NEW YORK STATE | Office of Children and Family Services

New York State Child Fatality Report 2016

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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 suspected 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[1]. Specifically, OCFS examines deaths that: 1) are reported to the Statewide Central Register of Child Abuse and Maltreatment (SCR); 2) occur while a child is in foster care, with the exception of foster children placed in facilities subject to the jurisdiction of the Justice Center for the Protection of People with Special Needs; or 3) occur while a child is involved in an open child protective or preventive services case.

For each of these fatalities, OCFS issues a report[2]. 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 2016 (and includes 2014 and 2015 data for comparison purposes). In recent years, as part of its fight against child abuse and maltreatment, New York State has taken several steps to expand the categories of people required to report abuse and maltreatment and to educate those reporters about the signs and sometime subtle indicators of risk. As a result, more New Yorkers are required by law to call the SCR when they suspect child abuse or maltreatment. And more mandated reporters than ever before have received specialized OCFS training to carry out their responsibilities and report cases to the SCR. All of these measures have enhanced the state's ability to identify

1 SSL section 20(5)

2 A child fatality report prepared by an OCFS approved local or regional child fatality review team in accordance with SSL section 422-b may take the place of an OCFS report.

potential cases of child abuse and maltreatment, including cases that might previously have gone undetected.

The data show that, upon investigation, many cases are not substantiated as having been caused by abuse or maltreatment. In fact, the percentage of substantiated cases as compared to those reported to the SCR consistently remains under 50%.

Fatalities Substantiated After Investigation
2014 – 2016

	2014	2015	2016
Fatalities Reported to SCR for Investigation	221	251	246[3]
Substantiated for the Allegation of DOA (fatality due to child abuse or maltreatment)	96	86	94
Percentage of Reports Substantiated for DOA	43%	34%	38%

By spearheading targeted initiatives specifically geared toward reducing infant fatalities, funding nationally recognized Child Fatality Review Teams and creating a dedicated team to oversee the child fatality investigation and prepare the individual child fatality reports, 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 child fatalities both nationally and in New York State. OCFS extensively analyzes these cases to pinpoint the greatest areas of risk and to guide prevention strategies at the state and local level. Unsafe sleep is a leading factor in infant fatalities reviewed by OCFS. Because many sleep-related fatalities are preventable, OCFS has been working closely with the New York State Department of Health (DOH) toward educating the public about reducing the related risks. As this report shows, in 2016 there was a substantial decrease in

fatalities involving an unsafe sleep environment, which may be attributed to these prevention efforts.

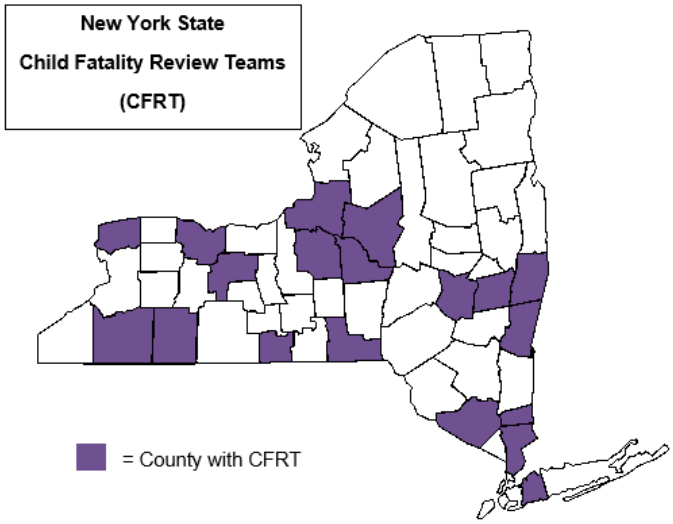
[3]. Prior to 2016, deaths that occurred in prior years but were reported in a subsequent year were included in the year in which they were reported. Although the numbers were not statistically significant, this makes year-to-year comparisons difficult. For this reason, beginning in 2016, data will be included only for children whose deaths occur in that calendar year.

Healthy Families New York is an OCFS-led, evidence-based home visitation program that supports expectant mothers and families in 43 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 or enters Head Start. 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 2015 and again in 2016, OCFS partnered with DOH and disseminated safe sleep kits to parents of newborns in hospitals. The kits include a tote bag, door hanger, baby book, magnets, window clings, a DVD with information about safe sleep, and a baby sleep sack. OCFS evaluated the effect of the kits on safe sleep practices and found that the materials were useful in increasing maternity nurses' ability to improve parental knowledge and safe sleep practices.

