months of age.

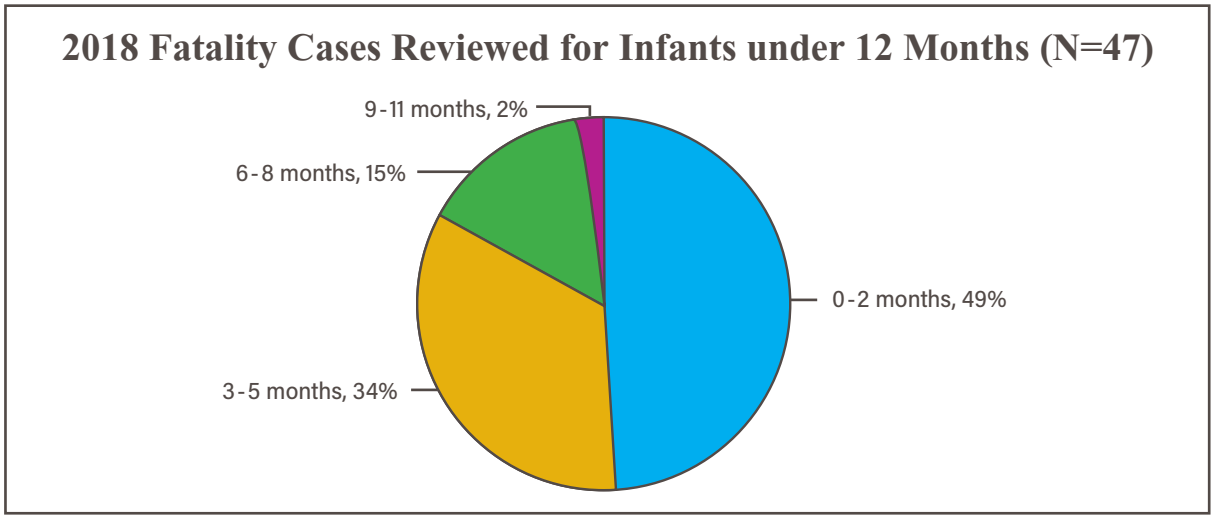


Figure 13: 2018 SUID Cases Reviewed for Infants Under 12 Months (n=47)

Sudden Unexpected and Sleep Related Infant Deaths

According to the CDC, sleep-related deaths, including SIDS and accidental strangulation or suffocation in bed, are the number one cause of death for children under 12 months old, in large part because of sleep practices. There have been dramatic improvements in reducing infant deaths during sleep since the 1990s, when recommendations were introduced to place babies on their back for sleep. However, since the late 1990s, declines have slowed.

Other recommended safe sleep practices today include eliminating hazards, such as keeping blankets, pillows, bumper pads, and soft toys out of the sleep area. Recommendations also include room sharing, but not bed sharing. These practices can help lower the risk of sleep-related infant deaths, including SIDS, accidental suffocation, and deaths from unknown causes. The National Safe Sleep campaign strives to educate parents/caregivers on ways to reduce SIDS and promotes the use of the ABC's of Safer Sleep.

The ABC's of Safe Sleep

A LONE *Infants should sleep alone*

In 52% of cases reviewed by the Board, the infant was sleeping with other people at the time of death

B ACK *Infants should sleep on their backs*

In 61% of cases reviewed by the Board, infants were not sleeping on their backs at the time of death

C RIB *Infants should sleep in an bare crib with a firm mattress*

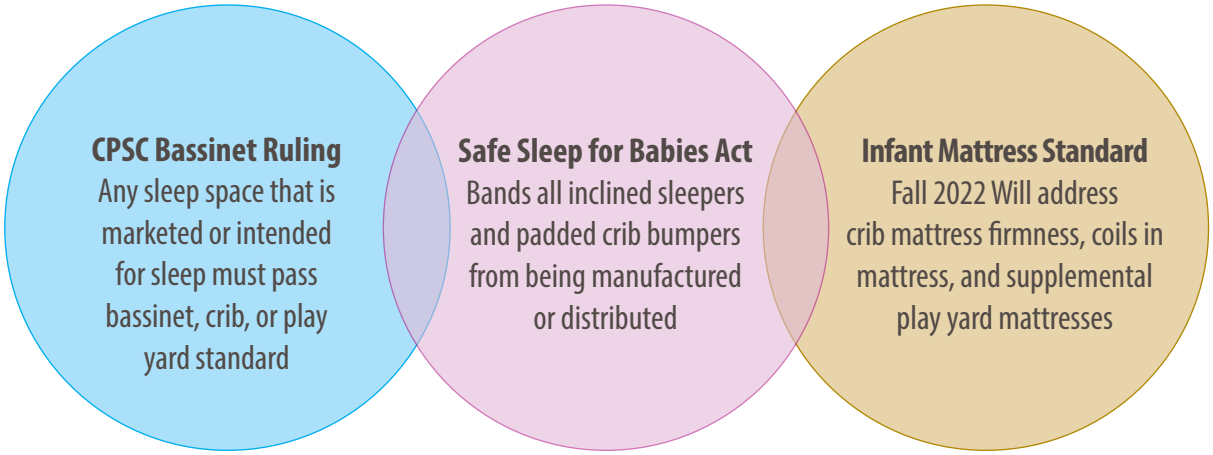
In 74% of cases reviewed by the Board, infants were not in a crib at the time of death

Unfortunately, different practices in investigating and reporting SUID can affect the ability to reliably monitor SUID trends and risk factors. On behalf of the Board, DCF's Fatality and Critical Incident Review Unit participates in the CDCs Division of Reproductive Health SUID monitoring program working to improve data quality on SUID cases. This effort leads to better understanding of circumstances that may increase the risk of SUIDs.

Sudden Unexpected and Sleep Related Infant Deaths

In addition to parents and caregivers ensuring infants are sleeping in safe environments, federal legislation mandates products marketed for infant sleep, such as inclined sleepers, travel and compact bassinets, and in-bed sleepers meet the Consumer Product Safety Commission (CPSC) standard.

Recent Federal Safe Sleep Rulings, Legislation and Recommendations



Suicide

According to the Child Mind Institute, suicide is a serious public health issue, with 5,000 adolescents in the United States completing suicide each year, and another 600,000 requiring medical attention for self-injury. In 2018, the Board reviewed 23 suicides of youth between the ages of 11 and 17 years old. This is a slight decrease from the 26 suicides reviewed in 2017. An analysis of the findings revealed a comparable impact across most age groups. The exceptions to these findings were amongst the 12-year-old age group, in which there were no suicide fatalities, and in the 16-year-old age group that had a high of six suicide fatalities reviewed (Figure 14).

