



**Office of Children  
and Family Services**

# **New York State Child Fatality Report 2010-2014**

**Andrew M. Cuomo, Governor  
Sheila J. Poole, Acting Commissioner**

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## **I. EXECUTIVE SUMMARY**

The New York State Office of Children and Family Services (OCFS) is charged with promoting the safety and well-being of children, families and communities. As part of its broad mandate, OCFS oversees New York State's child welfare system, which includes programs such as child protective services, preventive services to strengthen families and reduce the need for placement in foster care, foster care programs and adoption, among others.

Pursuant to Article 6 of the Social Services Law that governs the New York child welfare system, local departments of social services administer child welfare programs in each county, investigate reports of child abuse and maltreatment and provide an array of protective and preventive services. In New York City, the Administration for Children's Services (ACS) carries out these functions for all five boroughs. In its statewide oversight role, OCFS employs a rigorous framework of laws, regulations, policies and procedures designed to hold localities to established practices and standards in the delivery of child welfare services.

As required by law, OCFS reviews fatalities of children who have been brought to the attention of the child welfare system. Specifically, OCFS examines deaths that: 1) are reported to the Statewide Central Register of Child Abuse and Maltreatment (SCR) and are allegedly caused by abuse or maltreatment by a parent or caregiver; 2) occur while a child is in foster care; or 3) occur while a child is under the supervision of a local department of social services.

For each of these fatalities, OCFS issues a report. It then compiles information regarding the fatalities, collects annual data and produces cumulative reports, such as this one, summarizing its findings and recommendations.

This report presents and examines New York State child fatality data for 2010–2014. In recent years, as part of its fight against child abuse, New York State has taken several steps to expand the categories of people required to report abuse and maltreatment; to educate those reporters about the signs and sometime subtle indicators of risk; and to broaden the range of fatality cases accepted for review. As a result, more New Yorkers than ever before are required by law to call the SCR when they suspect child abuse or maltreatment. And more mandated reporters – approximately 135,000 in 2013-2014 – have

received specialized OCFS training to carry out their responsibilities and report cases to the SCR.

All of these measures have contributed to an increase in the amount of reported cases to the SCR and have enhanced the state’s ability to identify potential cases of child abuse and maltreatment, including cases that might previously have gone undetected. Accordingly, over this five-year period, with increased reporting, the number of fatalities reviewed by OCFS increased by 7 percent.

The data shows that, upon investigation, many cases are not substantiated as having been caused by abuse or maltreatment. During the five years covered by this report, the number of substantiated cases fluctuated, and then decreased by 25 percent between 2012 and 2014.

**Fatalities Substantiated After Investigation  
2012 – 2014**

	2012	2013	2014
Fatalities Reported to SCR for Investigation	225	231	221
Substantiated Allegations of Child Abuse or Maltreatment	128	111	96
Percentage of Allegations Substantiated	55%	48%	43%

OCFS and its local partners engaged in many prevention and education initiatives over this same time period, efforts that contributed to this decrease.

By spearheading targeted initiatives specifically geared toward reducing infant fatalities, funding nationally-recognized Child Fatality Review Teams and enhancing data collection, OCFS leads multiple efforts to promote the safety and well-being of New York’s children. These efforts are summarized below and described in more detail in this report.

## *Infant Death Prevention*

Infant deaths represent the largest segment of OCFS-reviewed child fatalities. OCFS extensively analyzes these cases to pinpoint the greatest areas of risk and to guide prevention strategies at the state and local level. The data shows that in approximately 50 percent of these cases, the deaths occurred in unsafe sleep environments. Because many sleep-related fatalities are preventable, OCFS has focused significant resources toward educating the public and reducing this risk.

Healthy Families New York is an OCFS home visitation program that supports expectant mothers and families in 36 high-risk communities across the state. Programs that begin working with parents during the prenatal period and immediately after birth provide the greatest opportunity to reduce risk factors and promote positive childhood outcomes. Through home visits, the program delivers information and other services to expectant parents and new families, beginning weekly and decreasing over time, until the child starts school. Among other things, this program educates parents about the risks associated with unsafe sleep environments and promotes safe sleep practices to keep babies safe.

In addition, in 2012 and 2013, OCFS partnered with “Cribs-for-Kids,” a national infant safe sleep initiative, to purchase and distribute approximately 3,000 safety-approved portable cribs to local departments of social services, day care centers and community-based organizations working with families in high need communities. OCFS recently announced that it will donate 1,700 cribs around the state this year to provide safe sleep options for infants whose families might otherwise be unable to afford them.

## *Child Fatality Review Teams*

OCFS remains committed to the collection and analysis of child fatality review data to inform its policies and programs and prevent future child deaths. To this end, OCFS has implemented a nationally recognized approach to this work – Child Fatality Review Teams. OCFS funds 18 local Child Fatality Review Teams around the state, comprised of a broad composition of experts who conduct in-depth examinations of individual child fatality cases, identify local trends and patterns and develop initiatives to prevent child deaths. During the period examined in this report, these Review Teams led to the creation of county-level initiatives targeting safe sleep, safe infant feeding practices and choking

prevention, water safety, prescription drug abuse, teen driving safety, car safety, pedestrian safety, bicycle safety, hyperthermia and shaken baby syndrome, among others.

### *Data Collection*

OCFS recognizes the importance of analyzing and incorporating data in the development and targeting of effective fatality prevention strategies. To this end, in 2010, OCFS invested significant resources to develop the Child Fatality Review and Prevention database. OCFS continues to improve the relevancy and timeliness of the data and to improve its capacity to identify trends and risk factors that could prevent a child fatality.

In the coming years, OCFS will continue to collect and analyze child fatality data, to collaborate with state and local partners to target risk factors associated with child fatality cases and to promote the safety and well-being of the children and families of New York State.