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 2016, these teams led to the creation of county-level initiatives targeting safe sleep, choking prevention, fire prevention, water safety, teen driving safety, car safety, suicide prevention, internet safety and traumatic head injury prevention, among others.



Centralized Child Fatality Report Team

In 2016, OCFS created a dedicated and centralized team to assume the oversight and reporting responsibilities for child fatalities occurring outside of New York City (The New York City regional office maintains responsibility for oversight of the

investigations conducted by the Administration for Children and Families). Child fatality investigations are analyzed by a team of reviewers in the OCFS home office, which has improved the capacity of OCFS to consistently identify practice issues, trends and emerging service needs. It is anticipated that as a result of this approach, there will be an improvement in practice and outcomes for families.

II. OVERVIEW

The Role of OCFS

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.[4] Each local department of social services must establish a Child Protective Service to investigate child abuse and maltreatment reports; to protect children from further abuse or maltreatment; and to provide rehabilitative services to children, parents and other family members involved[5].

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) of Child Abuse and Maltreatment

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, every day to allow New York State to respond immediately to allegations of

[4] In New York City, services are not delivered by county governments. Rather, the New York City Administration for Children's Services (ACS) provides child welfare services to all five boroughs.
[5] SSL Section 434

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 (SSL) section 20(5) charges OCFS with reviewing certain categories of child fatalities.[6] 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, exclusive of children residing in facilities subject to the jurisdiction of the Justice Center for People with Special Needs;[7] and

- deaths that occur while a child is in 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 and decides to close the case. A preventive services case may remain 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 applicable local department of social services to investigate the allegations.

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[6] In this report, the term "child fatalities" refers only to the types of deaths that the statute authorizes OCFS to review.

[7] 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.

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 where there is not reasonable cause to suspect the death was due to abuse or maltreatment, a call to the SCR is not required. Instead, the local department of social services or the community agency providing care to the child notifies the applicable OCFS regional office directly. The regional office will transfer this information to the home office team, for fatalities outside of New York City, to launch the fatality reporting 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 Regional Office notification – triggers an investigation into the child's death and all surrounding circumstances. The investigation of a death reported to the SCR is conducted by the local department of social services. 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; and what actions or inactions by the parents or caretakers contributed to the death. 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. When a notification is made about a fatality in an open CPS, foster care or preventive services case, essential practices include investigation into the circumstances and facts about the death, safety assessments of children in the home, and assessment of service needs for the family or caretakers in light of the death.

III. CHILD FATALITY REPORTING

The Social Services Law

OCFS prepares and issues a report on each fatality it reviews, as mandated by SSL section 20(5)(b). The OCFS report evaluates all aspects of the local department's investigation, including, but not limited to, its determination and handling of all aspects of the case prior and subsequent to the fatality. If OCFS finds statutory or regulatory 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. SSL 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 2014-2016

This report presents and examines child fatality data for 2014 to 2016 and includes an analysis of the data compiled during this period. Notably, two overall conclusions can be drawn from the data:

- The number of individuals receiving mandated reporter training increased significantly from 2015 to 2016.
- The number of fatalities reviewed involving an unsafe sleep decreased significantly from 2015 to 2016.

Child Fatalities Reviewed by OCFS
2014 – 2016

	2014	2015	2016
Total child fatalities reviewed by OCFS	283	299	290
Total child fatalities reviewed by OCFS that were reported through the SCR	221	251	246
Percentage of child fatalities reviewed by OCFS that were reported to the SCR	78%	84%	85%

Chart 1

Chart 1 depicts fatalities reported to the SCR as compared to the total number of fatalities reviewed by OCFS. The fatalities reported to the SCR are those in which the reporter alleges parental or caregiver abuse or maltreatment. OCFS has taken several affirmative steps to encourage comprehensive reporting of child abuse and maltreatment cases, described below.