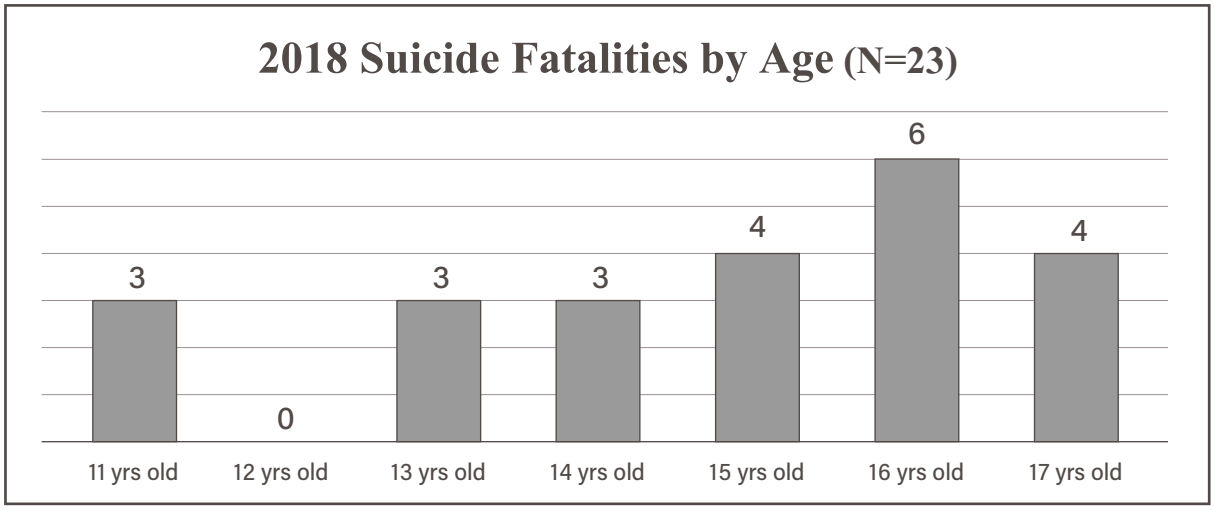


Figure 14: 2018 Suicide Fatalities by Age in Years (n=23)

The cause of death for the majority of the suicide fatalities was hanging; 18 (78%). Additional findings revealed:

- 2 (9%) of suicides completed by gunshots/use of firearm;
- 1 (4%) of suicides completed by carbon monoxide poisoning;
- 1 (4%) of suicides completed by drowning; and
- 1 (4%) of suicides completed by blunt force impact.

[6]*Child Mind Institute (2022). Suicide & Self-Harm Warning Signs. Retrieved from: https://childmind.org/topics/suicide-self-harm/*

Suicide

Gender is a risk factor for suicide. According to the Child Mind Institute, suicide is the leading cause of death for girls 15-19. For cases reviewed in 2018, the rate of suicide for females reviewed was slightly higher than males, 1.3 per 100,000 of NJ's child population compared to 1.1.

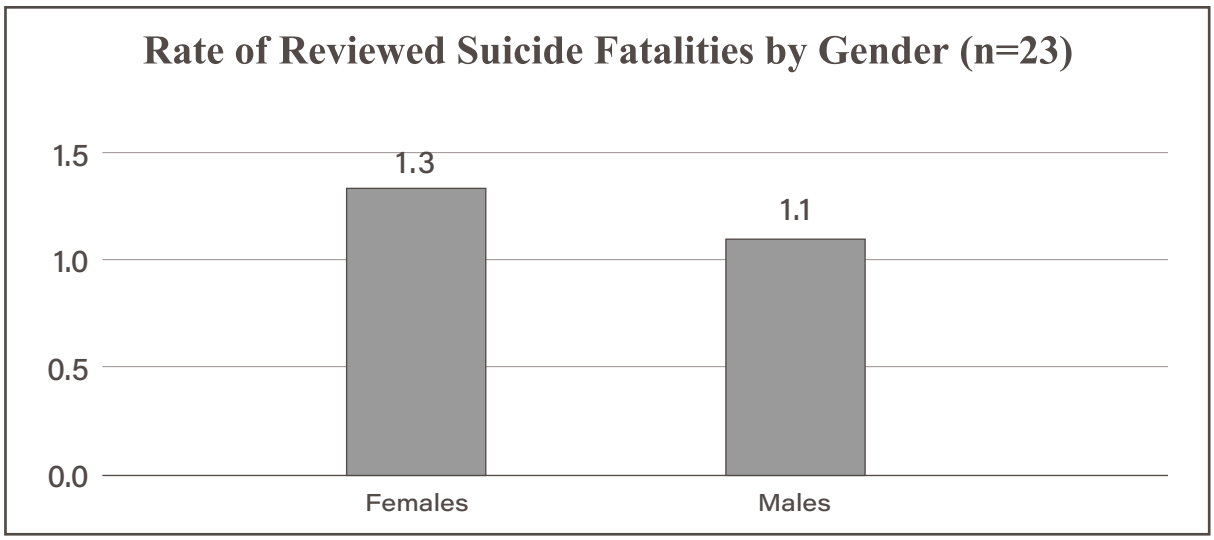


Figure 15: Rate of Reviewed Suicide Fatalities by Gender (n=23)

The chart below (Figure 16) provides an analysis of the suicide fatalities reviewed in 2018 by race and ethnicity. This data revealed disparities can be seen by race and ethnicity. The rate of suicide for Asian children is slightly higher than all other races. Additionally, of the four fatalities reviewed for Asian children, three were suicide.

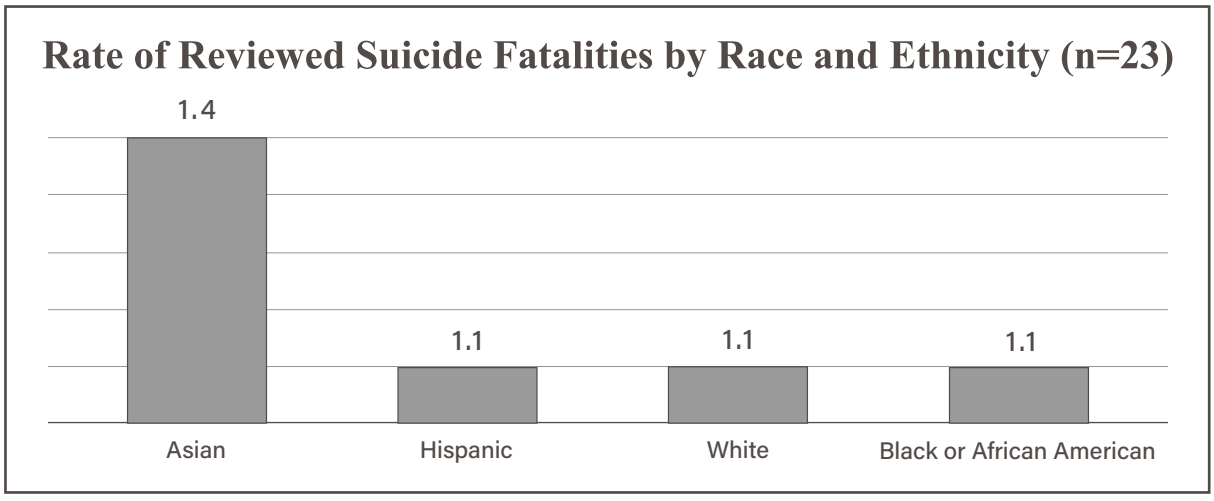


Figure 16: Rate of Reviewed Suicide Fatalities by Race and Ethnicity (n=23)

