NEW YORK STATE | Office of Children and Family Services

New York State Child Fatality Report 2015

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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 2015 (and includes 2013 and 2014 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 than ever before are required by law to call the SCR when they suspect child abuse or maltreatment.

[1] SSL section 20(5)

[2] A child fatality report prepared by a child fatality review team may take the place of an OCFS report.

And more mandated reporters 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, from 2014 to 2015, there was a 14% increase in the number of fatalities reported to the SCR.

The data shows that, upon investigation, many cases are not substantiated as having been caused by abuse or maltreatment. The percentage of substantiated cases steadily decreased from 2013 to 2015.

Fatalities Substantiated After Investigation
2013 – 2015

	2013	2014	2015
Fatalities Reported to SCR for Investigation	231	221	251
Substantiated for the Allegation of DOA (fatality due to child abuse or maltreatment)	111	96	86
Percentage of Reports Substantiated for DOA	48%	43%	34%

OCFS and its local partners engaged in many prevention and education initiatives in 2015, 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 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. 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 2015, OCFS partnered with the New York State Department of Health (DOH) and disseminated safe sleep kits to parents of newborns in hospitals. The kits include a tote bag, door hanger, baby book and a DVD with information about safe sleep, as well as a baby sleep sack. OCFS will be evaluating the impact of this education and outreach campaign on 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 2015, these Review Teams led to the creation of county-level initiatives targeting safe sleep, choking prevention, water safety, teen driving safety, car safety, suicide prevention, internet safety 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, OCFS requires all Child Fatality Review Teams to enter data on all deaths they review into the national data collection system (National Center for Child Death Review and Prevention). In 2010, OCFS invested significant resources to develop the New York 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 national, 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

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.[3] 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 rehabilitative services to children, parents and other family members involved[4].

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

[3] 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.

[4] SSL Section 434

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 (SSL) section 20(5) charges OCFS with reviewing certain categories of child fatalities.[5] 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;[6] or

- 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 and decides to close the

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

[6] 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.

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.

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 applicable OCFS Regional Office directly, which will 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 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, 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. When a notification is made about a fatality in an open CPS, foster care or preventative 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 2013-2015

This report presents and examines child fatality data for 2013 to 2015 and includes a detailed analysis of the data compiled during this period. Notably, two overall conclusions can be drawn from the data:

- The number of total child fatalities reviewed by OCFS annually increased by 9 percent between 2013 and 2015, a fact attributable to more robust reporting initiatives. [*See* Chart 1]
- The number of fatalities substantiated (or confirmed) as having been caused by abuse or maltreatment decreased steadily from 2013 to 2015 for a total decrease of 25 cases. [*See* Chart 3]. (The decrease may be attributable to the increased awareness and reporting regarding unsafe sleep fatalities which do not always result in sufficient evidence to confirm abuse or maltreatment.)

Child Fatalities Reviewed by OCFS
2013 – 2015

	2013	2014	2015
Total child fatalities reviewed by OCFS	276*	283*	299
Total child fatalities reviewed by OCFS that were reported through the SCR	231	221	251
Percentage of child fatalities reviewed by OCFS that were reported to the SCR	84%	78%	84%

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. This data indicates that notifications made to OCFS through the SCR and accepted for review increased from 2013 to 2015. This increase coincided with several affirmative steps taken by New York State to encourage more comprehensive reporting of child abuse and maltreatment cases, described below.

*This data has been updated since reported in the 2010-2014 Child Fatality Report.

Affirmative Steps Promoting Increased SCR Reporting

- **New York State delivered online training to nearly 77,000 individuals in 2015 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 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 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 76,704 in 2015. 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.

