NEW YORK STATE | Office of Children and Family Services

New York State Child Fatality Report 2017

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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.

Pursuant to Article 6 of the New York State Social Services Law (SSL) 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 2017 (and includes 2016 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 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 these measures have enhanced the state's

[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.

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

The data shows that upon investigation, many reports do not end up being substantiated as cases of abuse or maltreatment. The percentage of reports to the SCR that were substantiated was lower in 2017 than in the previous two years, and consistently remains under 40 percent.

Fatalities Substantiated After Investigation
2015 – 2017

	2015	2016	2017
Fatalities Reported to SCR for Investigation	251	246	268
Substantiated for the Allegation of DOA (fatality due to child abuse or maltreatment)	86	94	87
Percentage of Reports Substantiated for DOA	34%	38%	32%

By spearheading targeted initiatives geared toward educating the public about 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 analyzes these cases extensively to pinpoint the greatest areas of risk and to guide prevention strategies at the state and local level. Unsafe sleep continues to be 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 the risks related to unsafe sleep. As this report shows, in 2017 there was an increase in fatalities reviewed by OCFS involving an unsafe sleep environment (following a decrease in 2016). The increase in the number of reports of fatalities sent to OCFS may be attributed to outreach and education efforts aimed at mandated reporters and the general public.

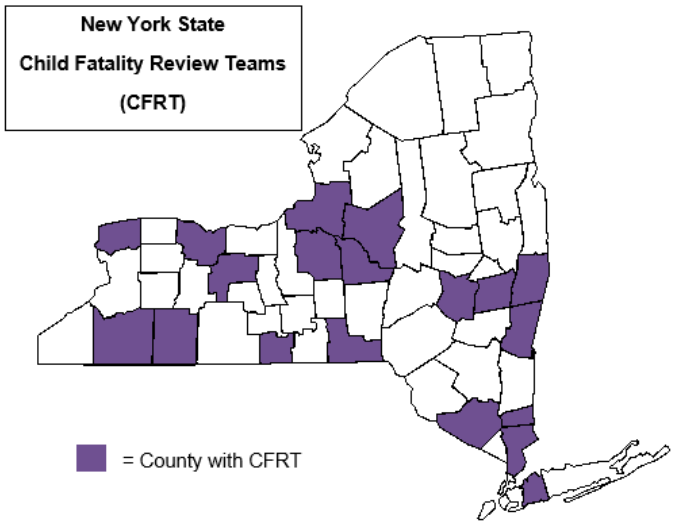
In 2017, OCFS continued to partner with DOH to disseminate safe sleep kits to parents of newborns in hospitals. The kits include a tote bag, door hanger, baby book, magnets, window clings, a DVD with information about safe sleep, and a baby sleep sack. OCFS also

developed new education and outreach campaigns to and continued to disseminate Pack ‘n Play cribs with safe sleep kits to local departments of social services and community based organizations.

Healthy Families New York is an OCFS-led, evidence-based home visitation program that is accredited by Healthy Families America. It supports expectant mothers and families in 47 high-risk communities across the state. Programs that begin working with parents either during the prenatal period or 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. Healthy Families New York educates parents about the risks associated with unsafe sleep environments, and promotes safe sleep practices for babies.

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 (CFRTs). OCFS funds 18 local CFRTs around the state, each comprised of members from a broad spectrum of expertise who conduct in-depth examinations of individual child fatalities, identify local trends and patterns, and develop initiatives to prevent child deaths. During 2017, these teams facilitated county-level initiatives targeting safe sleep, choking prevention, fire prevention, water safety, teen driving safety, car and bike safety, suicide prevention, drug prevention, 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. For example, the team identified a theme around the need to improve efforts to notify absent

parents and to increase training on the risk assessment tool used to identify the level of risk in child protective cases. It is anticipated that centralization and increased communication with the field will result in improvements 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.[3] Each local department of social services must establish child protective services 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. [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 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 "child abuse hotline," accepts telephone calls 24 hours a day, every day, 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

[3] 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.
[4] SSL Section 424.

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] and
- deaths that occur with a child for whom any local department of social services has an open child protective or open preventive services case.