[7]*Child Mind Institute (2022). Suicide & Self-Harm Warning Signs. Retrieved from: https://childmind.org/topics/suicide-self-harm/*

Suicide

73.2% of SUICIDAL ALOSCENTS HAVE BEEN ENGAGED WITH THE MENTAL HEALTH SYSTEM AND RECEIVED TREATMENT

CHILD MIND INSTITUTE*

According to the Child Mind Institute, 73% of suicidal adolescents have been engaged with the mental health system and received treatment. Reducing the incidences of adolescent suicide requires understanding the progression of adolescent mental health disorders and identifying young people at risk of suicidal thought and actions, who are already engaged with the mental health system.

The Board identified suicide risk factors during the review and used those risk factors to make recommendations that support the development of responsive public policy. These risk factors were synthesized using the Child Mind Institute's categorization. The most prevalent risk factor identified in the 2018 reviews was a diagnosed mental health disorder, followed by lack of social supports.

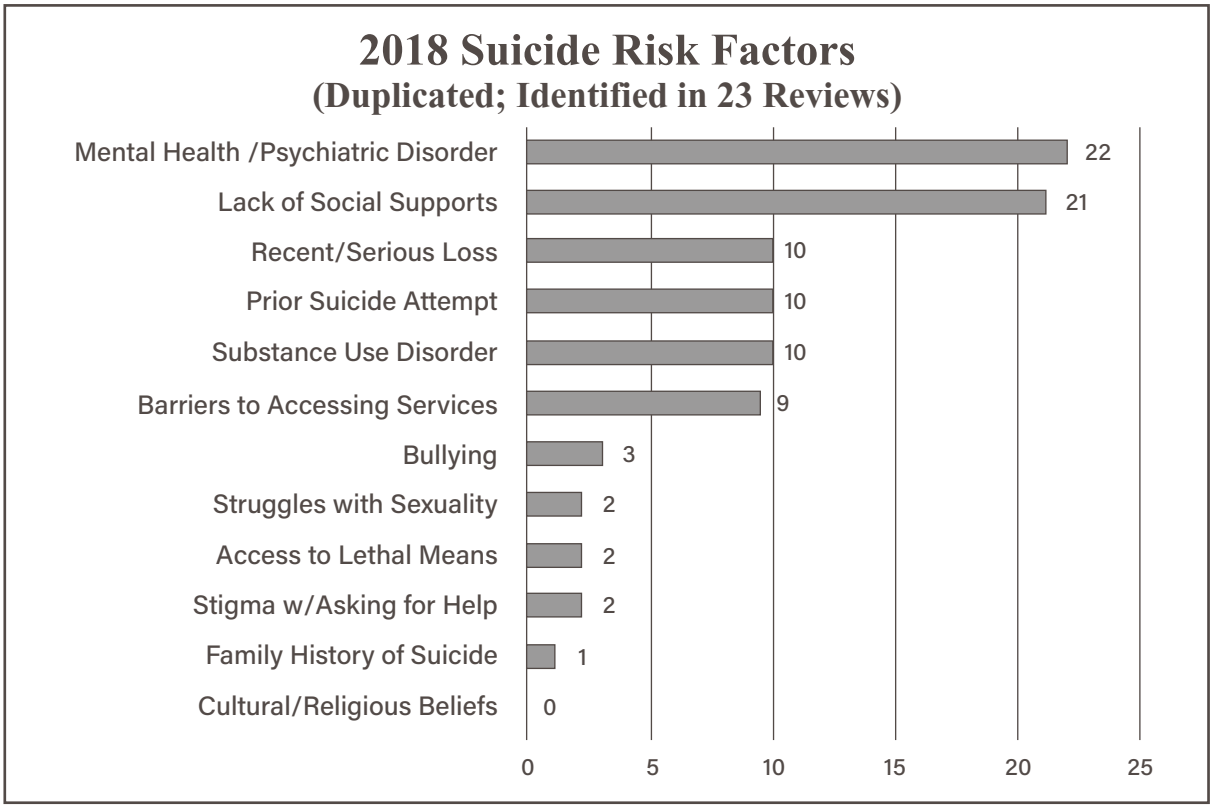


Figure 17: 2018 Suicide Risk Factors (Duplicated; Identified in 23 Case Reviews)

In addition to the risk factors identified in the 2018 suicide reviews, other risk factors identified by the Board included strained family relationships (1), lack of supervision (2), family history of mental health (2), medication change (2) and exposure to domestic violence (4).

[8]*Child Mind Institute (2022). Suicide & Self-Harm Warning Signs. Retrieved from: https://childmind.org/topics/suicide-self-harm/*

Suicide

According to the Child Mind Institute, there are individual characteristics and community efforts that may protect youth from suicidal thoughts and behavior. Some key protective factors include:

- Good coping and problem-solving abilities.
- Strong connections to family and community support.
- Restricted access to highly lethal means of suicide.
- Cultural and religious beliefs that discourage suicide.
- Easy access to appropriate individual/family therapy or medication.
- Effective care for mental, physical and substance use disorders.

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

People of any age can call the
NJ Suicide Prevention Hope Line at 1-855-654-6735,
text at **njhopeline@ubhc.rutgers.edu**, or
visit their website **www.njhopeline.com**

Additional resources include:
PerformCare
(provides linkage to various services for children)
1-877-652-7624
www.performcarenj.org

Homicide

The Board reviews homicides of children under 18 years old where child abuse and/or neglect contributed to the death, or a positive toxicology and drug involvement may have been a contributing factor. In 2018, the Board reviewed three times as many homicide fatalities than in 2017, increasing from 5 to 16.

As indicated in the chart below, of the 16 homicide fatalities reviewed by the Board in 2018, 14 of the victims were very young children under 5 years old.

