NEW YORK STATE | Office of Children and Family Services

New York State Child Fatality Report 2018

Published in December 2020

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

Table of Contents

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 State 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 New York State Justice Center for the Protection of People with Special Needs; and 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 2018 (and includes 2017 and 2016 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. Also, 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 ability to identify potential cases of child abuse and maltreatment, including cases that might previously have gone undetected.

[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.

The data show that upon investigation, many fatality reports do not end up being substantiated as cases of abuse or maltreatment. The percentage of reports registered by the SCR that were substantiated was lower in 2018 than in years prior to 2017 and remains consistently under 40 percent.

Fatalities Substantiated After Investigation
2016 – 2018

	2016	2017	2018
Fatalities Reported to SCR for Investigation	246	268	266
Substantiated for the Allegation of DOA (fatality due to child abuse or maltreatment)	94	87	89
Percentage of Reports Substantiated for DOA	38%	32%	33%

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. In 2018, the number of fatalities involving an unsafe sleep environment decreased from 2017 (Table 3, page 11). This decrease may be attributed to the ongoing outreach and education efforts aimed at mandated reporters and the general public.

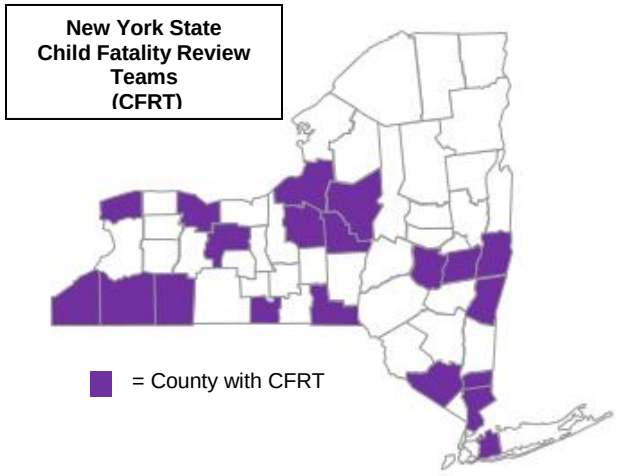
In 2018, OCFS continued to partner with DOH to disseminate safe sleep kits to parents and caregivers. The safe sleep kits included a "Follow the ABCs of Safe Sleep" tote bag, baby sleep sack, DVD with information about safe sleep, safe sleep baby book, and informational door hangers, magnets, and window clings. OCFS developed new education and outreach campaigns and continued to disseminate Pack 'n Play cribs along with safe sleep kits to local departments of social services and community-based organizations. OCFS also developed a

Safe Sleep webpage where safe sleep videos and publications can be viewed and downloaded. OCFS collaborated with DOH in developing two safe sleep videos, in English and Spanish. The videos were posted to OCFS's and DOH's websites. Additionally, OCFS and the Rensselaer County Child Fatality Review Team (CFRT) collaborated with a local news station, WTEN Channel 10 News, in developing a story for the Capital District on infant safe sleep practices. OCFS looks forward to expanding and improving its safe sleep initiatives in the coming year.

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 allocated funding to 18 local CFRTs that covered 20 counties 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 2018, 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 ACS. Child fatality investigations analyzed by a team of reviewers in the OCFS home office 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. Providing consistent feedback and guidance from a centralization team of fatality reviewers has increased communication with the field and 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, Westchester, 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 departments 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 of Child Abuse and Maltreatment

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. Callers to the SCR include mandated reporters (persons required by law to

[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.

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

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 regarding the allegations of child abuse or maltreatment and closes the investigation. A preventive services case may remain open if 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 most cases, OCFS learns of a child fatality through a CPS report registered by 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 OCFS home office fatality report team to launch the fatality

[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.

reporting process. Either of the two reporting methods, the 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; it must 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 the 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 due to the death.

III. CHILD FATALITY REPORTING

New York State 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 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 2016-2018

This report presents and examines child fatality data for 2016 to 2018 and includes an analysis of the data compiled during this period.