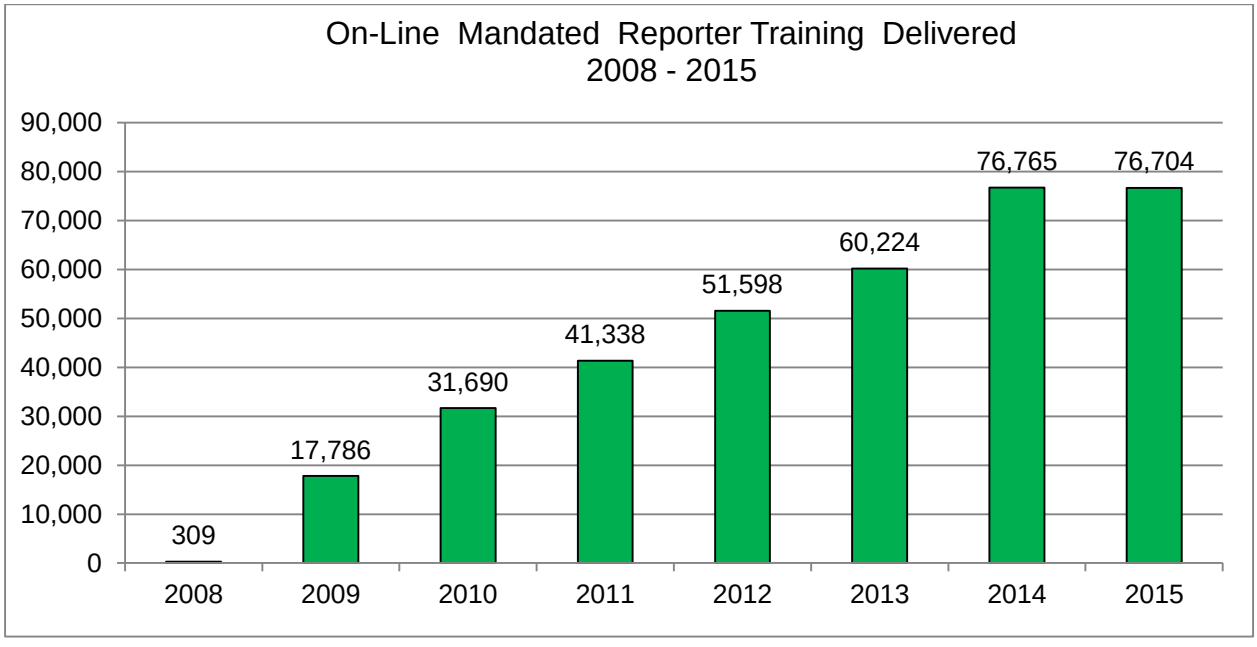


Chart 2

- **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 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. Section IV of this report provides further information about OCFS's leadership role in this area.

SCR Reported Fatalities

Fatalities Substantiated After Investigation
2013 – 2015

	2013	2014	2015
Fatalities Reported to SCR for Investigation	231	221	251
Substantiated for the allegation of DOA (fatality due to child abuse or maltreatment)	111	96	86
Percentage of reports substantiated for DOA	48%	43%	34%

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 number of reports substantiated as having been caused by abuse or maltreatment between 2013 and 2015 decreases by 14 percent (or 25 cases). This decrease may be attributable to the increased awareness and reporting regarding unsafe sleep fatalities which do not always result in sufficient evidence to confirm abuse or maltreatment