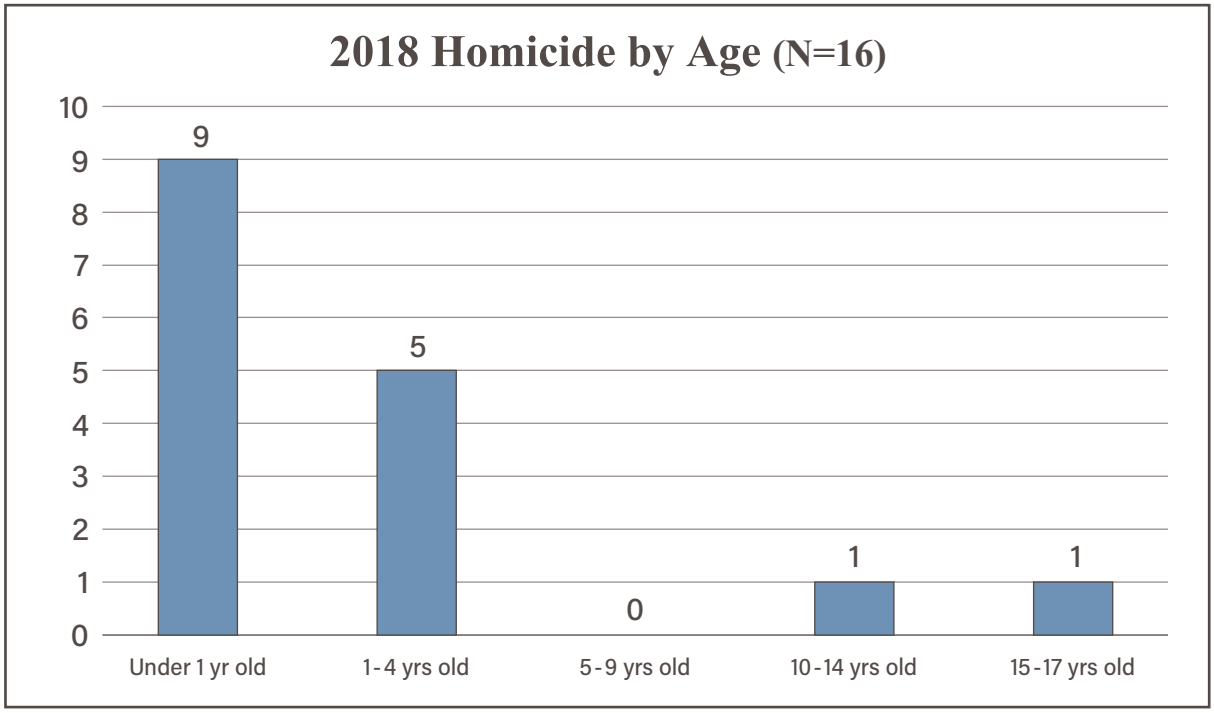


Figure 18: 2018 Homicide by Age (n=16)

Additional analysis of the homicide fatalities reviewed in 2018, highlighted in Figure 19, found the majority of the victims (12) were male, while 4 were female. A noteworthy finding revealed the trend of male over representation in all manners of death, with the exception of suicide.

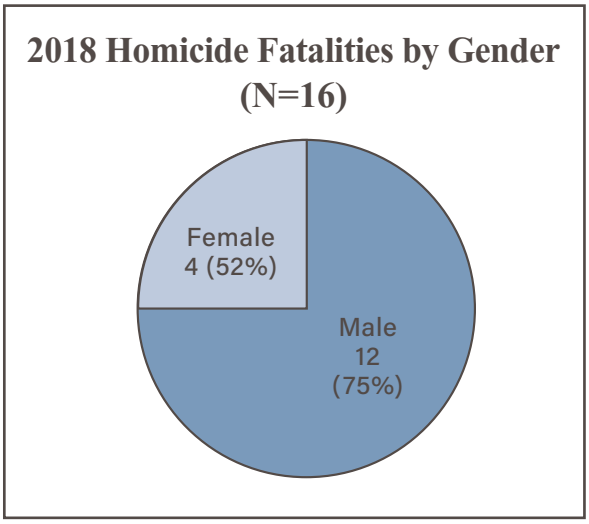


Figure 19: 2018 Homicide by Gender (n=16)

Homicide

The chart below provides further examination of homicide fatalities by race. These findings revealed each group was similarly impacted.

- 6 (38%) of homicide fatalities were White
- 5 (31%) of homicide fatalities were Black
- 5 (31%) of homicide fatalities were Hispanic

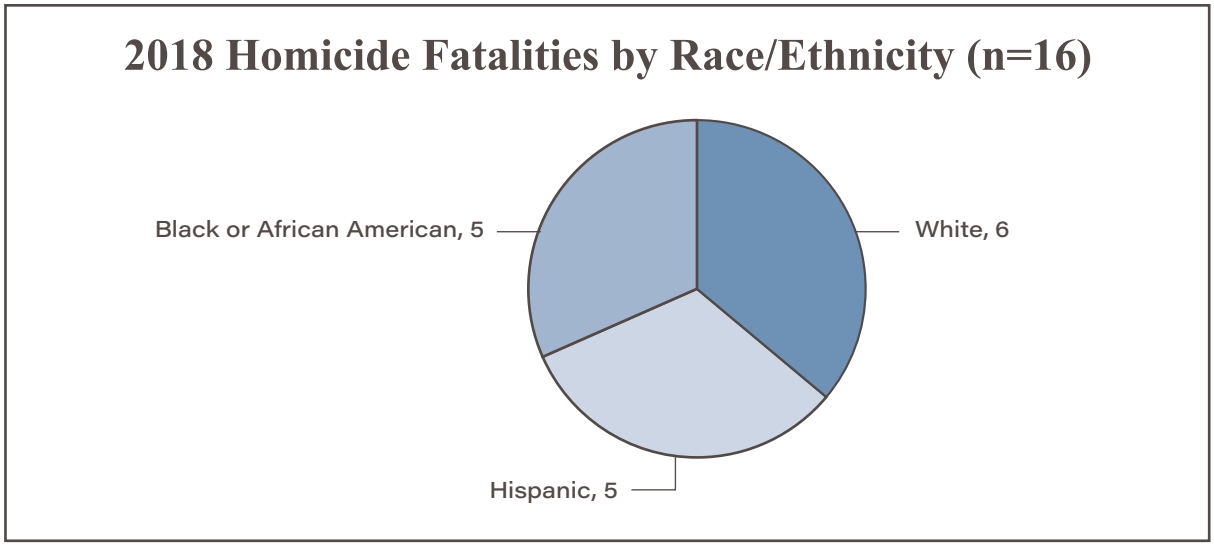


Figure 20: 2018 Homicide Fatalities by Race/Ethnicity (n=16)

In 2018, blunt force trauma was the leading cause of homicide fatalities (n=7). There were 8 other homicide fatalities resulting from gunshot wounds, drug overdose, neonatal substance misuse, and suffocation. There was one homicide with a cause of "undetermined homicidal violence."