A child protective services (CPS) 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 makes a determination about the allegations of child abuse or maltreatment and closes 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 that the death was caused by child abuse or maltreatment, the SCR registers the report with a fatality allegation 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 services case where there is no reasonable cause to suspect that 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. For fatalities outside of New York City the regional office relays this information to the appropriate fatality report team to launch the fatality reporting process.

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[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.

Either of the two reporting methods – SCR or the notification of an OCFS regional office – triggers an investigation into the child's death and all surrounding circumstances. For a death reported to the SCR, the investigation is conducted by the local department of social services. Such investigation must be comprehensive and complete and address not only the specific allegations but also the following: 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 that contributed to the death. The local department 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. For a death reported to an OCFS regional office, notification of a fatality in an open CPS, foster care, or preventive services case triggers a different, but also rigorous review. 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)(a). 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)(c) 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 2015-2017

This report presents and examines child fatality data for 2015 to 2017 and includes an analysis of the data compiled during this period.

Child Fatalities Reviewed by OCFS
2015 – 2017

	2015	2016	2017
Total child fatalities reviewed by OCFS	299	290	304
Total child fatalities reviewed by OCFS that were reported through the SCR	251	246	268
Percentage of child fatalities reviewed by	84%	85%	88%

OCFS that were reported to the SCR			

Table 1

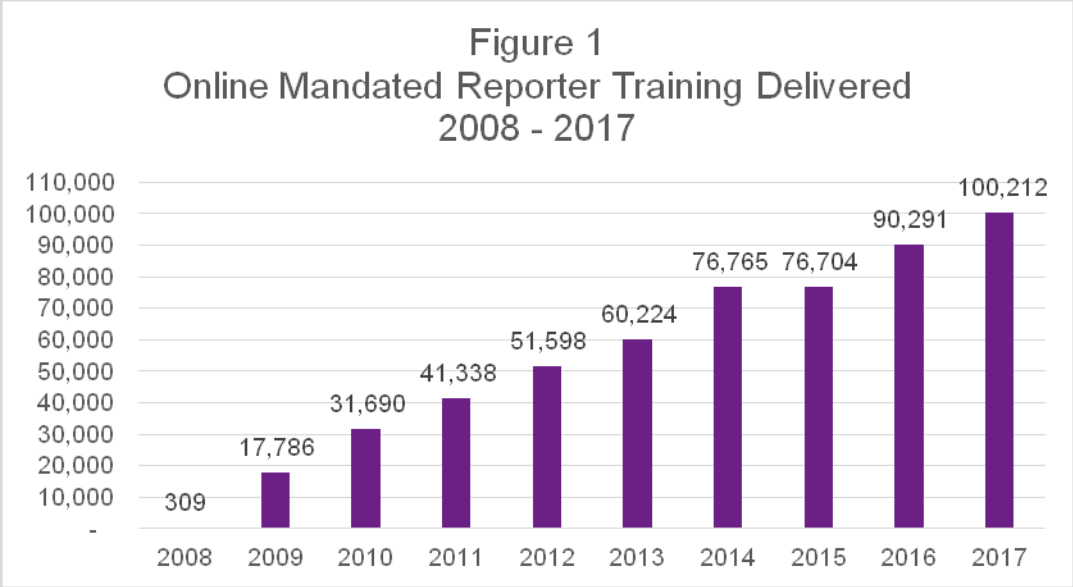
Table 1 shows fatalities reported to the SCR and the total number of fatalities OCFS reviewed. The fatalities reported to the SCR are those in which the reporter alleges parental or caregiver abuse or maltreatment. OCFS has taken several affirmative steps to encourage comprehensive reporting of child abuse and maltreatment cases, described below. The number of child fatalities reported to the SCR was higher in 2017 than in each of the past two years; the increased outreach and education efforts may be factors in the increased number of reports.

Affirmative Steps Promoting Increased SCR Reporting

New York State delivered online training to more than 100,000 individuals in 2017; an 11 percent increase from 2016.