Affirmative Steps Promoting Increased SCR Reporting

- **New York State delivered online training to more than 90,000 individuals in 2016 alone; an 18 percent increase from 2015.**
    - 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 and standardize this training, OCFS developed a specialized online training course in 2008 for all mandated reporters. This free online program emphasizes the duty to report suspicions of child abuse or maltreatment; educates mandated reporters about the signs and sometimes subtle indicators of abuse or maltreatment; and encourages them to convey vital information that can alert SCR intake staff to issues, including unsafe sleep conditions and traumatic head injury.
    - 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 90,291 in 2016, representing the greatest year to year increase since 2008. 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.

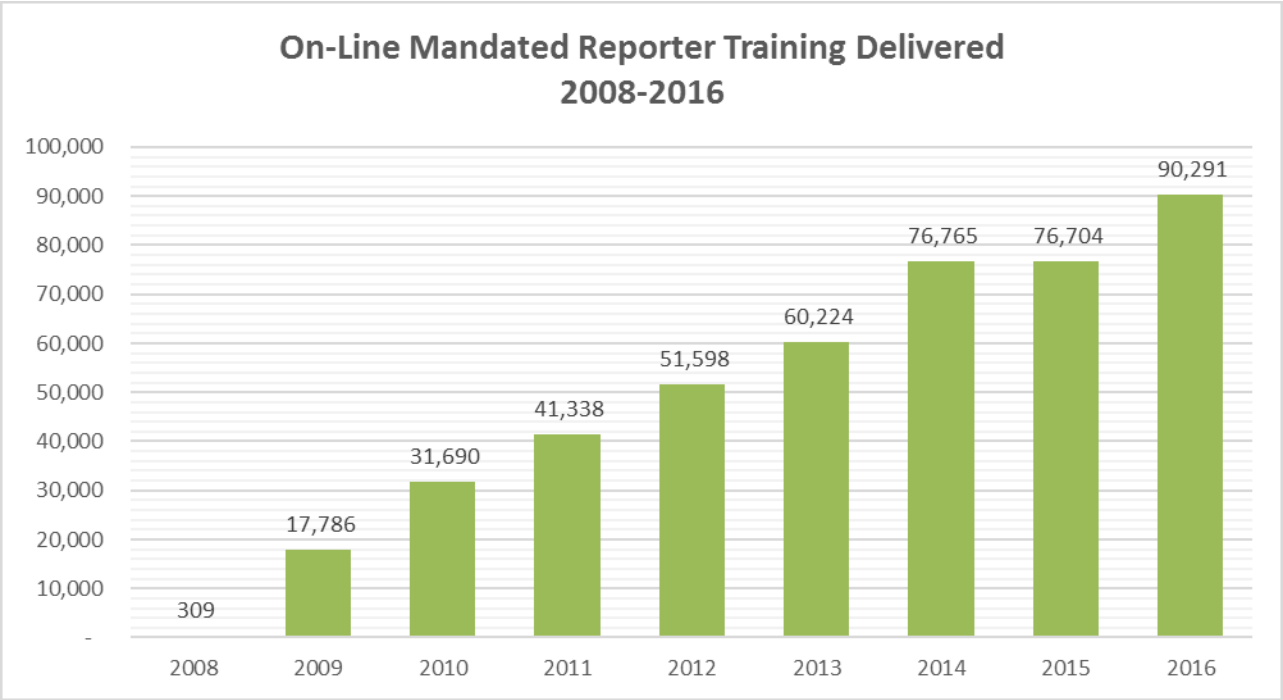


Chart 2

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 children's overnight camp, traveling summer day camp and summer day camp directors to the list of mandated reporters, as these professionals are well positioned to protect children in their care. In 2014, New York State added licensed behavior analysts and certified behavior analyst assistants to the list of mandated reporters. In addition, in 2015, New York State added full-time and part-time compensated school employees who hold a temporary coaching license or a professional coaching certificate.

- **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 educating the families with whom they work. The number of child fatalities reviewed involving unsafe sleep environments decreased from 2015 to 2016. Section IV of this report provides further information about OCFS's leadership role in this area.

SCR Reported Fatalities

Fatalities Substantiated After Investigation
2014 – 2016

	2014	2015	2016
Fatalities Reported to SCR for Investigation	221	251	246
Substantiated for the allegation of DOA (fatality due to child abuse or maltreatment)	96	86	94
Percentage of reports substantiated for DOA	43%	34%	38%

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) on the basis of some credible evidence less than half of the time. The percentage of fatality reports substantiated as having been caused by abuse or maltreatment between 2014 and 2016 continues to remain below 50 percent and decreased from 2014 to 2016. This decrease may be attributable to the increased awareness and reporting regarding unsafe sleep fatalities which do not always result in evidence to confirm abuse or maltreatment.