## **II. OVERVIEW**

### **The Role of OCFS**

The New York State Office of Children and Family Services (OCFS) is charged with promoting the safety and well-being of children, families and communities, and oversees a wide range of programs and services as part of its broad mandate, including oversight of New York's child welfare system. OCFS maintains regional offices in Albany, Buffalo, Long Island, New York City, Rochester, Spring Valley and Syracuse to support agency programs and provide local oversight and technical assistance.

While OCFS supervises New York State's child welfare system, local departments of social services deliver services to residents of each county.<sup>1</sup> Pursuant to the Child Protective Services Act of 1973, each local department of social services must establish a Child Protective Service to investigate child abuse and maltreatment reports; to protect children (under 18 years old) from further abuse or maltreatment; and to provide

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<sup>1</sup> In New York City, services are not delivered by county. Rather, the New York City Administration for Children's Services (ACS) provides child welfare services to all five boroughs.

rehabilitative services to children, parents and other family members involved. By law, local departments of social services must also conduct child protective investigations.

In its oversight role, OCFS employs a rigorous framework of laws, regulations, policies and procedures designed to hold localities to established practices and standards in the delivery of child welfare services. Through data analysis, on-site reviews and case record reviews, OCFS monitors the performance of each local department of social services and, if circumstances warrant, directs the local department to implement corrective action. OCFS also supports counties by providing funding for the development of community-based programs and services that strengthen and support families and reduce risks to children.

### **The Statewide Central Register (SCR)**

As part of its mandate, OCFS operates the Statewide Central Register of Child Abuse and Maltreatment (SCR). The SCR, also known as the “Hotline,” accepts telephone calls 24 hours a day, seven days a week, to allow New York State to respond immediately to allegations of child abuse or maltreatment. SCR callers include mandated reporters (persons required by law to report suspected cases of child abuse or maltreatment) as well as members of the general public. Mandated reporters include, but are not limited to, doctors, hospital and medical personnel, teachers and school officials, social services workers, day care workers and members of law enforcement.

### **Child Fatality Investigations**

New York State Social Services Law section 20(5) charges OCFS with reviewing certain categories of child fatalities.<sup>2</sup> Specifically, the statute directs OCFS to investigate:

- Deaths reported to the SCR that allegedly occurred as a result of abuse or maltreatment by a parent or caregiver;
- Deaths that occur while a child is in foster care;<sup>3</sup> or

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<sup>2</sup> In this report, the term “child fatalities” refers only to the types of deaths that the statute authorizes OCFS to review.

<sup>3</sup>OCFS investigates deaths of children in foster care up to age 21. However, as of June 30, 2013, the New York State Justice Center for the Protection of People with Special Needs is responsible for investigating deaths of children who reside in residential foster care facilities.

- Deaths that occur while a child is the subject of an open child protective or open preventive services case.

A Child Protective Service case is considered open as soon as the SCR registers a report and transmits it to the local department of social services for investigation. The investigation remains open until the local department determines whether to substantiate the allegation of child abuse or maltreatment. A preventive services case is considered open as long as the child and family are receiving services in order to avoid foster care placement, to expedite the child's return home from foster care or to reduce the likelihood of returning to foster care.

There are two ways in which child fatalities are brought to the attention of OCFS. In the majority of cases, OCFS learns of a child fatality through a call made to the SCR. In these cases, highly trained SCR staff answer each call and follow a carefully structured interview protocol to obtain as much relevant information as possible about the fatality. If reasonable cause exists to suspect the death was caused by child abuse or maltreatment, the SCR registers the report and immediately transmits it to the local department of social services to investigate the allegations.

In the event a death occurs while a child is in foster care, or is the subject of an open child protective or preventive case, a call to the SCR is not usually required. Instead, the local department of social services or the community agency providing care to the child notifies the OCFS Regional Office directly, which will launch the investigatory process. SCR notification in these instances occurs, in addition, only if there is an allegation of abuse or maltreatment in relation to the fatality.

Either of these two methods – SCR or OCFS notification – triggers an in-depth investigation into the child's death and all surrounding circumstances that begins within 24 hours of notification. The investigation itself is conducted by the local department of social services, with oversight and monitoring by OCFS Regional Office staff. Such investigation must be comprehensive and complete and address: how the child died; the safety of the child's siblings or other children in the home; what actions or inactions by the parents or caretakers contributed to the death; and what actions were taken or decisions made by the local department of social services or foster care agency. The local departments of social services must also determine whether some credible evidence exists to conclude (or substantiate) that the fatality was the result of child abuse or maltreatment.



### **III. CHILD FATALITY REPORTING**

#### **The Social Services Law**

OCFS prepares and issues a report on each fatality it reviews, as mandated by Social Services Law section 20(5)(b). The OCFS report evaluates all aspects of the local department's investigation, including its credible evidence determination and its handling of all aspects of the case prior and subsequent to the fatality. If OCFS finds deficiencies at the local level, the report identifies such deficiencies, and OCFS will require the local department of social services to implement a corrective action plan that OCFS must approve.

Social Services Law section 20(5) also requires OCFS to prepare and issue cumulative reports, such as this one, which aggregate the data extracted from individual child fatality reports.

## **Child Fatality Data 2010-2014**

This report presents and examines child fatality data for 2010–2014, and includes a detailed analysis of the data compiled during this five-year period. Notably, two overall conclusions can be drawn from the data:

- The number of total child fatalities reviewed by OCFS annually increased by 7 percent between 2010 and 2014, a fact attributable to more robust reporting initiatives and an expansion of SCR intake categories. [See Chart 1]
- The number of fatalities substantiated (or confirmed) as having been caused by abuse or maltreatment fluctuated and then decreased between 2012 and 2014 by 25 percent (or 32 cases). [See Chart 3].