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 reasonable suspicions of child abuse or maltreatment, educates mandated reporters about the signs and indicators of abuse and 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 the online mandated reporter training, the number of online trainings delivered has increased dramatically. As Figure 1 illustrates, the number of individuals OCFS trained online per year increased from 309 in 2008 to 100,212 in 2017. 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.



Expanded Categories of Mandated Reporters: New York State 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. In 2017, employees of publicly-funded emergency shelters for families with children were added.

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

SCR Reported Fatalities

Fatalities Substantiated After Investigation
2015 – 2017

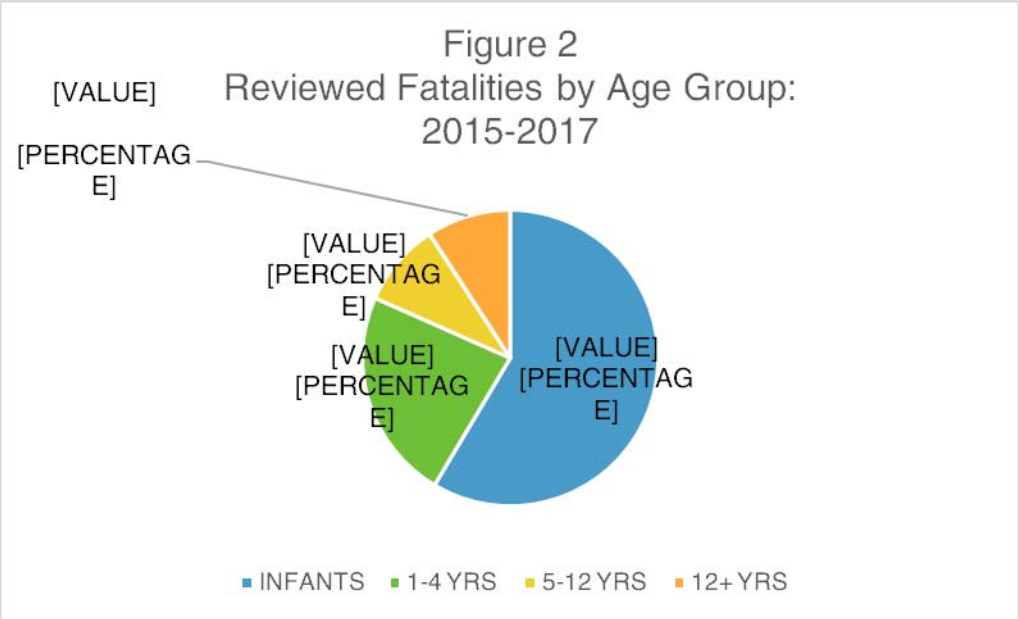
	2015	2016	2017
Fatalities Reported to SCR for Investigation	251	246	268

Substantiated for the allegation of DOA (fatality due to child abuse or maltreatment)	86	94	87
Percentage of reports substantiated for DOA	34%	38%	32%

Table 2

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 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 2016 and 2017 declined to the lowest rate in the last three years and remains well below 40 percent.

Fatality Reviews by Age



Between 2015 and 2017, the majority of child fatalities were of infants less than one-year-old. Figure 2 also shows that children ages 1 to 4 years old constituted almost one-quarter of fatalities, while less than 20 percent of all child fatalities occurred to children ages older than five.

Because infant deaths consistently represent the largest number of all reported child fatalities, OCFS collects extensive data on these deaths to pinpoint areas of greatest risk and to guide prevention strategies. After a decrease from 2015 to 2016, the number of child fatalities involving unsafe sleep environments rose in 2017 (Table 3).

Child Fatalities Involving Unsafe Sleep Environments
2015 – 2017

	2015	2016	2017
Fatalities Reviewed for Children Under 12 Months of Age (Infants)	188	155	180
Total Identified Unsafe Sleep Environments	85	60	85
Unsafe Sleep Percent of All Infant Fatalities	45%	39%	47%

Table 3

Unsafe sleep is a leading factor in infant fatalities reviewed by OCFS. Unsafe sleep environments may include those in which an adult and a child are sleeping on 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. PARTNERSHIPS AND PREVENTION**, promoting safe sleep is an OCFS child welfare priority.