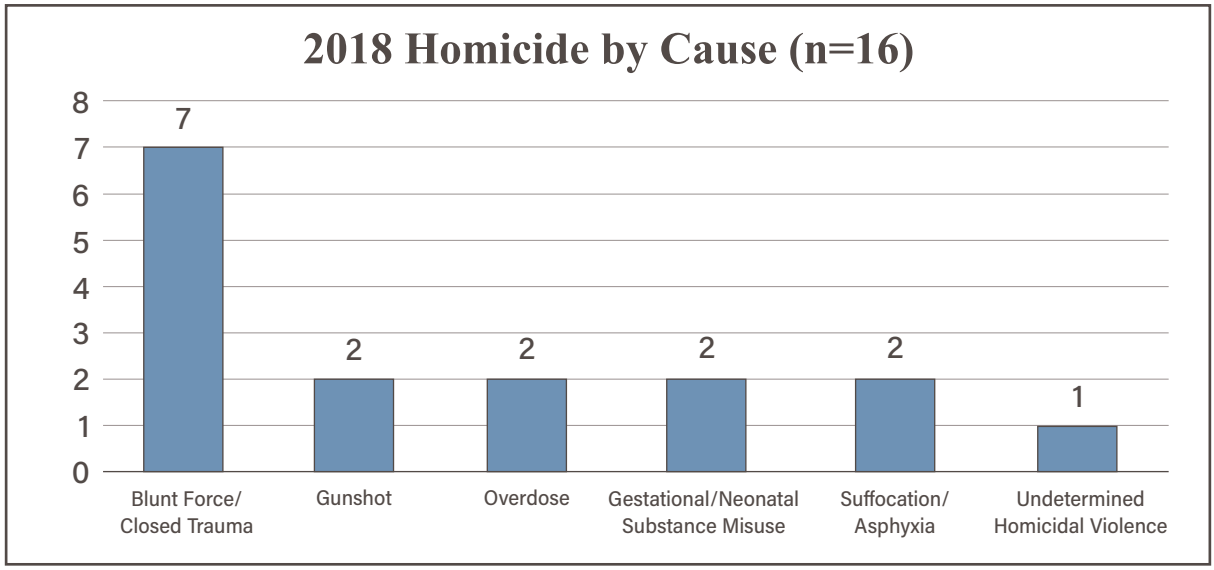


Figure 21: 2018 Homicide by Cause (n=16)

Homicide

Parents were responsible for 11 of the 16 homicide fatalities reviewed in 2018. The other category included two older children (aged 10 and 17 years old), who were both gunshot victims. The 10-year-old victim was an innocent bystander and the 17 year old victim was shot by a friend.

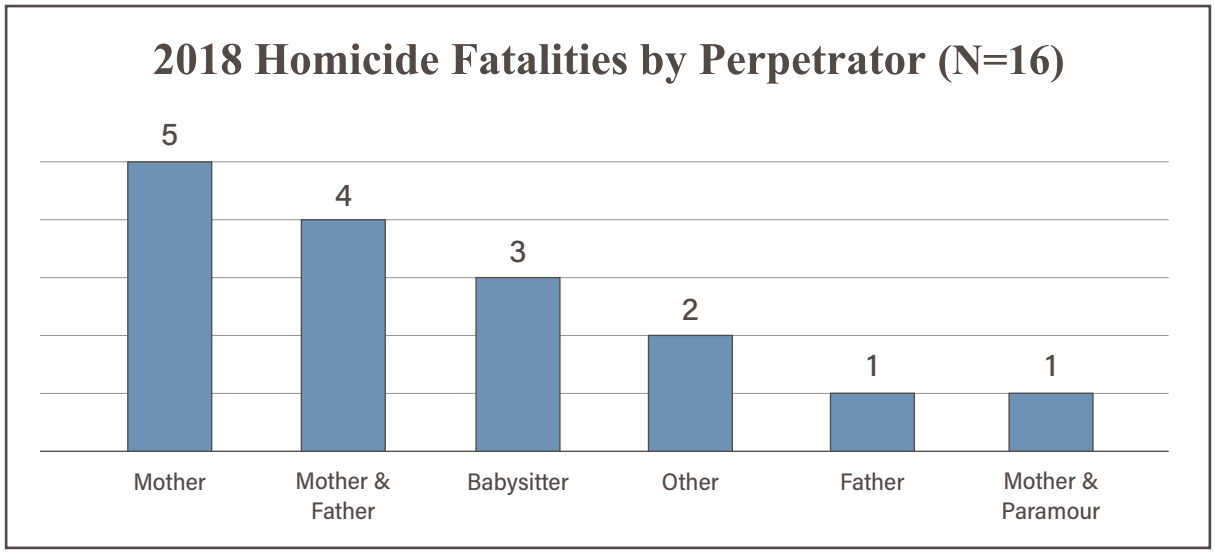


Figure 22: Homicide Fatalities by Perpetrator (n=16)

Drowning

Among preventable injuries, drowning is the leading cause of death for children ages 1 to 4 years old. In 2018, across the country, 918 children under the age of 19 drowned.

The Board reviewed ten drowning fatalities in 2018, and most children were between the ages of 1 to 4 years, accounting for 60% of the drowning fatalities (Figure 23). The manner of death for nine of the children was accidental, while one drowning was a result of suicide. This child is also counted in the suicide section of this report.

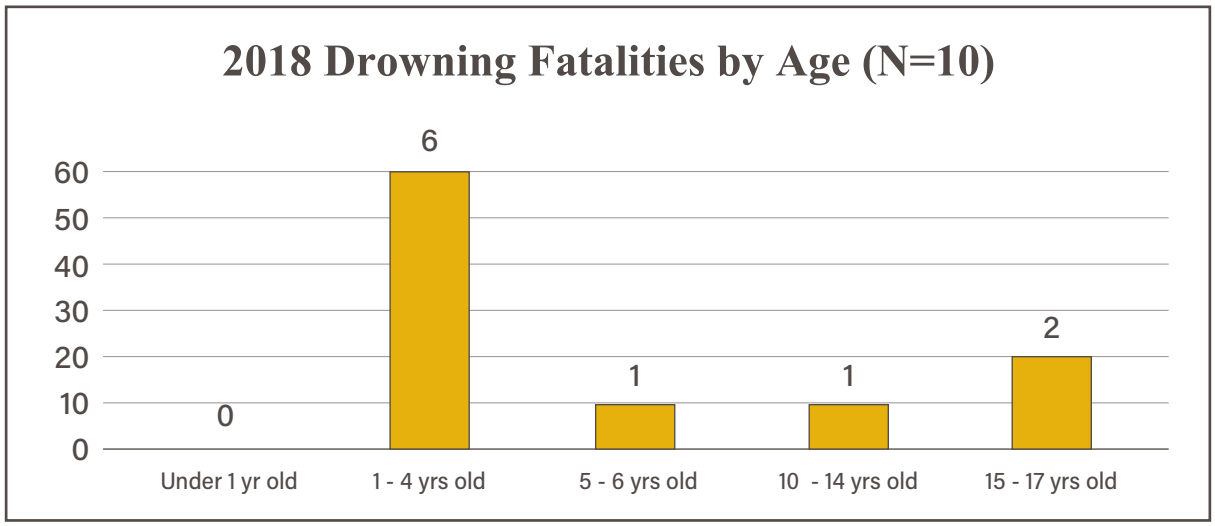


Figure 23: 2018 Drowning Fatalities by Age (N=10)

In 2018, 6 (60%) of the ten drowning victims reviewed by the Board were white (Figure 24).