### **Child Fatalities Reviewed by OCFS 2010 – 2014**

<b><u>Type</u></b>	<b><u>2010</u></b>	<b><u>2011</u></b>	<b><u>2012</u></b>	<b><u>2013</u></b>	<b><u>2014</u></b>
<u>SCR Notification</u>	198	193	225	231	221
<u>Open Cases</u> <sup>4</sup>					
• Child Protective	45	51	30	32	44
• Foster Care	9	17	12	3	9
• Preventive Services	13	11	9	9	10
<u>Total</u>	265	272	276	275	284

Chart 1

<sup>4</sup> It is important to note that children sometimes receive more than one service. However, to prevent duplicative counting of a child fatality, the data is presented as follows: if a fatality occurred while a child was the subject of an open protective case, that fatality is categorized under open protective regardless of other services provided; if the child was not the subject of an open protective case but was in foster care and received preventive services, that child fatality is categorized under foster care. All remaining fatalities are categorized as preventive cases.

During the five years covered by this report, the number of fatalities that occurred in open child protective, foster care and preventive services cases remained relatively unchanged. It is important to note that the fatalities in these categories were not caused by child abuse or maltreatment by a parent or caregiver. Rather, these fatalities resulted from accidents and medical conditions, among other causes.

Chart 1 also depicts SCR notifications, in which the reporter alleges parental or caregiver abuse or maltreatment. This data indicates that notifications made to OCFS through the SCR and accepted for review increased beginning in 2012. This increase coincided with several affirmative steps taken by New York State to encourage more comprehensive reporting of child abuse and maltreatment and to investigate a broader range of cases, described below.

#### Affirmative Steps Promoting Increased SCR Reporting

- **New York State delivered online training to more than 135,000 mandated reporters in 2013 and 2014 alone.**
  - Since 1989, the New York State Education Department has required mandated reporters in 16 professions to undergo mandated reporter training prior to receiving their professional licenses. However, for many years, this training was only delivered in-person by OCFS and other providers. To expand the delivery of and standardize this training, OCFS developed a specialized online training course in 2008 for all mandated reporters. This free online program, which reached 135,000 mandated reporters in 2013 and 2014, emphasizes the duty to report suspicions of child abuse or maltreatment; educates mandated reporters about the signs and sometimes subtle indicators of risk; and encourages them to convey vital information that can alert SCR intake staff to issues, including unsafe sleep conditions and shaken baby syndrome.
  - Since the launch of online mandated reporter training, the number of online trainings delivered has increased dramatically. As Chart 2 illustrates, the number of individuals trained online by OCFS per year increased from 309 in 2008 to 76,765 in 2014. In addition to those licensed by the State Education Department, mandated reporters accessing OCFS's training include employees of local departments of social services, foster care agencies and other child welfare services programs. With increased knowledge, comes increased reporting.

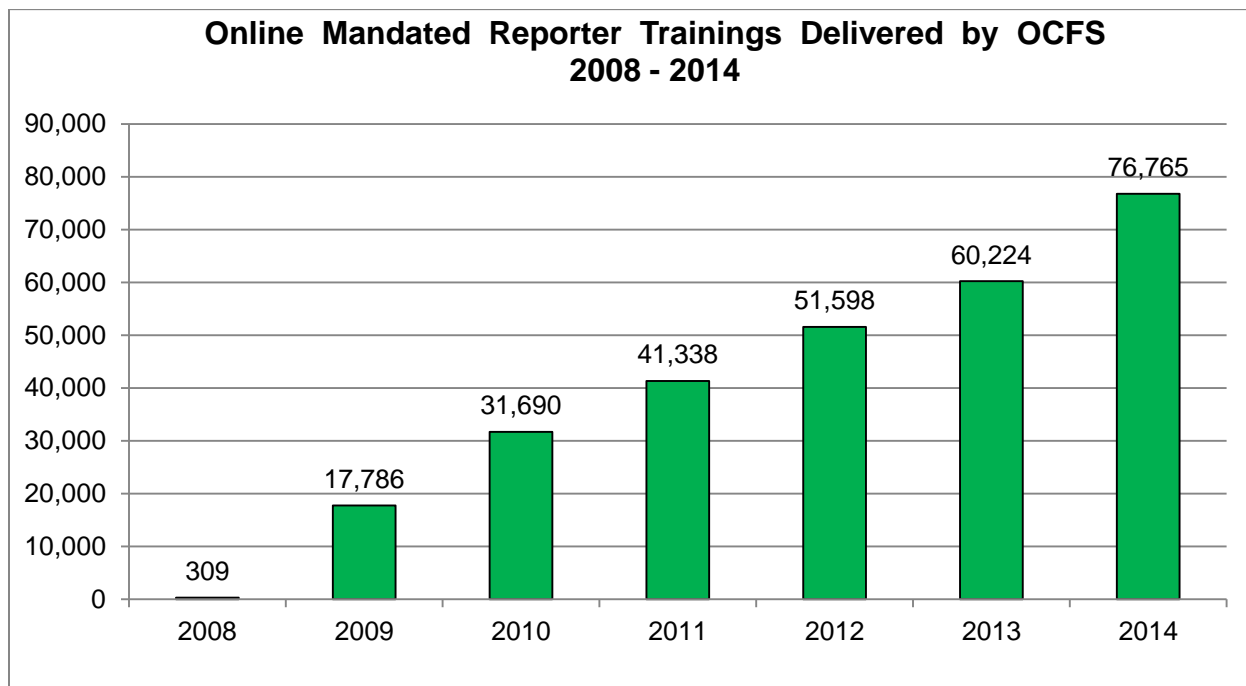


Chart 2

- Expanded Categories of Mandated Reporters:** New York has repeatedly amended its mandated reporting law to expand the ranks of those required to report suspected child abuse or maltreatment. This push continued with the addition, in June 2011, of summer camp directors to the list of mandated reporters, as these professionals are well positioned to protect children in their care. In addition, in 2014, New York State added licensed behavior analysts and certified behavior analyst assistants to the list of mandated reporters.
- Broadened the Range of Cases the SCR Accepts for Review:** OCFS has also expanded the range of reports the SCR accepts and refers to localities for investigation. As a result, the SCR now routinely registers reports in cases where unsafe sleep practices may have caused a death. Since April 2013, the SCR also accepts reports involving the death of an “otherwise healthy child.” This label applies to a fatality in which a child dies, but no health condition, injury or reason is readily apparent. Such cases are accepted in order to rule out any possibility of child abuse or maltreatment. These recent policy changes have increased the number of fatality cases OCFS accepts and reviews, thereby extending this level of scrutiny to a broader range of cases.