As Table 3 above shows, there has been an increase in the number of fatalities reviewed for children under 12 months of age and a concomitant increase in the number of fatalities reviewed for this population involving an unsafe sleep environment. While direct causation cannot be proven, the 2016 decrease might have been influenced by the extensive outreach and education strategies employed by OCFS and the New York State Department of Health (DOH) to maternity hospital nurses and parents of newborns during 2016.

Table 4 shows child fatalities that occur in unsafe sleep environments most frequently occur when infants are placed in adult beds. Additionally, the fatalities that occur in adult beds usually involve a co-sleeping scenario with one or more other adults or children. The second most frequent unsafe sleep surface in infant deaths was a couch.

OCFS Reviewed Child Fatalities Involving Unsafe Sleep Environments
2015 – 2017

If the child died in an unsafe sleeping environment, what was the location?	Count: (Children < One Year)	Percent of Total
Adult Bed	141	61%
Couch	28	12%
Crib	20	9%
Other	13	6%
Bassinet	11	5%
Air Mattress	6	2%
Car seat/Stroller	4	1%
Floor	1	1%
Unknown	1	1%
Chair	4	1%
Playpen	1	1%
Total:	230	100%

Table 4

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. The chart below shows the guidelines provided by the Centers for Disease Control and Prevention to coroners/medical examiners and used in New York State for categorizing the 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.

Number of Fatalities by Manner of Death in Reviewed Cases
2015 - 2017

Manner of Death	2015	2016	2017
Natural	77	74	62
Accident	61	64	63
Homicide	36	32	20
Suicide	6	7	7
Pending	64	76	112
Undetermined/Unknown	55	37	40
Total	299	290	304

Table 5

As Table 5 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 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

percentage of pending determinations, conclusions cannot be drawn from the data. 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

Table 6 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.

Total Verified Deaths by County
2015 - 2017

	2015	2016	2017
New York State	**299**	**290**	**304**
New York City	102	119	112
Rest of State	197	171	192
Albany	6	4	6
Allegany	2	1	0
Broome	7	7	5
Cattaraugus	1	0	1
Cayuga	0	3	0
Chautauqua	3	4	4
Chemung	6	3	3
Chenango	1	1	3
Clinton	5	0	2
Columbia	2	1	2
Cortland	1	1	1
Delaware	2	0	1
Dutchess	4	3	2
Erie	25	18	14
Essex	0	0	0
Franklin	2	0	1
Fulton	1	2	0
Genesee	1	2	2
Greene	0	2	0
Hamilton	0	0	0
Herkimer	2	0	2
Jefferson	5	4	3
Lewis	0	2	0
Livingston	0	1	0
Madison	2	1	1
Monroe	26	14	27
Montgomery	0	3	0
Nassau	5	4	6
Niagara	6	4	6
Oneida	6	7	3
Onondaga	11	17	16
Ontario	1	2	1
Orange	3	9	3

Orleans	0	1	1
Oswego	3	3	4
Otsego	0	0	0
Putnam	0	0	0
Rensselaer	3	4	2
Rockland	3	2	5
St. Lawrence	3	1	5
Saratoga	0	1	2
Schenectady	7	3	4
Schoharie	1	0	0
Schuyler	0	0	1
Seneca	1	1	2
Steuben	1	0	6
Suffolk	18	10	23
Sullivan	2	3	3
Tioga	0	0	0
Tompkins	1	1	3
Ulster	0	3	2
Warren	0	1	2
Washington	1	1	2
Wayne	3	2	0
Westchester	11	13	10
Wyoming	2	0	0
Yates	0	1	0
St. Regis	0	0	0
Bronx	33	35	23
Kings	23	30	40
Manhattan	16	24	15
Queens	22	21	20
Richmond	6	8	11
ACS/OSI	2	1	3
OTHER	1	0	0

Table 6

In 2017, 17 counties had no fatalities reviewed by OCFS; an additional 19 had one or two investigations. The greatest increase was in Monroe and Suffolk counties where each had 13 more fatalities in 2017 than in 2016. Erie County showed a significant decrease in fatalities for the third year in a row. In New York City, OCFS reviewed significantly fewer fatalities in the Bronx and Manhattan in 2017 than in 2016.