Child Fatalities Reviewed by OCFS
2016 – 2018

	2016	2017	2018
Total child fatalities reviewed by OCFS	290	304	326

Table 1

Table 1 shows the total number of fatalities OCFS reviewed. 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 OCFS was higher in 2018

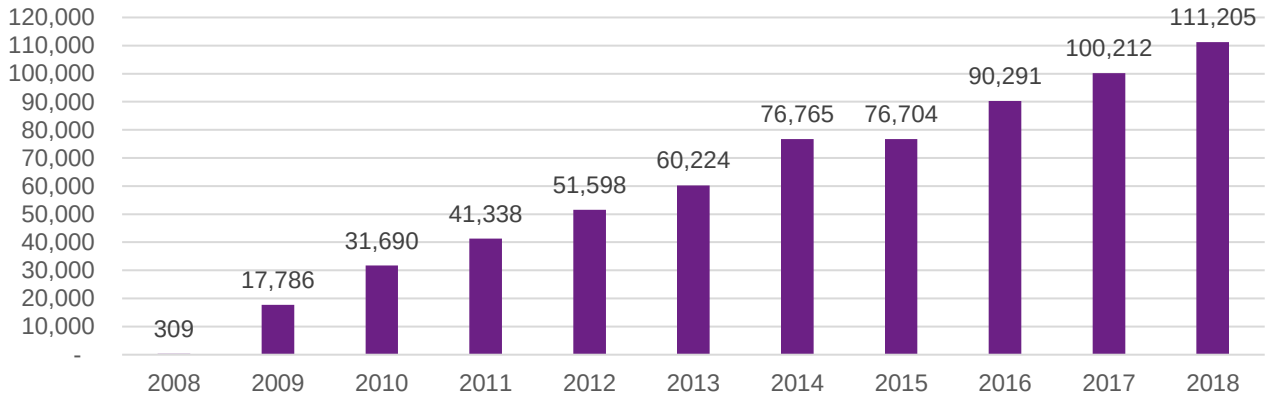
than in each of the past two years; the increased outreach and education efforts may be factors in the increased number of reports. This increased outreach also creates more opportunity to further prevention efforts, including continuation of the safe sleep campaign.

Affirmative Steps Promoting Increased SCR Reporting

New York State delivered online training to more than 111,000 individuals in 2018; an 11 percent increase from 2017.

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.

Figure 1
Online Mandated Reporter Training Delivered
2008 - 2018



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. In 2018, employees of a health home or health home care management agency who are expected to have regular and substantial contact with children were added to the list of mandated reporters.

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 111,205 in 2018. In addition to those licensed by the New York 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.

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, multimedia 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

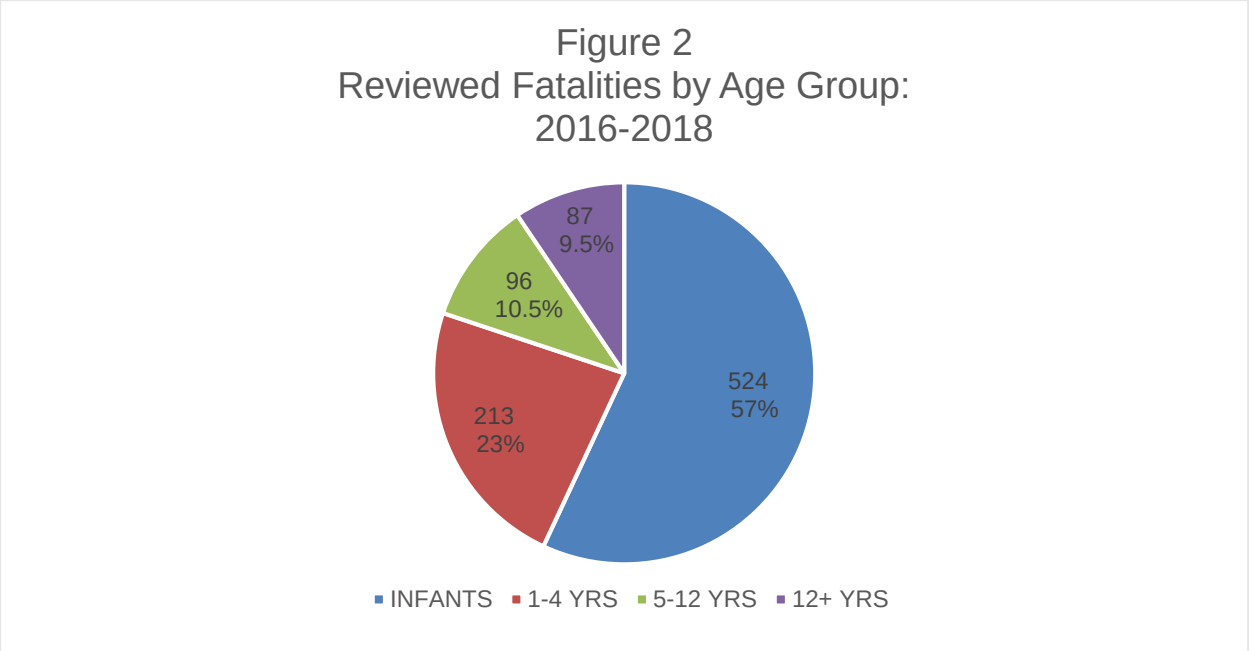
Fatalities Substantiated After Investigation
2016 – 2018