- **Safe Sleep Campaigns:** Recognizing the importance of avoiding preventable infant deaths, OCFS – alone and in conjunction with state and community partners – has engaged in a targeted, multi-media campaign to raise public awareness of the risks of co-sleeping and other unsafe sleep practices. As a result, mandated reporters have become increasingly attuned to recognizing unsafe sleep environments and to reporting fatalities that may have been caused by them. Section IV of this report provides further information about OCFS’s leadership role in this area.

SCR Reported Fatalities

**Fatalities Substantiated After Investigation  
2010 – 2014**

	2010	2011	2012	2013	2014
Fatalities Reported to SCR for Investigation	198	193	225	231	221
Substantiated Allegations of Child Abuse or Maltreatment	110	93	128	111	96
Percentage of Allegations Substantiated	55%	47%	55%	48%	43%

Chart 3

It is important to note that this report, in large part, analyzes data pertaining to fatalities reported to the SCR. Such reports, by definition, contain an allegation that the child’s death occurred as a result of abuse or maltreatment by a parent or caregiver. However, after in-depth investigations conducted at the local level, such allegations were substantiated (or confirmed) approximately half of the time.

During the five years covered by this report, the precise number of reports substantiated as having been caused by abuse or maltreatment fluctuated. Notably, however, this number decreased between 2012 and 2014 by 25 percent (or 32 cases).

## Fatality Reviews by Age

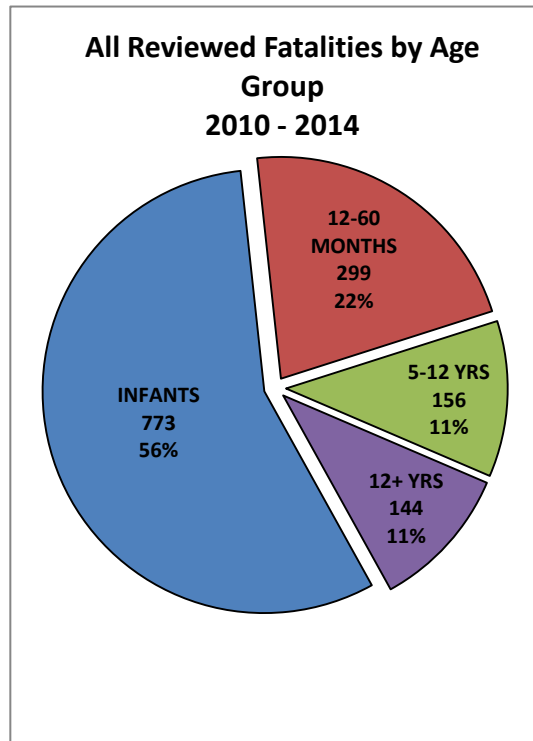


Chart 4

Between 2010-2014, infants less than 12 months of age constituted the largest segment of child fatalities. As seen in Chart 4, children ages 12–60 months constituted the next largest segment of fatalities, followed by children ages 5–12 years and by children older than 12.

Because infant deaths consistently represent the largest segment, OCFS extensively analyzes these deaths to pinpoint the greatest areas of risk and to guide prevention strategies. The data reveals that in approximately 50 percent of these cases, the deaths occurred in unsafe sleep environments (Chart 5).

**Child Fatalities Involving Unsafe Sleep Environments  
2010 – 2014**

	2010	2011	2012	2013	2014
Fatalities Reviewed for Children Under 12 Months of Age (Infants)	151	155	153	162	152
Total Identified Unsafe Sleep Environments	79	64	71	81	75
Unsafe Sleep Percent of All Infant Fatalities	52%	41%	46%	50%	49%

Chart 5

Unsafe sleep is a leading factor in infant fatalities reviewed by OCFS. Unsafe sleep environments may include those in which an adult and child are sleeping in the same bed (co-sleeping) and those in which the child is sleeping somewhere other than a crib or bassinet. Because many sleep-related fatalities are preventable, OCFS has focused significant resources toward educating the public and reducing this risk. As described in Section IV, promoting safe sleep is an OCFS child welfare priority.

Chart 6 further examines the various sleep environments, both those deemed safe and unsafe. When a child fatality occurs in an unsafe sleep environment, it most frequently involves an infant sleeping in an adult bed, usually in a co-sleeping scenario.

2010 – 2014		
If the child died in an unsafe sleeping environment, what was the location?	Count: (Children < One Year)	Percent of Total
Adult Bed	230	62%
Couch	48	13%
Crib	30	8%
Bassinet	17	5%
Other	9	2%
Playpen/Portable	8	2%
Car seat/Stroller	9	2%
Floor	6	2%
Air Mattress	6	2%
Chair	3	1%
Unknown	3	1%
Child/Toddler bed	0	0%
Waterbed	1	0%
Total:	370	-

Chart 6

## Fatality Reviews by Manner of Death

In compiling its data, OCFS accepts the manner of death certified by the medical examiner or coroner responsible for each child's death certificate. Below are the guidelines provided by the National Centers for Disease Control to coroners/medical examiners for categorizing manner of death:

### **Medical Examiner Categories for Manner of Death**

Natural	Due to disease and/or the aging process.
Accident	Unintentional; little or no evidence that an injury or poisoning occurred with intent to harm or cause death.
Suicide	Result of an injury or poisoning that is an intentional, self-inflicted act.
Homicide	Occurs when death results from an injury, a poisoning or "a volitional act committed by another person to cause fear, harm, or death."
Undetermined/Unknown	Cause of death cannot be determined.
Pending	This code is used by the coroner or medical examiner when the determination depends on further information.