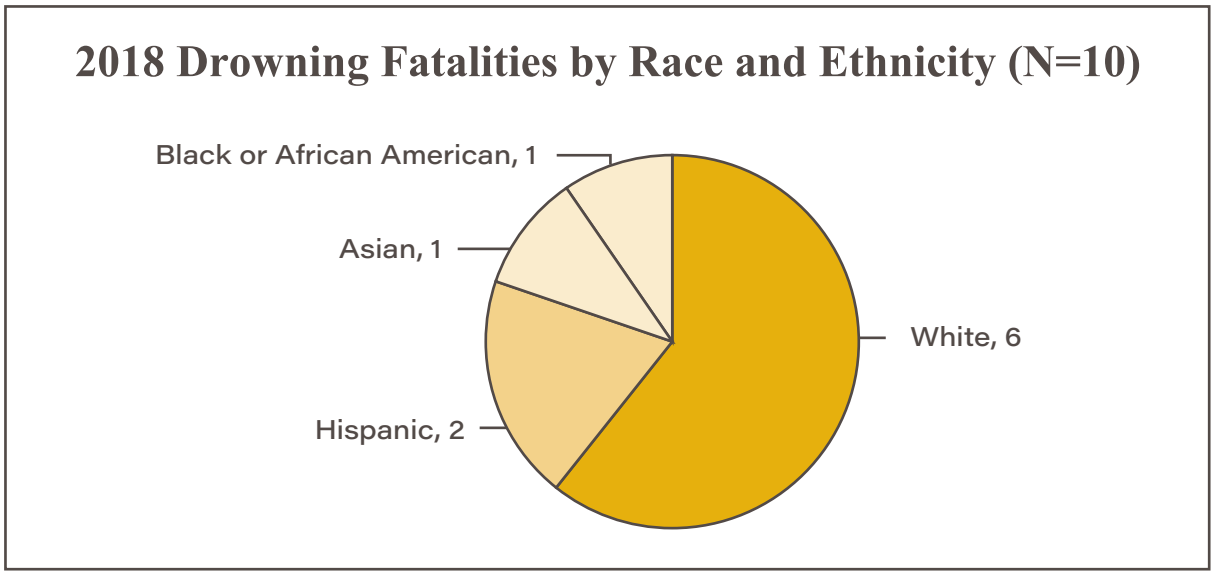


Figure 24: 2018 Drowning Fatalities by Race and Ethnicity (N=10)

[9] *Safe Kids (2022). Pool safety. Retrieved from: https://www.safekids.org/poolsafety*

Drowning

Overall, there were more male fatality drowning victims than female in 2018 (Figure 25).

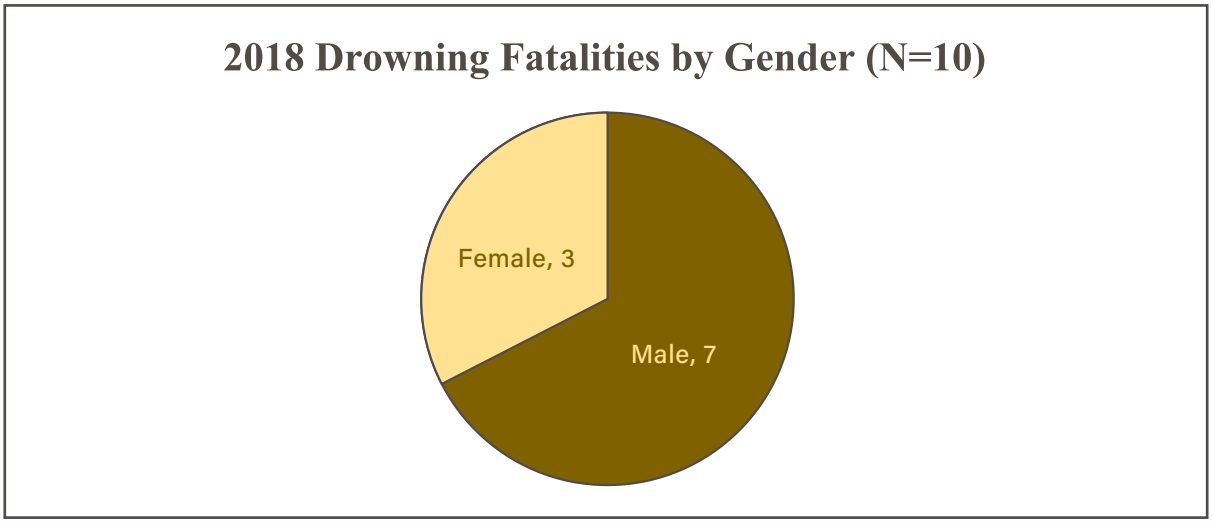


Figure 25: Drowning Fatalities by Gender (N=10)

Drownings can occur in any body of water. A child can drown in a few inches of water within seconds, often without any splashing or screaming.

In 2018, slightly more drownings occurred in natural bodies of water than residential swimming pools.

- 5 (50%) of the drowning fatalities occurred in natural bodies of water (i.e., lake, river, ocean).
- 4 (40%) of the drowning fatalities occurred in residential swimming pools.
- 1 (10%) drowning fatality occurred in a commercial swimming pool

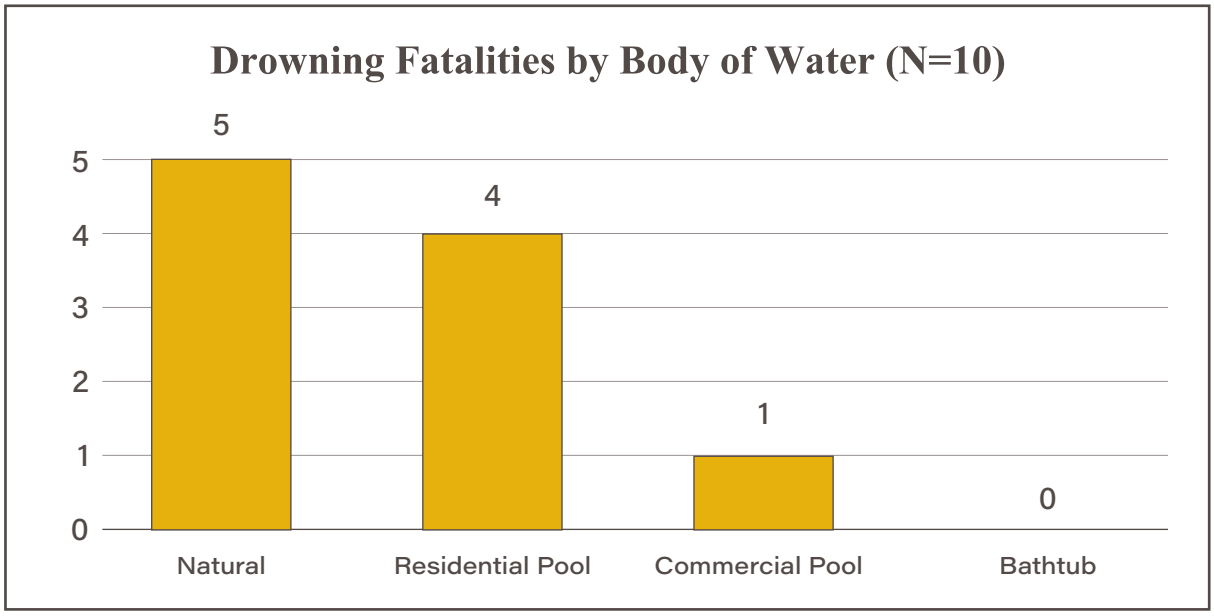


Figure 26: Drowning Fatalities by Body of Water (N=10)