Fatality Reviews by Age

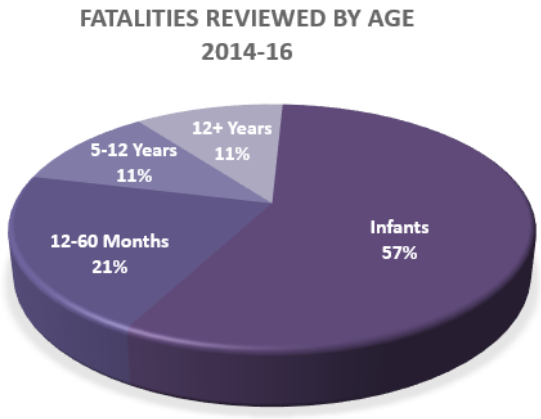


Chart 4

Between 2014 and 2016, 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 collects extensive data on these deaths to pinpoint the greatest areas of risk and to guide prevention strategies. The data reveals that the percentage of child fatalities involving unsafe sleep environments decreased by 18.6 percent from 2014 to 2016 (Chart 5). OCFS will continue to analyze the data to determine if this trend continues.

Child Fatalities Involving Unsafe Sleep Environments
2014 – 2016

	2014	2015	2016
Fatalities Reviewed for Children Under 12 Months of Age (Infants)	152	188	154
Total Identified Unsafe Sleep Environments	75	85	61
Unsafe Sleep Percent of All Infant Fatalities	49%	45%	39%

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 or other surface (co-sleeping) and those in which the child is sleeping anywhere with soft bedding or items that could obstruct the child's air flow. 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. As the chart above shows, there has been a 1.3 percent increase in the number of fatalities reviewed for children under 12 months of age and an 18.6 percent decrease in the number of fatalities reviewed for this population involving an unsafe sleep environment from 2014 to 2016. While direct causation cannot be proven, this decrease may be attributed to the extensive prevention strategies employed by OCFS and DOH.

Chart 6 further examines the various sleep environments. 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 with one or more other adults or children.

2014 – 2016		
If the child died in an unsafe sleeping environment, what was the location?	Count: (Children < One Year)	Percent of Total
Adult Bed	138	62%
Couch	8	4%
Crib	7	3%
Other	3	1%
Bassinet	3	1%
Air Mattress	23	10%
Car seat/Stroller	17	8%
Floor	3	1%
Unknown	15	7%
Chair	1	0%
Playpen	2	1%
Waterbed	1	0%
Total:	221	100%

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 Centers for Disease Control and Prevention to coroners/medical examiners and used in New York State for categorizing manner of death:

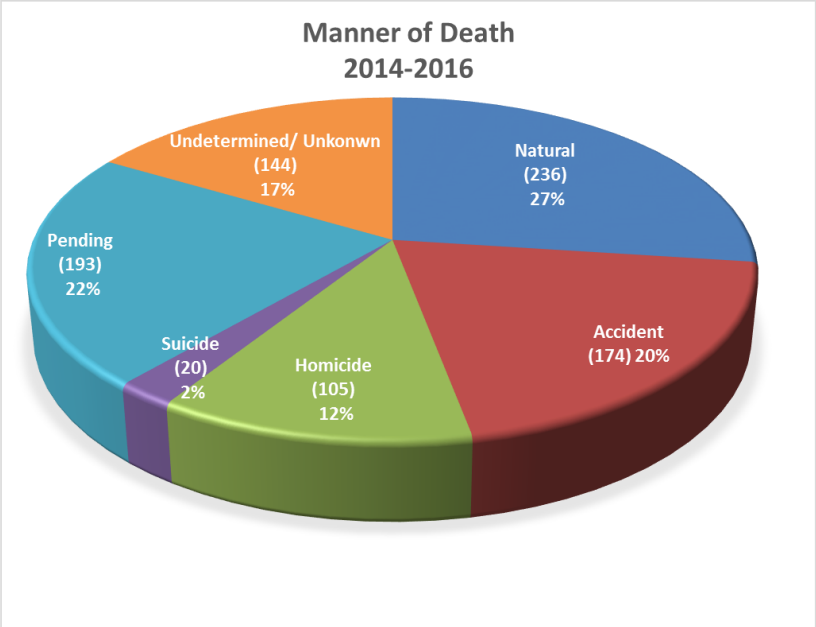
Medical Examiner Categories for Manner of Death

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. The cause of death noted is based on the coding at the time of the issuance of the fatality report.