Chart 7

Application of these guidelines can vary among medical examiners and coroners. Thus, the cause of death in a fatality may be characterized in different ways depending upon the jurisdiction.



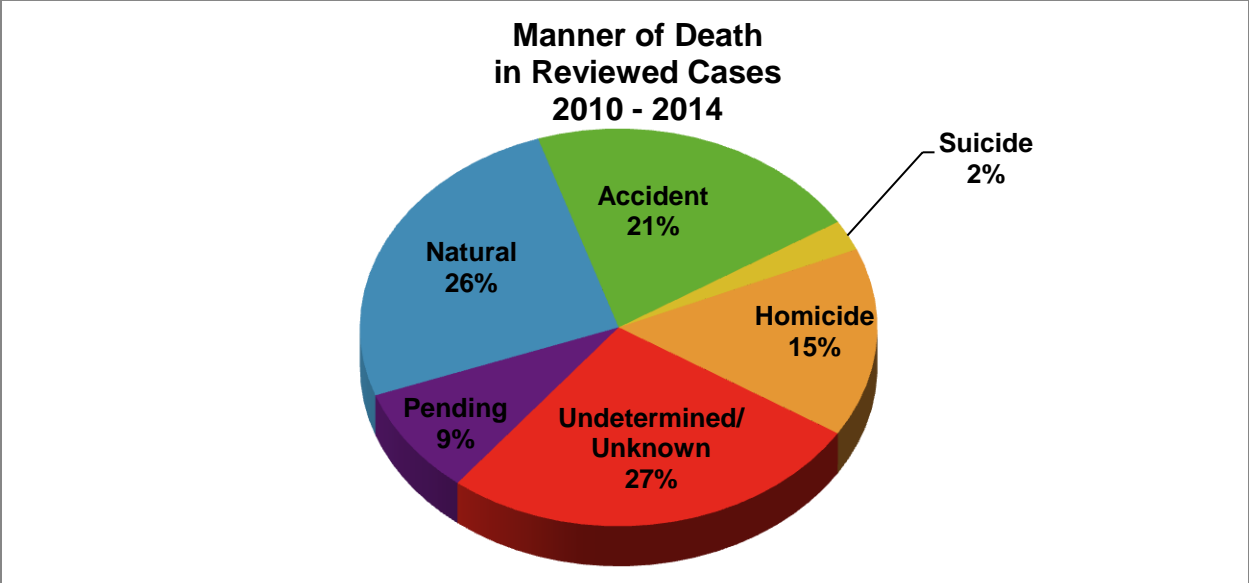


Chart 8

Manner of Death	2010	2011	2012	2013	2014
NATURAL	65	86	61	54	85
ACCIDENT	64	39	61	78	49
HOMICIDE	50	45	42	36	38
SUICIDE	3	6	8	10	7
PENDING	6	8	17	36	53
UNDETERMINED/UNKNOWN	77	88	87	61	52
TOTAL	265	272	276	275	284

Chart 9

As Chart 8 shows, 27 percent of OCFS-reviewed fatalities were classified by medical examiners or coroners as undetermined/unknown, a rate similar to that seen in previous years. The undetermined/unknown category is frequently associated with infant fatalities, particularly Sudden Unexpected Infant Deaths (SUID), the leading cause of death among infants. SUID is a term that describes fatalities that occur suddenly and unexpectedly in previously healthy infants and indicate no obvious cause of death prior to investigation. In many of these cases, the death remains unexplained even after a thorough case investigation, autopsy, examination of the death scene and medical history.

Within the group of OCFS-reviewed fatalities, natural deaths (26 percent) and accidental deaths (21 percent) occurred with almost equal frequency, comprising almost half of the total deaths reviewed. The largest causes of accidental death include asphyxia, drowning, fire and motor vehicle accidents.

Finally, during the period of time covered by this report, the number of suicides reviewed by OCFS slightly increased before decreasing in 2014. OCFS collaborates with the New York State Office of Mental Health Suicide Prevention Center which delivers many programs to support the mental health of children. They include Lifeline, a school program that promotes suicide prevention and intervention, and Source of Strength, a school-wide health promotion and suicide prevention network that trains both peers and adult mentors to build strong student support systems. In addition, other community-based coalitions/task forces are working in partnership with local departments of social services in approximately 40 counties across the state to address local issues related to suicide.

## Fatality Reviews by Geographic Distribution

Chart 10 lists the total number of child fatalities reviewed by OCFS by year and by county. Fatalities are identified by the county in which the child resided at the time of his or her death.

<b>OCFS Reviewed Child Fatalities by County 2010-2014</b>					
	2010	2011	2012	2013	2014
<b>Total Verified Deaths</b>	<b>265</b>	<b>272</b>	<b>277</b>	<b>275</b>	<b>284</b>
Albany	5	5	6	6	8
Allegany	0	1	3	0	0
Broome	7	4	13	3	6
Cattaraugus	2	1	3	0	1
Cayuga	3	1	1	2	3
Chautauqua	3	1	3	2	1
Chemung	4	2	3	1	4
Chenango	4	1	0	2	0
Clinton	2	1	0	1	0
Columbia	1	0	1	1	0
Cortland	0	0	0	1	0
Delaware	0	2	1	1	1
Dutchess	3	0	4	4	1
Erie	16	14	13	12	24
Essex	0	0	2	0	0
Franklin	2	1	0	0	2
Fulton	3	0	0	3	2
Genesee	0	2	0	1	0
Greene	1	3	1	0	1
Hamilton	0	0	0	0	0
Herkimer	2	1	1	0	1
Jefferson	4	1	5	8	4
Lewis	0	0	0	0	0
Livingston	1	0	0	2	0
Madison	0	0	1	2	1
Monroe	15	16	17	16	9
Montgomery	0	0	2	1	1
Nassau	5	11	6	7	2
Niagara	6	5	4	4	4
Oneida	8	5	5	9	5
Onondaga	10	10	8	12	11
Ontario	0	0	0	0	3
Orange	6	13	2	8	4
Orleans	0	0	0	0	0
Oswego	2	3	1	4	4
Otsego	1	0	0	0	0
Putnam	0	0	0	0	1