Fatality Reviews by Age

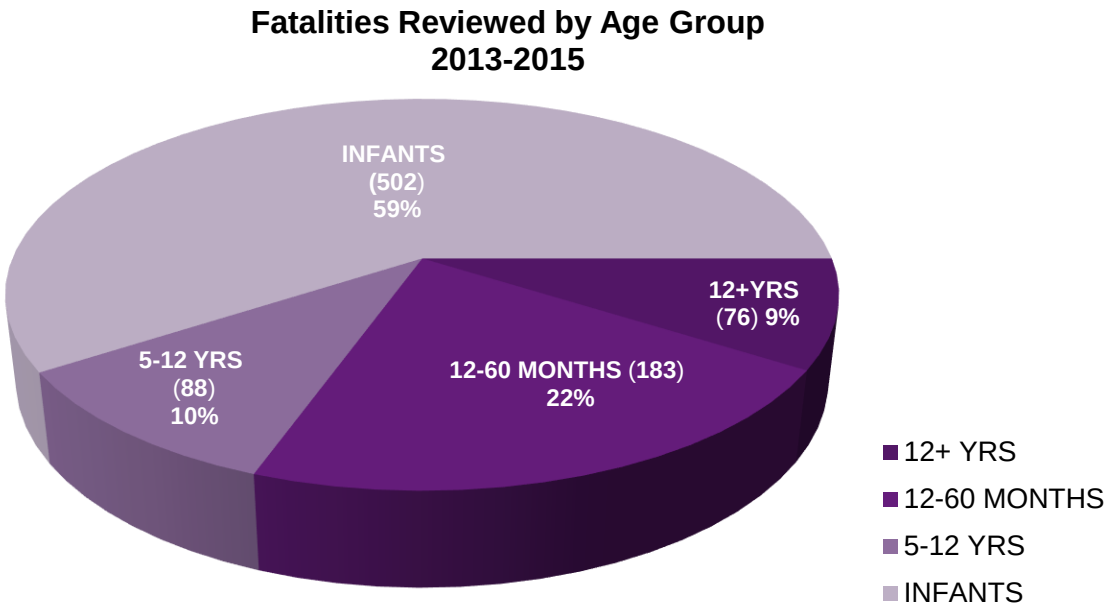


Chart 4

Between 2013 and 2015, 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
2013 – 2015

	2013	2014	2015
Fatalities Reviewed for Children Under 12 Months of Age (Infants)	162	152	188
Total Identified Unsafe Sleep Environments	81	75	85
Unsafe Sleep Percent of All Infant Fatalities	50%	49%	45%

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 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.

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.

2013 – 2015		
If the child died in an unsafe sleeping environment, what was the location?	Count: (Children < One Year)	Percent of Total
Adult Bed	151	62%
Couch	26	11%
Crib	20	8%
Other	15	6%
Bassinet	7	3%
Air Mattress	7	3%
Car seat/Stroller	5	2%
Floor	4	1%
Unknown	3	1%
Chair	1	1%
Playpen	1	1%
Waterbed	1	1%
Total:	241	100%

Chart 6

Fatality Reviews by Manner of Death

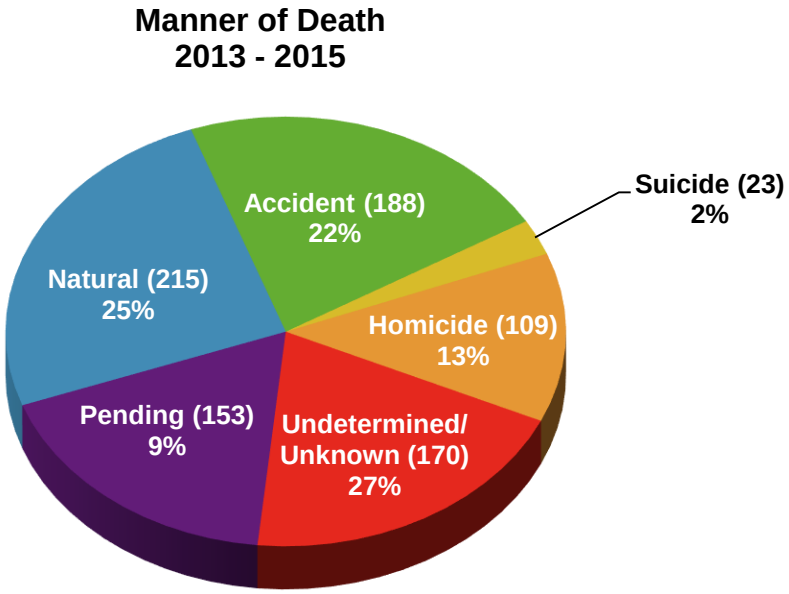
In compiling its data, OCFS accepts the manner of death certified by the medical examiner or coroner responsible for each child's death certificate. Below are the guidelines provided by the National Center for Disease Control to coroners/medical examiners and used in New York State for categorizing manner 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	2013	2014	2015
NATURAL	53	85	77
ACCIDENT	78	49	61
HOMICIDE	36	37	36
SUICIDE	10	7	6
PENDING	36	53	64
UNDETERMINED/UNKNOWN	63	52	55
TOTAL	276	284	299

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.

Due to the number of pending and undetermined/unknown manners of death, conclusions cannot be drawn from the data. In an effort to improve the identification of the manner of death, OCFS included Medical Examiners in the Child Fatality Review Team convening described later in this report.

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.