From 2015 to 2017, some of the remaining counties experienced fluctuations from 2015 to 2017 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. 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. PARTNERSHIPS AND PREVENTION** 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 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.

Child Fatality Review Teams

In 2017, OCFS hosted its third annual child fatality review team (CFRT) convening. OCFS and partners from DOH, the New York State Office of Alcohol and Substance Abuse Services, Prevent Suicide NY, and the Office of the Onondaga County Medical Examiner provided information to CFRTs from across the state on safe sleep, opiate/heroin prevention and child suicide prevention.

CFRTs 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. These teams 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.

Child Fatality Review Team Prevention Initiatives

Throughout 2017, CFRTs created and implemented a variety of prevention initiatives in their local counties. Many teams focused on safe sleep as well as other outreach and awareness activities. The following are examples of successful initiatives:

- Albany County CFRT conducted a media campaign on Albany County bus shelters and interior bus placards during Child Abuse Prevention Month. The campaign was aimed at providing outreach and education on safe sleep for infants.

- Broome County CFRT partnered with the Broome County SAFE Coalition and continued its work to assist all districts to have up-to-date protocols for crisis response and information management when a member of the school community dies. Mother and Babies Perinatal Network, a team partner, ran radio ads regarding proper vehicle restraints for children.

- Columbia County CFRT participated in multiple community and school events to educate and raise awareness on safe sleep, shaken baby syndrome, water safety, teen suicide, drug prevention, and car/bike safety. All families with a child under two years of age who are receiving homeless services are seen by local district staff to provide safe sleep equipment and education. The CFRT collaborated with emergency medical technicians and other agencies to develop a comprehensive Safe Haven program in the county.

- Madison County CFRT and the Madison County Health Department conducted an annual car seat check and provided replacements for unsafe car seats identified during the check.

- Monroe County CFRT collected data on teen suicides in an effort to identify prevention initiatives to decrease the rate of teen suicides.

- Nassau County CFRT created "Safe Sleep Zones" at birthing hospitals on Long Island. Letters encouraging safe sleep were sent to the birth hospitals on any case reviewed where unsafe sleep circumstances were identified encouraging safe sleep.

- Niagara County CFRT implemented a digital marketing campaign consisting of a 15-second video and banner ads as well as a social media campaign that highlighted safe sleep information. Niagara CFRT also worked with the Niagara Falls Memorial Medical Center (NFMMC) for Moms, Teens and Kids to facilitate the Crib for Kids program. Safe Sleep kits continue to be distributed to all families after the birth of their child at NFMMC. The "Now I Lay Me Down to Sleep" initiative began in April with a press campaign. The campaign includes social media, an online toolkit, a small card with safe sleep information, and a special edition of *Buffalo Healthy Living*.

- Oneida County CFRT produced the *Oneida County Bereavement Support* pamphlet, listing community-based agencies available to families experiencing a child fatality. The CFRT continues its public outreach campaign by providing safe sleep and other safety information on televisions strategically placed in the waiting rooms of two county buildings.

- Onondaga County CFRT presented safe sleep education to female inmates and created a Facebook page called "Safe Sleep Syracuse-Just for Men," which includes safe sleep and other infant safety topics.

- Putnam County CFRT continues to partner with the Suicide Prevention Center of NY to develop a strategic plan and create a team to respond to the community and surviving family members following a suicide or child death.

- Rensselaer County distributed quick reference tip sheets on safety topics including hyperthermia, water safety and pool safety.

- Southern Tier CFRT (Allegany and Cattaraugus counties) partnered with the American Red Cross during fire prevention month and assisted the Red Cross with their Home Fire Campaign, which is credited with saving 27 lives. Red Cross volunteers conduct home fire safety assessments and provide free smoke alarms.

- Westchester County CFRT continued its county-wide safe sleep initiative through bus shelter advertisements and ads on public transportation as well as public service announcements in various public areas including courthouses, medical, prosecutor waiting rooms and WIC offices.