Rensselaer	2	3	4	5	7
Rockland	3	4	3	5	3
St. Lawrence	2	1	4	2	2
Saratoga	4	2	0	2	1
Schenectady	2	7	3	9	7
Schoharie	0	0	2	0	0
Schuyler	0	0	0	0	0
Seneca	2	1	1	2	0
Steuben	1	2	4	2	3
Suffolk	12	16	13	10	12
Sullivan	1	1	2	0	0
Tioga	0	1	1	1	0
Tompkins	0	0	3	1	0
Ulster	1	3	3	3	1
Warren	1	0	3	1	0
Washington	2	0	2	1	1
Wayne	1	0	0	2	3
Westchester	2	9	7	4	6
Wyoming	0	0	0	0	1
Yates	0	0	1	1	0
St. Regis	0	0	0	0	2
Bronx	28	33	32	42	38
Kings	39	43	36	34	40
New York	21	19	24	5	16
Queens	18	17	16	23	31
Richmond	7	6	5	7	4
OSI <sup>5</sup>	0	0	0	0	2
OTHER <sup>6</sup>	0	0	1	0	0
<b>NYC</b>	<b>113</b>	<b>118</b>	<b>113</b>	<b>111</b>	<b>131</b>
<b>Statewide</b>	<b>265</b>	<b>272</b>	<b>277</b>	<b>275</b>	<b>284</b>

Chart 10

In 2013, 17 counties had no fatalities reviewed by OCFS, and an additional 22 counties counted two or fewer investigations. Outside of New York City, the highest number of fatalities in 2013 was 16 in Monroe County. Monroe is one of the largest counties in the state and the majority of these deaths were attributed to unsafe sleep practices. Due to comprehensive evaluations by the Monroe County Child Fatality Review Team (discussed further in Section IV), Monroe County developed a safe sleep campaign, which succeeded in drastically reducing the number of safe sleep related fatalities in 2014. In addition, in 2014, 20 counties had no fatalities reviewed by OCFS, and an additional 18 counted two or fewer investigations.

<sup>5</sup> The New York City Administration for Children's Services Office of Special Investigations investigates reports involving children in New York City child care and foster care facilities.

<sup>6</sup> This fatality occurred in a foster care residential facility and cannot be attributed to a county.

Some of the remaining counties experienced fluctuations over this five-year period in the number of local cases that OCFS reviewed. Each county is subject to a unique set of local circumstances, which can make data analysis difficult. For example, tragedies that claim the lives of multiple children, such as fires or car accidents, may be reported to the SCR and referred to local departments for investigation. These situations can cause unpredictable spikes in a county's numbers. Such was the case in some counties during the years covered by this report.<sup>7</sup> Thus, a close examination of all circumstances is essential to a complete understanding of annual child fatality data.

For instance, in 2014, the number of fatalities reviewed in Erie County and New York City increased. In Erie County, a greater number of unsafe sleep cases and natural deaths contributed to the upward trend. New York City also experienced an increased number of unsafe sleep reports. Public awareness campaigns and more robust mandated reporting contributed to an increased number of SCR notifications regarding child fatalities in New York City.

Data analysis remains a vitally important part of OCFS's mission to prevent child fatalities in New York State. As Section IV describes, data analysis has allowed OCFS and its local partners to begin to focus on specific risk factors and to develop targeted initiatives to prevent child fatalities.

#### **IV. PARTNERSHIPS AND PREVENTION**

OCFS is committed to child fatality prevention efforts. To that end, OCFS, alone and in partnership with other state, local and national organizations, has engaged in important initiatives designed to prevent child fatalities.

As this section explains, OCFS:

- created its own working database to store and analyze child fatality data that comports with New York State child fatality data reporting requirements;
- continues to support and expand the use of Child Fatality Review Teams, which include a broad composition of community members well suited to analyze child fatalities and propose community-based initiatives; and
- promotes statewide initiatives to address the most common risk factors contributing to child fatalities.

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<sup>7</sup> Confidentiality laws prohibit the disclosure of the names of the counties.

## **The Child Fatality Review and Prevention Database**

OCFS recognizes the importance of data in developing and targeting effective fatality prevention strategies. In 2009, OCFS joined the National Center for Child Death Review data system to enable the agency to enter and analyze individual fatality report data and access data from other states. Subsequently, OCFS decided to develop a New York State-specific data collection system tailored to local needs.

In 2010, OCFS invested significant resources to develop the Child Fatality Review and Prevention database, which began accepting data in 2013. Since 2013, OCFS has worked to improve the relevancy and timeliness of the data; to improve its internal data analytic capacity to identify trends and risk factors that could result in a child fatality; and to expand its programmatic capacity to implement programs to reduce fatalities.

## **Child Fatality Review Teams**

Child Fatality Review Teams are nationally recognized as among the most promising approaches for accurately counting, responding to, and preventing child abuse and neglect fatalities, as well as other preventable deaths. OCFS provides funding to 18 Child Fatality Review Teams. Each Review Team conducts in-depth examinations of individual child fatality cases and identifies local trends and patterns to develop preventive and educational initiatives in their counties. Since 2007, OCFS has increased the number of Review Teams from 10 to 18, covering 19 counties in the state. They have proven valuable to OCFS and the communities they serve.