Manner of Death	2014	2015	2016
NATURAL	85	77	74
ACCIDENT	49	61	64
HOMICIDE	37	36	32
SUICIDE	7	6	7
PENDING	53	64	76
UNDETERMINED/UNKNOWN	52	55	37
TOTAL	283	299	290

Chart 8

As Chart 8 shows, the number of OCFS-reviewed fatalities classified by medical examiners or coroners as undetermined/unknown and pending continues to be a significant number of the total deaths. 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. While the number of cases that fit into this category appears to be decreasing, conclusions cannot be drawn from the data due to the number of pending cases. In an effort to improve the

identification of the manner of death, CFRTs include medical examiners. These examiners are invited to the CFRT annual convening described later in this report.

Fatality Reviews by Geographic Distribution

Chart 9 lists the 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.

	2014	2015	2016
Total Verified Deaths	**283**	**299**	**290**
Albany	8	6	4
Allegany	0	2	1
Broome	6	7	7
Cattaraugus	1	1	0
Cayuga	3	0	3
Chautauqua	1	3	4
Chemung	4	6	3
Chenango	0	1	1
Clinton	0	5	0
Columbia	0	2	1
Cortland	0	1	1
Delaware	1	2	0
Dutchess	1	4	3
Erie	24	25	18
Essex	0	0	0
Franklin	2	2	0
Fulton	2	1	2
Genesee	0	1	2
Greene	1	0	2
Hamilton	0	0	0
Herkimer	1	2	0
Jefferson	4	5	4
Lewis	0	0	2
Livingston	0	0	1
Madison	1	2	1
Monroe	9	26	14
Montgomery	1	0	3
Nassau	2	5	4
Niagara	4	6	4
Oneida	5	6	7
Onondaga	11	11	17
Ontario	3	1	2
Orange	4	3	9
Orleans	0	0	1
Oswego	4	3	3
Otsego	0	0	0
Putnam	1	0	0
Rensselaer	7	3	4
Rockland	3	3	2
St. Lawrence	2	3	1

Saratoga	1	0	1
Schenectady	7	7	3
Schoharie	0	1	0
Schuyler	0	0	0
Seneca	0	1	1
Steuben	3	1	0
Suffolk	12	18	10
Sullivan	0	2	3
Tioga	0	0	0
Tompkins	0	1	1
Ulster	1	0	3
Warren	0	0	1
Washington	1	1	1
Wayne	3	3	2
Westchester	6	11	13
Wyoming	1	2	0
Yates	0	0	1
St. Regis	2	0	0
Bronx	38	33	35
Kings	40	23	30
New York	16	16	24
Queens	30	22	21
Richmond	4	6	8
OSI[8]	2	2	1
OTHER[9]	0	1	0
NYC	130	102	119
Statewide	**283**	**299**	**290**

Chart 9

In 2016, 15 counties had no fatalities reviewed by OCFS; an additional 22 had only one or two investigations. Outside of New York City, the greatest increase was in Onondaga County which had 11 fatalities in 2015 and 17 in 2016. In 2016, two sets of siblings died in fires and one set of twins died due to medical complications in Onondaga county. Erie, Monroe and Suffolk each show significant decreases in fatalities from 2015 to 2016. In New York City, fatalities reviewed by OCFS from all five boroughs increased by 17. New York City experienced a number of high profile fatalities in 2016 which often results in a surge of reporting.

Some of the remaining counties experienced fluctuations from 2014 to 2016 in the number of local cases that OCFS reviewed. Like Onondaga and New York City, each county is subject to a unique set of local circumstances, which can make data analysis difficult. These situations can cause unpredictable spikes in a county's numbers. Thus, a close examination of all circumstances is essential to a complete understanding of annual child fatality data.

[8] 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.

[9] This fatality occurred in a foster care residential facility with the jurisdiction of NYCRO

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 a centralized team to oversee child fatality reviews outside of New York City and to write individual child fatality reports;
- continues to support and expand the use of local and regional 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.