Child Fatalities Reviewed by OCFS 2013-2015			
	2013	2014	2015
Total Verified Deaths	**276**	**283**	**299**
Albany	6	8	6
Allegany	0	0	2
Broome	3	6	7
Cattaraugus	0	1	1
Cayuga	2	3	0
Chautauqua	2	1	3
Chemung	1	4	6
Chenango	2	0	1
Clinton	1	0	5
Columbia	1	0	2
Cortland	1	0	1
Delaware	1	1	2
Dutchess	4	1	4
Erie	12	24	25
Essex	0	0	0
Franklin	0	2	2
Fulton	3	2	1
Genesee	1	0	1
Greene	0	1	0
Hamilton	0	0	0
Herkimer	0	1	2
Jefferson	8	4	5
Lewis	0	0	0
Livingston	2	0	0
Madison	2	1	2
Monroe	16	9	26
Montgomery	1	1	0
Nassau	7	2	5
Niagara	4	4	6
Oneida	9	5	6
Onondaga	12	11	11
Ontario	0	3	1
Orange	8	4	3
Orleans	0	0	0
Oswego	4	4	3
Otsego	0	0	0
Putnam	0	1	0
Rensselaer	5	7	3
Rockland	5	3	3
St. Lawrence	2	2	3
Saratoga	2	1	0

Schenectady	9	7	7
Schoharie	0	0	1
Schuyler	0	0	0
Seneca	2	0	1
Steuben	2	3	1
Suffolk	10	12	18
Sullivan	0	0	2
Tioga	1	0	0
Tompkins	1	0	1
Ulster	3	1	0
Warren	1	0	0
Washington	1	1	1
Wayne	2	3	3
Westchester	4	6	11
Wyoming	0	1	2
Yates	1	0	0
St. Regis	0	2	0
Bronx	42	38	33
Kings	34	40	23
New York	5	16	16
Queens	24	30	22
Richmond	7	4	6
OSI[7]	0	2	2
OTHER[8]	0	0	1
NYC	111	131	103
Statewide	**276**	**283**	**299**

Chart 9

In 2015, 17 counties had no fatalities reviewed by OCFS, and an additional 19 counties counted two or fewer investigations. Outside of New York City, the highest number of fatalities in 2015 was 26 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 and medically fragile infants. The Monroe County Child Fatality Review Team is conducting comprehensive evaluations to identify the factors contributing to these fatalities and effective prevention efforts.

The number of fatalities reviewed from New York City decreased from 2013 to 2015. New York City ACS formed a Safe Sleep Unit and convened a multidisciplinary stakeholder's coalition that launched a safe sleep outreach and education initiative in 2015. OCFS arranged for and accompanied representatives from the New York City coalition to visit the Monroe County Child Fatality Review Team to share lessons learned.

[7] 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.

[8] This fatality occurred in a foster care residential facility and cannot be attributed to a county.

Some of the remaining counties experienced fluctuations from 2013 to 2015 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. Thus, a close examination of all circumstances is essential to a complete understanding of annual child fatality data.

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 local or 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.

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 maltreatment fatalities, as well as other preventable deaths. OCFS provides funding to 18 Child Fatality Review Teams throughout New York State. 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, law enforcement agencies, district attorneys' offices as well as medical examiners/coroners, first responders and other community stakeholders.

In 2015, OCFS convened a two-day summit for members of Child Fatality Review Teams to share information and collaborate on new strategies to reduce fatalities.

Review Team Prevention Initiatives

Throughout 2015, Review Teams 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 2015. In Onondaga, a safe sleep education program was provided for female inmates. The team also worked with "Babies r Us" to remove bumper pads from their crib displays. The Alleghany and Cattaraugus Team launched a second "ABCs of Safe Sleep" campaign during December 2015 with nine billboards along major travel routes in Allegany and Cattaraugus counties.

In Broome county, over 600 public service radio announcements were aired throughout the year providing tips on creating a safe sleep environment. Safe Baby booklets were developed and Community Health Workers provide them to families during home visits, outreach and parent classes. In Binghamton, Safe sleep advertisements were posted on key bus stop shelters throughout the city.

In Chemung County, the team maintained a free Pack-N- Play program to enhance safe sleep environments and reduce the risk of unsafe sleep related deaths in the community. Safe sleep resources were provided at multiple health fairs and community events. Safe sleep materials were also included in the mailing of every birth certificate in the county.

The Westchester County Team continued to work on countywide safe sleep initiatives. Materials are available in Spanish, Chinese and English and are distributed widely at health care facilities throughout Westchester.

The Albany County Team distributed safe sleep posters and magnets as well as child abuse prevention magnets.