Review Teams are composed of diverse stakeholders with experience related to child fatalities, including staff from local departments of social services, OCFS, county departments of health, child advocacy centers, law enforcement agencies, district attorneys' offices as well as medical examiners, first responders, mental health providers and other community stakeholders.

In 2014 and 2015, OCFS convened two-day summits for members of Review Teams to bring them together to share information and collaborate on new strategies to reduce fatalities.

## Review Team Prevention Initiatives

Throughout 2010-2014, Review Teams created and implemented a variety of prevention initiatives in their local counties. The following are some examples of successful initiatives:

Safe Sleep – As a result of sleep-related deaths, the Albany and Rensselaer County Review Team started a local chapter of Cribs-for-Kids, a national infant safe sleep initiative, which distributes cribs and informational materials directly to families in need. The Albany Review Team also ran public service announcements on local television stations regarding safe sleep environments for infants.

Similarly, as a result of the findings of the Monroe County Review Team regarding sleep-related deaths, in 2011, Monroe County established the “Baby Safe Sleep Coalition,” a collaboration of professionals, organizations and concerned individuals committed to eliminating preventable infant fatalities caused by unsafe sleep practices. The coalition works to improve knowledge, attitudes and beliefs about the risk of unsafe sleep environments in order to change local social norms and parent and caretaker behavior. As noted earlier in this report, Monroe County, one of the largest counties in the state, had one of the highest number of child fatalities for the examined period, most of which were attributed to unsafe sleep practices. By establishing the Baby Safe Sleep Coalition, Monroe County is taking a significant step in lowering child fatalities, an initiative that is a direct result of the OCFS-funded Review Team.

Choking Prevention – The Nassau County Review Team developed and distributed a choking prevention brochure and additional information to pediatricians, family practitioners, the local department of social services, libraries and other community-based providers in the county.

Water Safety – To respond to water-related child fatalities, the Nassau County Review Team worked with the county health department and County Executive to post information regarding drowning prevention on the county health department’s website.

Similarly, the Niagara County Review Team provided water safety informational materials to the local Sudden Infant and Child Death Resource Center, the Community Health Worker Program and the local department of social services.

The Review Team also mailed water safety information to more than 40 child care providers across Niagara County, distributed water safety information at the county fair, and placed a water safety advertisement in three community newspapers.

*Additional Awareness Campaigns* – Review Teams across the state have launched a variety of other campaigns to increase awareness regarding a variety of child safety issues:

- The Albany County Review Team spearheaded a media campaign to increase public awareness about risk factors that contribute to preventable child deaths, such as pedestrian safety, bicycle safety, hyperthermia, pool safety and shaken baby syndrome. The media print campaign appeared in bus shelters, bus exteriors and bus interiors throughout the county.
- The Allegany County Review Team distributed brochures and magnets to parents, grandparents and other caregivers that included information about safe sleep, car safety and safe infant feeding practices. The magnet displayed the ABCs of safe sleep – that babies sleep safest Alone, on their Backs, in a Crib – and included a contact number for more information. The Review Team also issued a press release to stress the importance of water safety.
- The Orange County Review Team launched several awareness campaigns targeting both the general public and physicians. The campaigns address drowning prevention, safe sleeping, reducing risk factors associated with Sudden Infant Death Syndrome (in collaboration with the State SIDS Resource Center), prescription drug abuse and teen driving safety.
- The Putnam County Review Team implemented the Conscious Fathering Program, a hospital-based program to educate new and expectant fathers on how to meet their babies' needs. In partnership with the local health department, the Review Team also sent “new parent packets” with important safety information to all families with a newborn.



## **OCFS Statewide Initiatives**

In addition to local and county initiatives, OCFS has established statewide programs to address recurring risk factors and reduce fatalities of children under the age of one. OCFS partners with other state agencies and not-for-profits to enhance programs and to broaden their impact.

Of the child fatalities that OCFS reviewed from 2010 to 2014, 56 percent involved infants under the age of one. Accordingly, OCFS focuses significant resources on combating child fatalities for this vulnerable age group. Programs that begin working with parents during the prenatal period and right after birth provide the greatest chance of reducing risk factors and promoting positive childhood outcomes. They include:

### **Healthy Families New York**

Healthy Families New York is an OCFS-led home visiting program<sup>8</sup> that focuses on the safety of children by supporting families in high-risk communities. Healthy Families New York currently operates 36 programs throughout the state.<sup>9</sup> The program provides information during the prenatal period and delivers other services to expectant parents and new families, beginning weekly and decreasing over time, until the child starts school.

Healthy Families New York has been rigorously evaluated over a seven-year period to determine the effectiveness of the program in preventing child maltreatment and delinquency. This evaluation showed that Healthy Families New York cut the rate of low birth weight babies by half, promoted positive parenting skills and sustained access to health care. For mothers involved in a substantiated Child Protective Service report prior to entering the program, Healthy Families New York significantly reduced the rate of subsequent substantiated Child Protective Service reports and generated even greater reductions in the rate of cases opened for preventive services. Healthy Families

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<sup>8</sup> Healthy Families New York is an OCFS initiative, in partnership with the not-for-profit Prevent Child Abuse New York, the Center for Human Services Research at SUNY Albany and DOH.

<sup>9</sup> Since 2011, OCFS, in collaboration with DOH, has successfully applied for and received the federal Maternal, Infant and Early Childhood Home Visiting Program grant. In 2011, this grant enabled OCFS to expand Healthy Families New York in three programs in the Bronx and one program in Erie County. In 2013, the federal grant funds were awarded to expand another program in Brooklyn, and in 2015 additional grant funds were awarded to expand four of the 36 existing programs and to establish a new program in Brooklyn.

New York mothers also reported engaging in 80 percent fewer acts of serious physical abuse than mothers in the evaluation control group.