	2016	2017	2018
Fatalities Reported to SCR for Investigation	246	268	266
Substantiated for the Allegation of DOA (fatality due to child abuse or maltreatment)	94	87	89
Percentage of Reports Substantiated for DOA	38%	32%	33%

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 based on some credible evidence less than half of the time. The percentage of fatality reports substantiated as having been caused by abuse or maltreatment remains well below 40 percent.

Fatality Reviews by Age



Between 2016 and 2018, the highest number of child fatalities were infants under the age of 1. Figure 2 also shows that children ages 1 to 4 years old constituted almost one-quarter of fatalities, while the remaining 20 percent of all child fatalities occurred to children older than 5.

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 in 2016, the number of child fatalities involving unsafe sleep environments rose in 2017 but declined again in 2018 (Table 3).

Child Fatalities Involving Unsafe Sleep Environments
2016 – 2018

	2016	2017	2018
Fatalities Reviewed for Children Under 12 Months of Age (Infants)	155	180	189
Total Identified **Unsafe Sleep** Environments	60	85	73
Unsafe Sleep Percent of All Infant Fatalities	39%	47%	39%

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, with a concomitant decrease 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 DOH to maternity hospital nurses and parents of newborns during that time period. With renewed prevention efforts in 2018, percentage of deaths due to unsafe sleep is again declining.

Table 4 shows that 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.

OCFS Reviewed Child Fatalities Involving Unsafe Sleep Environments 2016 – 2018		
If the child died in an unsafe sleeping environment, what was the location?	Count: (Children < One Year)	Percent of Total
Adult Bed	134	61%
Couch	24	11%
Crib with hazardous conditions	21	10%
Bassinet with hazardous conditions	13	6%
Other	11	5%
Air Mattress	5	2%
Chair	5	2%
Car seat/ Stroller	2	1%
Floor	2	1%
Playpen/Portable with hazardous conditions	1	1%
Total:	218	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 1

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 2016 - 2018

Manner of Death	2016	2017	2018
Natural	74	62	76
Accident	64	63	51
Homicide	32	20	27
Suicide	7	7	9
Pending	76	112	93
Undetermined/Unknown	37	40	70
Total	290	304	326

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 currently drawn from these data. To improve the identification of the manner of death in these fatalities, 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 OCFS reviewed 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
2016 - 2018

	2016	2017	2018
New York State	**290**	**304**	**326**
New York City	119	112	125
Rest of State	171	192	201
Albany	4	6	6
Allegany	1	0	1
Broome	7	5	10
Cattaraugus	0	1	0
Cayuga	3	0	3
Chautauqua	4	4	2
Chemung	3	3	5
Chenango	1	3	2
Clinton	0	2	2
Columbia	1	2	2
Cortland	1	1	1
Delaware	0	1	0
Dutchess	3	2	9
Erie	18	14	22
Essex	0	0	0
Franklin	0	1	1
Fulton	2	0	1
Genesee	2	2	0
Greene	2	0	2
Hamilton	0	0	0
Herkimer	0	2	0
Jefferson	4	3	3
Lewis	2	0	0
Livingston	1	0	0
Madison	1	1	1
Monroe	14	27	18
Montgomery	3	0	1
Nassau	4	6	1
Niagara	4	6	6
Oneida	7	3	11
Onondaga	17	16	10
Ontario	2	1	2
Orange	9	3	13

Orleans	1	1	2
Oswego	3	4	2
Otsego	0	0	2
Putnam	0	0	2
Rensselaer	4	2	4
Rockland	2	5	5
St. Lawrence	1	5	2
Saratoga	1	2	4
Schenectady	3	4	3
Schoharie	0	0	0
Schuyler	0	1	0
Seneca	1	2	1
Steuben	0	6	2
Suffolk	10	23	11
Sullivan	3	3	4
Tioga	0	0	1
Tompkins	1	3	3
Ulster	3	2	1
Warren	1	2	1
Washington	1	2	2
Wayne	2	0	0
Westchester	13	10	13
Wyoming	0	0	0
Yates	1	0	1
St. Regis	0	0	0
Bronx	35	23	37
Kings	30	40	36
Manhattan	24	15	24
Queens	21	20	21
Richmond	8	11	4
ACS/OSI	1	3	3

Table 6

In 2018, 13 counties had zero fatalities reviewed by OCFS. Suffolk County showed a 53% decrease in fatalities (23 in 2017 and 11 in 2018). Orange County experienced the highest increase from 3 deaths in 2017 to 13 deaths in 2018. It is important to note, however, an incident such as a fire or vehicle accident, can account for multiple child deaths.