The Oneida County Team continued to participate in the Mohawk Valley Safe Sleep Coalition. Members from both Oneida and Herkimer Counties collaborate and discuss the various issues, practices and policies surrounding safe sleep with the goal of reducing infant sleep-related deaths in Oneida and Herkimer Counties. The coalition also supports a portable crib program, consumer education and provider education.

Additional Awareness Campaigns

- The Madison County Review Team distributed posters and billboards; “Look Before You Lock,” about leaving children in hot cars. The team also provided glow sticks to elementary school children and preschoolers at day care centers and Head Start for use while trick-or-treating.
- The Oswego County Review Team provided grief counseling to surviving siblings and family members in an effort to prevent issues that often accompany suicide.
- The Putnam County Review Team distributed information on internet safety, suicide prevention and distracted driving at a teen health fair. The team also disseminated a press release on “Safe Toys for Holidays”. They continued with their suicide prevention campaign and mailed posters to gun retailers and local pharmacies about the need to keep guns and medications locked up.
- The Oneida Review Team supplied partners with the “Oneida County Bereavement Support” pamphlet. Produced by the Oneida County Team, this pamphlet lists community-based agencies available to families experiencing a child fatality.
- Allegany and Cattaraugus Counties’ Review Teams issued press releases to stress the importance of water safety, hyperthermia prevention, back to school safety and Halloween safety.
- The Schoharie Team provided smoke and carbon monoxide detectors to homes in need, sent letters to local hotels and motels to promote the safe sleep message and produced an article in the local newspapers regarding E-cigarette toxicity.

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 2013 to 2015, 59 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[9] that focuses on the safety of children by supporting families in high-risk communities. Healthy Families New York currently operates 37 programs throughout the state.[10] 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, 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.

Healthy Families New York mothers reported engaging in 80 percent fewer acts of "serious physical abuse[11]" when the target child was seven years old, 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.

[9] 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.

[10] 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.

[11] "Serious physical abuse" as defined by the "Conflicts Tactics Scale"

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.

- OCFS began collaborating with the DOH in 2015 to conduct a safe sleep pilot project, *Safe Sleep Kits*, in select counties in New York State. Two Child Fatality Review Teams and four hospitals are currently participating in the project. OCFS collaborated with DOH to incorporate safe sleep education materials from DOH into the kits.

  This initiative involves giving parents of newborns a kit containing safe sleep materials when they are leaving the hospital with their newborn. The kits include a tote bag, a door hanger, a baby book and a DVD with safe sleep information, as well as a sleep sack. In addition, parents are asked to give (or decline) permission to be contacted approximately one month post-discharge about their sleep practices.

  The goal of this initiative is 1) to educate parents on safe sleep practices, and 2) to determine if providing parents with safe sleep information has an impact on safe sleep practices. The follow-up survey will allow OCFS to measure the usage and effectiveness of the safe sleep educational products.

- In 2015, OCFS purchased approximately 3,400 “Pack-n-Play” cribs for distribution 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.

- The “Safe Sleep for Your Baby” video was updated in 2015 and is available for viewing through the OCFS website: http://ocfs.ny.gov/main/cps/safe sleep video asp. The video provides information about the ABCs of safe sleep; alone, on the back and in a crib.

- In 2015, OCFS convened a statewide Safe Sleep Strategy Forum. The forum included approximately 45 participants from across systems, including the DOH, Administration of Children’s Services, Casey Family Programs, the Westchester Child Fatality Review Team, Westchester County Department of Social Services, The Center for Sudden Infant and Child Death Resource Center, and the Monroe County Safe Sleep Coalition.

The results of this convening were provided to DOH to incorporate into the statewide Collaborative Improvement and Innovation Network (CoIIN) subcommittee on Safe Sleep. Additionally, OCFS posted a safe sleep video produced by the Monroe Coalition on the OCFS website, Facebook and You Tube sites in both English and Spanish.

- 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.[12]

    - 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.[13]

    - 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.[14]

[12] 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.

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

[14] (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.

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 project was expanded and now covers all of New York State. OCFS continues to support 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.

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 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** – OCFS will be evaluating the impact of the Safe Sleep Pilot outreach and education materials on sleep practices and will pursue broader dissemination of those items with evidence of usage or effectiveness. Safe sleep information will be disseminated to child care providers and other community based organizations. OCFS will continue to participate in the DOH-led Infant Mortality Reduction Collaborative Improvement and Innovation Network, an initiative that involves public-private partnerships working toward a shared goal of reducing child deaths.