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 2015 to 2017, 58 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 (HFNY) is an OCFS-funded home visiting program[7] that focuses on the health, development, and safety of children by supporting high-need families in high-risk communities. HFNY currently operates 44 programs in 47 high-risk communities throughout the state.[8] 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.

HFNY has been rigorously evaluated over a seven-year period to determine the effectiveness of the program. This evaluation showed that HFNY was successful in improving birth outcomes, sustaining children's access to health care, promoting children's success in school, supporting positive parenting practices, and preventing child abuse and neglect. Specifically, HFNY mothers reported engaging in 80 percent fewer acts of "serious physical abuse[9]" when the target child was 7 years old than mothers in the study's control group reported. For mothers involved in a substantiated CPS report prior to entering the program, HFNY significantly reduced the rate of subsequent substantiated indicated CPS that occurred and generated even greater reductions in the rate of cases opened for preventive services.

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

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[7] 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.

[8] 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. HFNY has also used adoption savings funding to expand the program to underserved and unserved communities of the state.

[9] "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.

Safe Sleep Education

In 2017, OCFS distributed over 5,000 Safe Sleep kits for parents and caregivers. The kits include a "Follow the ABCs of Safe Sleep" tote bag, door hanger, magnet, brochure, window cling, and a *Sleep Baby: Safe and Snug* carboard book. The kit also includes a SleepSack for the baby. In addition, OCFS distributed over 1,300 Pack 'n Plays with the safe sleep kits to local department of social services, community-based organizations and CFRTs. To help further disseminate the message, the OCFS Human Services Call Center produced a call waiting message about the ABCs of safe sleep. This provides an opportunity to reach thousands of callers a day. Additionally, OCFS continues to post safe sleep information on the OCFS social media sites.

OCFS proactively addressed the increase in unsafe sleep related fatalities by creating additional safe sleep education campaigns for implementation in 2018. Two 15-second videos were produced in collaboration with the DOH. The videos are in English and Spanish and are designed to help parents, caregivers and families understand the importance of the "ABCs of Safe Sleep." The videos have been posted to OCFS social media sites and will be shown in various public settings over the next year. OCFS will be working with DOH to develop a one page "frequently asked questions" document with safe sleep tips based on lessons learned and feedback from parents and other caregivers.

Also in 2018, OCFS will be creating a web-based safe sleep training to be incorporated into the newly designed skill-based training for local social service district and voluntary agency child welfare workers and supervisors. The safe sleep training will be incorporated into OCFS' Foundational Training which will be offered to all new child welfare workers, and into the Child Protective Response Training specifically designed for child protective workers.

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 CPS sleep-related investigations.

- In November 2010, OCFS disseminated *Guidance for CPS Investigations of Infant Fatalities and Injuries Involving Unsafe Sleeping Conditions*. This guidance assisted CPS regarding factors to consider when investigating a report of a death that may have been related to unsafe sleep conditions.[10]
- In January 2013, OCFS issued *Investigation and Determination of Sleep-Related Fatality and Injury CPS Reports*. This guidance provides information for CPS

[10] LCM 10-OCFS-LCM-15. An OCFS Local Commissioners Memorandum is an external policy release that transmits information on specific topics to the commissioners of local departments of social services commissioners on specific topics.

caseworkers to use throughout the investigation and substantiation of reports of safe-sleep-related fatalities and injuries.[11]

- 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.[12]

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 will focus on the following three areas:

- **Data Analysis and Practice Improvement** – In partnership with child fatality report teams, 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 (CFRTs)** – Currently, local and regional CFRTs 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.

- **Safe Sleep Initiative** – OCFS will continue to collaborate with DOH to develop and disseminate standard safe sleep messages. OCFS will be incorporating safe sleep training into the new skills-based training curriculum. OCFS will collaborate with DOH on safe sleep prevention strategies based on lessons learned and including a one-page tip sheet for parents and caregivers. OCFS will continue to purchase and disseminate safe sleep kits and Pack 'n Plays.

[11] 13-OCFS-LCM-01.

[12] 13-OCFS-ADM-02. An Administrative Directive (ADM) is an OCFS external policy release designed to advise local departments of social services and voluntary agencies, as necessary, of policy and procedural requirements, which mandate specific action and must be followed.