OCFS, in collaboration with the Center for Human Services Research at State University of New York (SUNY) Albany, has embarked on a 15-year follow up with the participating mothers and expects to provide findings in 2019.

### **Unsafe Sleep Conditions**

In approximately half of the fatalities for infants under the age of one, OCFS noted at least one unsafe sleep risk factor. Recognizing the significance of unsafe sleep risk factors in child fatalities, OCFS has invested significant resources to prevent unsafe sleep-related fatalities.

- Since 2012, OCFS has partnered with “Cribs-for-Kids” to purchase and distribute approximately 3,000 safety-approved portable cribs to families through local departments of social services, day care centers and community-based organizations in high need communities. OCFS will distribute an additional 1,700 free cribs in 2016 to prevent future unsafe sleep-related fatalities.
- OCFS produces an array of outreach materials including Safe Sleep videos, posters and memo boards, available in both English and Spanish, which may be ordered or downloaded for free through the OCFS website. This work is funded through the William B. Hoyt Memorial Children and Family Trust Fund<sup>10</sup> –launched in 1984 to combat family violence.<sup>11</sup>
- On an ongoing basis and throughout the time period covered in this report, OCFS provides local departments of social services with policy directives and guidance documents to promote unsafe sleep prevention efforts, to enhance safe-sleep conditions and to improve consistency in Child Protective Service sleep-related investigations.

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<sup>10</sup> The Trust Fund was launched in 1984 under the leadership of Assemblyman William B. Hoyt, who partnered with Prevent Child Abuse New York and other key stakeholders to combat family violence. The legislation was established through the passage of the New York State Social Services Law, Article 10-A, Section 481-e. The Trust Fund was renamed in Assemblyman Hoyt’s memory upon his death in 1992.

<sup>11</sup> <http://ocfs.ny.gov/main/cps/tips.asp>

- In November 2010, OCFS disseminated “Guidance for CPS Investigations of Infant Fatalities and Injuries Involving Unsafe Sleeping Conditions.” This guidance assisted Child Protective Service regarding factors to consider when investigating a report of a death that may have been related to unsafe sleep conditions.<sup>12</sup>
- In January 2013, OCFS issued “Investigation and Determination of Sleep-Related Fatality and Injury CPS Reports.” This guidance provides information for Child Protective Service caseworkers to use throughout the investigation and substantiation of reports of safe sleep related fatalities and injuries.<sup>13</sup>
- In February 2013, OCFS issued “Safe Sleeping of Children in Child Welfare Cases.” This release includes information to assist caseworkers in educating parents, guardians and foster parents about preventing sleep-related risks to children.<sup>14</sup>

### **NYS Sudden Infant and Child Death Resource Center (NYS Center for SID)**

In 2010, the New York State Department of Health (DOH) awarded funds to the SUNY Research Foundation and the School of Social Welfare at Stony Brook University to create and operate the NYS Center for SID. OCFS works with DOH and Stony Brook University to develop and provide training, resource information and community prevention initiatives regarding Sudden Infant Death Syndrome to local OCFS-funded Child Fatality Review Teams and other community organizations.

### **Shaken Baby Syndrome Prevention**

In 1988, OCFS began supporting what was then called the New York State Shaken Baby Prevention Project, in several counties in the western region of the state. After documenting a 50 percent decrease in abusive head trauma, the

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<sup>12</sup> LCM 10-OCFS-LCM-15. An OCFS Local Commissioners Memorandum (LCM) is an external policy release that transmits information to the local social service districts' commissioners on specific topics.

<sup>13</sup> (LCM) 13-OCFS-LCM-01.

<sup>14</sup> (ADM) 13-OCFS-ADM-02. An Administrative Directive (ADM) is an OCFS external policy release designed to advise local social services districts and voluntary agencies, as necessary, of policy and procedural requirements which must be followed and which mandates specific action.

project was expanded and now covers all of New York State. OCFS supports the New York State Shaken Baby Prevention hospital-based education program, in collaboration with DOH, to educate parents of newborns about the dangers of shaking.

Additional research in 2011 documented a 75 percent reduction in abusive head trauma after expansion of the program into the Hudson Valley region. In 2012, the program reached over 157,000 families statewide, or more than 87 percent of all live births.

In 2013, in addition to educational videos, OCFS and DOH generated *A Guide for Parents*, which delivers both “safe sleep” and “never shake a baby” messages, for distribution in hospitals statewide. In 2014, OCFS and DOH released another video: *Never, Ever Shake a Baby* which is currently being distributed to maternity hospitals statewide.

## V. FOCUS AREAS AND PLANNED ACTION

OCFS has worked, and will continue to work, to create and implement initiatives that directly address the most common risk factors associated with the child fatality cases it is mandated to review. OCFS continues to analyze its data to enhance its current programs and develop additional initiatives to further prevent child fatalities in New York State. Moving forward, OCFS will focus on the following three areas:

- **Data Analysis** – With the recent launch of its Child Fatality Review and Prevention database, OCFS has increased access to meaningful and precise data. OCFS will continue to delve deeper into county-specific data to identify additional risk factors and trends and target more precise interventions.
- **Child Fatality Review Teams** – Currently, Review Teams conduct reviews of child fatality cases to assess the underlying risk factors that may have contributed to the child’s death and develop prevention initiatives targeted to their communities. Going forward, Review Teams will continue this work and collaborate statewide to inform OCFS’s broader statewide prevention efforts.
- **Safe Sleep Initiative**– In July 2014, OCFS joined the DOH-led Infant Mortality Reduction Collaborative Improvement and Innovation Network, an initiative that involves public and private partnerships working toward a shared goal of reducing child deaths. Thirty-seven states are involved in this national initiative.

As part of this initiative, New York State is working to improve safe sleep practices and decrease sleep-related mortality rates. OCFS plans to disseminate additional portable cribs and outreach materials, and to evaluate the impact on their recipients.