Centralized Child Fatality Report Team

Effective November 1, 2016, OCFS created a dedicated team of home office staff to review fatality investigations and write the fatality reports for counties exclusive of the City of New York. By centralizing this function, OCFS has increased its capacity to improve the consistency and timeliness of reports. For fatalities reported to the SCR, a team member reaches out to the local department of social services within the first day of receiving the SCR notification and again at 15 and 30 days to review progress, offer feedback, provide guidance and respond to requests for assistance regarding the fatality investigation. By providing regulatory and practice guidance throughout the process, it is expected that local practice and outcomes for families will improve. OCFS has received very positive feedback on this new process from a number of local district social services offices.

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 maltreatment fatalities, as well as other preventable deaths. OCFS provides funding to 18 Child Fatality Review Teams throughout New York State. Each 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, law enforcement agencies, district attorneys' offices, medical examiners/coroners, first responders, and other community stakeholders.
In 2016, OCFS convened a two-day summit for members of Child Fatality Review Teams to share information and collaborate on new practice and prevention strategies to reduce child fatalities. A focus of the 2016 convening was on "Investigations of Infant Death and Infant Safe Sleep."

Child Fatality Review Team Prevention Initiatives

Throughout 2016, Child Fatality Review Teams (CFRT) created and implemented a variety of prevention initiatives in their local counties. The following are some examples of successful initiatives:

Safe Sleep – Many of the teams focused on safe sleep outreach and education in 2016. In Nassau County, "Safe Sleep Zones" were created in two birthing hospitals, displaying full-size cribs and educational information.

When an infant dies in Onondaga County, the team sends to the child's pediatrician a condolence letter that also contains data about unsafe sleep fatalities and safe sleep information for the doctor to share with the patients. The team also contacts retailers and media sources when unsafe sleep images are used, and requests that they be removed.

In Chemung County, safe sleep materials are distributed to local pediatricians, OB/GYNs and midwives. Safe sleep materials are included in the mailing of every birth certificate.

The Albany County CFRT maintains a safe sleep campaign using advertisements on buses and bus shelters. Niagara County has a digital marketing campaign and Broome County held a "Safe Sleep for Babies" fundraiser and education day at the local mall to coincide with Child Abuse Prevention Month.

Additional Awareness Campaigns

- The Oneida County CFRT collaborates with the Oneida County Healthy Neighborhoods Program which provides free home health and safety inspections. The CFRT purchased 50 fire extinguishers to be distributed through this program.
- The Putnam County CFRT partners with the Suicide Prevention Center of New York to develop a strategic plan and create a team to respond to the community and surviving family following a suicide or child death
- The Southern Tier CFRT partnered with the American Red Cross during fire safety month with their Home Fire Campaign, providing home fire safety assessments and free smoke alarms.

- The Rensselaer County CFRT coordinators met with National Grid about continued training for workers to identify and report child abuse and maltreatment.
- The Westchester County CFRT is working with community providers to explore the intersection of domestic violence and custody disputes on child safety.

OCFS Statewide Initiatives

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

Of the child fatalities that OCFS reviewed from 2014 to 2016, 57 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. Two such programs are described below.

Healthy Families New York

Healthy Families New York is an OCFS-led home visiting program[10] that focuses on the safety of children by supporting high need families in high-risk communities. Healthy Families New York currently operates 38 programs throughout the state.[11] The program provides information, referrals, assessments and connections to needed services to expectant parents and new families, beginning weekly and decreasing over time, until the child starts school or enters Head Start.

Healthy Families New York has been rigorously evaluated over a seven-year period to determine the effectiveness of the program in preventing child maltreatment, success in school, positive parenting and improved birth outcomes. 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.

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[10] 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.

[11] 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.

Healthy Families New York mothers reported engaging in 80 percent fewer acts of "serious physical abuse[12]" when the target child was seven years old, then 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.

Safe Sleep Education

In 2016, OCFS partnered with two Child Fatality Review Teams and four maternity hospitals in western New York to improve safe sleep education of parents of newborns. The strategy included using safe sleep kits focusing on the ABC's of safe sleep to encourage thoughtful conversations between nurses and parents about evidence-based advice from the American Academy of Pediatrics (AAP) on how to prevent tragedies of accidental suffocation and reduce the risk of SIDS. Approximately 1,000 safe sleep kits were distributed to parents during the seven-month study period (August 2016-February 2017).