Drowning

Top Tips for Swimming Safety (safekids.org)

Around pools and open bodies of water, give kids your undivided attention

1. Watch kids when they are in or around water, keeping young children and weak swimmers within arm's reach of an adult.

2. Choose a "Water Watcher." When there are several adults present, choose one to be responsible for watching children in or near the water for a certain period of time, such as 15 minutes. Switch after 15 minutes.

3. Teach children how to swim.

4. Make sure kids learn these five water survival skills.
    - Step or jump into water over their head and return to the surface.
    - Turn around in the water and orient to safety.
    - Float or tread water.
    - Combine breathing with forward movement in the water.
    - Exit the water.

5. Teach children that swimming in open water is different from swimming in a pool.

6. Learn CPR and basic water rescue skills.

Substance Misuse

Substance misuse in New Jersey and across the country continues to be an ongoing issue, especially with regard to the opioid crisis. There has been a continued increase in opioid-related overdose deaths in New Jersey in the last few years and additional prevention efforts are needed to address the impact opioid use disorders (OUDs) have on children and families. In addition to prenatal substance exposure, substance misuse and parents without support may struggle to provide children necessary care needed to be safe, healthy, and connected. Children and adolescents are also at-risk of accidental opioid exposure and misuse.

In 2018, the Board reviewed five substance misuse fatalities. Each of the fatalities reviewed were previously captured in other sections of this report. More specifically, four of the fatalities were in the homicide section, and one of the fatalities was captured in the suicide section.

- Of the substance misuse fatalities reviewed, 1 case occurred in each of the following counties Bergen, Essex, Mercer, Middlesex, and Morris.
- The substance misuse fatalities involved a wide age range of children, including 2 infants (days old), 2 toddlers (1 and 2 years old) and 1 teenager (14 years old).
- 4 of the children were males and 1 child was a female.
- The children were of the following racial/ethnic backgrounds; 1 Black, 3 white and 1 Hispanic.
- There was no history with DCP&P in 3 of the incidents, while 2 families had an open case at the time of the incident.
- All 5 substance misuse fatalities were determined to be as a result of abuse and/or neglect and met the requirements for CCAPTA.

Call PerformCare at 877-652-7624
to access child behavioral healthcare and other services

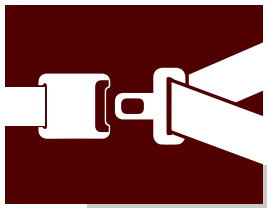
Near Fatality

A near fatality is defined as a "serious medical condition, as certified by a physician, in which a child suffers either a permanent mental or physical impairment, a life-threatening injury or a condition that creates a probability of death within the foreseeable future."

In 2018 the Board reviewed 5 near fatalities.

- Of the near fatalities, 2 occurred in Essex County, 2 in Morris County, and 1 in Cape May County.
- All of the near fatalities involved children 5 years old and younger, including 4 females and 1 male.
- The children were of diverse racial/ethnic backgrounds, including 1 Asian, 1 Black, 2 White, and 1 Hispanic child.
- There was no history with DCP&P in 4 of the incidents, while 1 family had an open case at the time of the incident.
- All 5 near fatalities were determined to have resulted from abuse and/or neglect and met the NJ CCAPTA determination.

Injuries like falls, slips, and tumbles, are part of childhood. But there are preventative measures we can take to ensure that children avoid the more serious injuries that can lead to disabilities and even death.

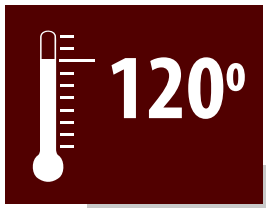


Prevent Falls

- Keep babies and young children strapped in when using highchairs, swings, strollers, etc.
- Properly install window guards and stops to prevent window falls.
- Keep babies and young children strapped in when using highchairs, swings, strollers, etc.

Medication Safety

- Put all medicine and vitamins up, away and out of sight after each use.
- Use the dosing device that comes with the medicine, not a kitchen spoon.
- Put all medicine and vitamins up, away and out of sight after each use.
- Use the dosing device that comes with the medicine, not a kitchen spoon.



Preventing Burns

- Don't carry a child while cooking on the stove.
- To prevent accidental scalding, set your water heater to 120º Fahrenheit.

Preventability

A goal of the Board is to evaluate the response of governmental 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.

If intervention by a government or local agency, community, or individual could have reasonably changed the circumstances leading to a child's fatality or near fatality, that incident is considered to have been preventable. The Board carefully examines each death in an effort to determine preventability.

In 2018, there were 124 fatalities and near fatalities that met the review criteria. The Board conducted a full review of 107 of those cases.

Initially, 17 fatalities were identified as resulting from circumstances in which it would have been extremely unlikely to change with or without intervention by a government or local agency, community, or individual. As a result, administrative reviews were conducted for those fatalities. Those fatalities were also determined to have occurred from natural causes or by accidental means and there was no evidence of abuse and/or neglect concerns, substance misuse, or drug toxicity. The administrative reviews of those 17 fatalities were conducted by the Board's DCF liaisons and are listed below by cause and/or manner:

- 10 natural fatalities resulting from a natural disease process;
- 3 drowning fatalities due to accidental drowning in regularly swum waters;
- 2 homicide gunshot wound fatalities not due to a caregiver's action; and
- 2 accidents, a non-natural (violent or traumatic) death resulting from an event occurring by chance or unknown causes, with a lack of intention (such as a car accident or being hit by a car)

Following the administrative reviews, it was determined that 4 of the 17 cases would require a full Board review. Those reviews and preventable determinations were pending at the time this report was published.

Of the 107 cases that received a full review, the Board determined that 62 fatalities (58%) were probably preventable, and warranted recommendations for system improvement, while 31 fatalities (29%) were probably not preventable (Figure 27). In 14 fatalities (13%), there was not enough information from relevant records, including but not limited to an autopsy, death scene investigation, law enforcement, education, mental health, medical and social services, and warranted recommendations for improving sources of data collection.