The effects of the ABCs of Safe Sleep educational approach on safe sleep practices at home include some positive findings, as well as areas needing improvement or more refinement. For example:

- A= Alone: No stuffed animals, toys, other children or pets were reported to be in any baby's sleep environment in the two weeks prior to the survey. Very few parents reported using pillows (4%) or crib bumpers (3%). The use of baby blankets was still a challenge as 39% used a blanket in the crib.
- B= Back: 86% of parents reported that they "always" laid their baby on his/her back to sleep.
- C= Crib: 81% of parents reported that baby usually slept in an AAP-approved sleep surface, such as a crib or bassinet. The Rock 'N Play (14%) and parent's bed (3%) were the most frequently reported sleep surfaces that were not approved by the AAP.

One of the most useful findings for further safe sleep education efforts was that the usual place to sleep is not the only place that babies are put to sleep. For example, 29 percent of babies were moved from their crib/bassinet to the parent's bed to sleep at least once during the two weeks prior to the survey. The effect of more nuanced conversation between parents and nurses was evident in the increase in the percentage who reported they never

[12] "Serious physical abuse" as defined by the "Conflicts Tactics Scale". Straus, M.A., Hamby, S.L., Finkelhor, D., Moore, D.W. & Runyan, D. (1998). Identification of child maltreatment with Parent-Child Conflict Tactics Scales. Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect*, *22,* 249-270.

moved the infant to the parents' bed: from 66 percent in the early months of the study to 81 percent in the last few months of the study.
In addition to increasing the maternity nurses' abilities to improve parental knowledge and safe sleep practices, the safe sleep kits project helped increase the hospitals' and CFRT's commitment to practicing and modeling safe sleep. Institutional changes that occurred during the study included hospitals replacing traditional blankets with Sleepsack Swaddle wearable blankets in the hospital nursery and gift shops, qualifying for National Safe Sleep Hospital Certification, and becoming "Cribs for Kids Community Partners" to distribute low-cost portable cribs while providing one-on-one safe sleep education in their local communities. Pre-natal childbirth orientation classes at some of the hospitals also included showing the OCFS safe sleep video.

Recommendations after the study include:

- explicitly warning parents that couches and reclining chairs are extremely high-risk places for infants;
- sleeping on the stomach is risky even on a safe surface;
- addressing misperceptions about the likelihood of choking if a baby is placed face-up by showing parents anatomical drawings of baby's air and food tubes;
- providing tips on how to encourage better sleep for fussy babies, and discussing ahead of time safe sleep strategies for when parents are exhausted, traveling, and other situations; and
- developing culturally appropriate education efforts including other family members, and caregivers such as grandparents, who have significant influence on whether new parents follow the safe sleep recommendations.

In 2016, OCFS continued the safe sleep initiative to distribute "Pack-n-Play" cribs to families in need. OCFS partnered with local departments of social services and community based organizations to distribute these cribs to families that had no other means of keeping their infants in a safe sleeping environment. Along with the cribs, educational materials were provided to families. Over the last three years, OCFS has distributed more than 5,000 cribs to families in need.

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.

- 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.[13]

- 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.[14]

- 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.[15]

V. FOCUS AREAS AND PLANNED ACTION

OCFS will continue 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. OCFS will focus on the following three areas:

- **Data Analysis and Practice Improvement** – With the newly formed Child Fatality Report Team, OCFS will be better positioned to analyze and address practice issues and trends. OCFS continues to design data reports to support analysis and practice improvement. OCFS will continue to use this data to identify risk factors and practice trends and target more precise interventions.

- **Child Fatality Review Teams** – Currently, local and regional Child Fatality 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. Child Fatality Review Teams will continue this work and collaborate statewide to inform OCFS's broader statewide prevention efforts

[13] 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.

[14] (LCM) 13-OCFS-LCM-01

[15] (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.

- **Safe Sleep Initiative** – OCFS will evaluate the recommendations from the Safe Sleep Pilot outreach and education materials on sleep practices and will pursue broader dissemination of those items that are demonstrated to be effective. OCFS will continue to collaborate with DOH on safe sleep prevention strategies based on lessons learned and evaluation results.