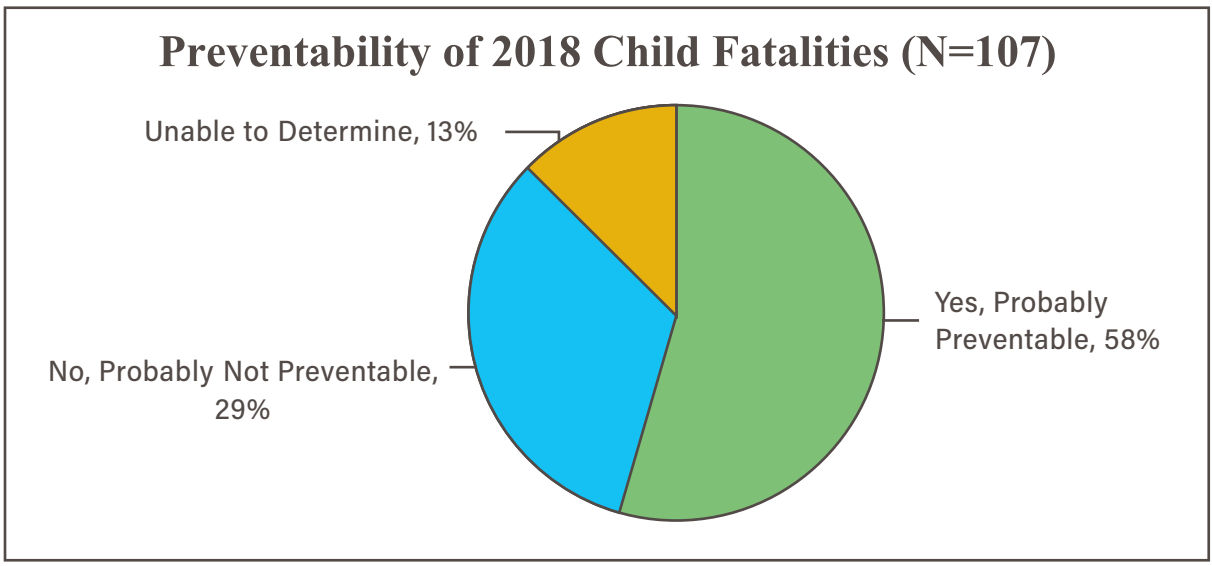


Figure 27: Preventability of 2018 Child Fatalities (n=107)

Recommendations

The number of preventable fatalities in children highlights the need for a continued focus on coordination and collaboration among State and local agencies, system-wide improvements in services to prevent fatalities and near fatalities among children, careful review of every child death, thoughtful identification of opportunities for prevention, and implementation of strategies to prevent future child deaths within governmental systems available and/or responsible for supporting New Jersey's children and families. To address preventable fatalities, the CFNRBR has made the following recommendations.

Suicide Prevention Recommendations

- *To Department of Children and Families:*
  - The Board recommends that when a case is open with DCP&P and CSOC there should be enhanced communication.
  - The Board recommends that when a child is transitioning genders, providers and caseworkers that are involved with the child need to ensure the child is connected to resources that are supportive and receive the services they need.
- *To Department of Education:*
  - The Board recommends that schools use an evidence-based approach to follow up on isolation that may result from out-of-school suspensions to not further isolate vulnerable youth.
  - The Board recommends that schools provide education to their students on how to respond if a classmate is struggling with mental health issues.
- *To Department of Human Services:*
  - The Board recommends that when a youth is discharged from a crisis screening center there needs to be more uniformity on discharge recommendations and include resources with contact information for the family.
- *To: State Board of Medical Examiners:*
  - The Board recommends that pediatricians receive training in the connection between mental health and physical health.

Drowning Prevention Recommendations

- *To Department of Children and Families:*
  - The Board supports continued public service campaigns regarding pool and water safety.
- *To All NJ Municipalities:*
  - The Board recommends that all townships should be required to pass legislation regarding enclosing of pools.

Substance Misuse Prevention Recommendations

- *To Department of Children and Families:*
  - The Board recommends a public service campaign ensuring families child proof their home prior to their child learning to walk.
  - The Board recommends increased interstate collaboration.

Other Recommendations

- *To Department of Human Services:*
  - The Board recommends that additional Human Service Police Officers are hired to assist the DCP&P in their work.
- *To Department of Human Services, Division of Family Development and Department of Children & Families:*
  - The Board supports the exploration of increasing more affordable childcare options specifically for shift workers that require childcare outside of routine work hours.

Appendix A:


NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES
WHAT HAPPENS AFTER THE CHILD ABUSE HOTLINE IS CALLED?
Call comes to NJ Child Abuse Hotline 1-877 NJ ABUSE.
A concerned caller can reach DCF at any time to report child abuse/neglect or to request child welfare services. The caller does not need proof and can make the report anonymously.
In NJ, the law requires any person having reasonable cause to believe a child was abused/neglected to immediate report the concern to DCF. Failure to report is a disorderly persons offense, punishable by fine or incarceration.
Information and Referral
If the caller's concerns do not meet the criteria for assessment or investigation, DCF provides the caller with information about services and referral options through community service providers.
Child Welfare Assessment or Child Protection Investigation
If the caller's concerns do not meet the criteria for assessment or investigation, DCF provides the caller with information about services and referral options through community service providers.
Related Information
If the caller provides updated or additional information on an open assessment/investigation or an opent case, the information is recorded and shared with the assigned worker.
A person or family's participation in an assessment is entirely voluntary.
Child Welfare Services (CWS) Assessment
A CWS assessment results when there is a request for services or an expressed concern about a family who may need assistance in ensuring the basic health and welfare of a child. A worker assesses child welfare issues and what supportive services might be needed. If the worker learns information during the CWS assessment that potentially meets the statutory definition of abuse/neglect, the CWS assessment can be converted to a CPS investigation.
Child Protective Services (CPS) Investigation
During a CPS investigation, CP&P seeks to understand the facts surrounding the allegations and ensure the child(ren)'s safety. The worker interviews the source of the report, each child and caregiver, and others involved in the family's life, i.e., doctors, teachers, etc. CP&P may request and review clinical and social service reports and may request forensic examinations of children. Ultimately, a worker makes an investigative determination, concluding one of four findings, and assesses whether the family would benefit from ongoing supportive services.
If a person or family refuses to cooperate with an investigation, CP&P can seek court intervention.
At the conclusion of an assessment or investigation, the investigator determines whether to open the case for services or terminate involvement. Even when an allegation is determined to be "not established" or "unfounded," CP&P may find that there are service needs and/or other concerns that warrant opening a case. A family's decision to accept ongoing services with CP&P is voluntary UNLESS CP&P has sought the Court's approval to:
• remove child(ren) and place in state custody; or
• provide ongoing care and supervision.
CP&P may seek the Court's permission to remove children and place them into State custody at any point, and regardless of whether or not there is a substantiated or established CPS report.
SUBSTANTIATED
ESTABLISHED
NOT ESTABLISHED
UNFOUNDED
*Substantiated findings are disclosed for a Child Abuse Information (CARI) check