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 CFRTs, 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. In 2018, 99 percent of OCFS fatality reports were issued on time. 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 as needed throughout the investigation 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, anecdotal data show improved adherence to assistance around best casework practice, and it is expected that outcomes for families will improve.

Child Fatality Review Teams

In 2018, OCFS hosted its fourth annual child fatality review team (CFRT) conference. OCFS partnered with the New York State Division of Homeland Security and Emergency Services' Office of Fire Prevention and Control, Westchester County Department of Health, and Albany County Sheriff's Office to educate CFRTs from across the state on fire safety and prevention, water safety and prevention, and the opioid epidemic.

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 CFRTs that cover 20 counties throughout New York State. In 2018, OCFS provided technical assistance and support to one unfunded CFRT. 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 2018, CFRTs created and implemented a variety of prevention initiatives in their local counties. Seven CFRTs partnered with Cribs for Kids for their infant safe sleep initiatives. All the teams focused on infant safe sleep as well as other outreach and awareness prevention activities. The following are examples of successful initiatives:

- Albany County CFRT conducted a media campaign that included infant safe sleep public service announcements on local television, buses and bus shelters. The Albany CFRT also maintained its agreement with the Cribs for Kids program and provided Pack 'n Plays to Albany County families in need, accompanied with infant safe sleep education.

- Allegany/Cattaraugus County CFRT focused efforts on water safety due to the popularity of kayaking, paddling, and other water sports in the region. The team created informational water safety signs, with OCFS approval, and posted them near popular local waterways. The signs included information on life jacket laws and safety tips for parents and children to remember before paddling. Additionally, the team addressed concerns about child and youth suicide and partnered with the Suicide Prevention Coalition of Cattaraugus and Allegany counties to host a series of suicide gatekeeper trainings for community members, EMS providers, and child-serving organizations.

- Broome County CFRT coordinated its safe sleep campaign with the Mothers and Babies Perinatal Network. Two television ads aired, and safe sleep signs were posted at bus stops. The CFRT also supported the B.C. SAFE Coalition (Broome County Suicide Awareness for Families and Educators) and engaged in numerous activities throughout the year, including the annual World Suicide Prevention Day Breakfast, community panels, and tabling at various community events.

- Chemung County CFRT held its annual month-long Child Abuse Prevention and Awareness campaign in April 2018. Multiple events were held in the community, including TV interviews, pinwheel gardens throughout the community, and educational materials distributed to local community providers and businesses. Local school districts started a trauma response team with a multidisciplinary team of providers, including the CFRT coordinator. The CFRT will coordinate a response to any tragic event that may impact the students, families, and staff within the school district.

- Columbia County CFRT provided prevention outreach at numerous community events, including the Migrant Fair, the Children's Book Festival, Lowe's Family Day, Community Night Out, Hudson City School District's Employee Wellness Fair, Out of the Darkness Walk, Mentor Foundation, and the Chatham Fair. Information provided included infant safe sleep, bullying, suicide, substance abuse, home safety, and car seat safety checks. The CFRT worked with the Hudson City School District elementary school staff and the Hudson Fire Department to hand out over 450 fire prevention calendars to children during

a fire prevention event that took place at the school. The team also secured a limited supply of smoke detectors and made them available to families in the school district.

- Madison County CFRT supported the local health department and social services departments' safe sleep programs by purchasing Pack'n Plays, sheet sets, and sleep sacks. The CFRT also supported the health department's Car Seat Safety Program by purchasing car seats to replace defective/outdated car seats at their quarterly safety checks.

- Monroe County CFRT supported the Baby Safe Sleep Coalition with the updating of the coalition's prevention information. The CFRT also worked on developing prevention initiatives that focused on child suicides.

- Nassau County CFRT coordinated efforts to display bilingual infant safe sleep information in waiting areas at the local department of social services. The CFRT also issued letters to birth hospitals encouraging safe sleep education consistent with the American Academy of Pediatrics guidelines. The CFRT coordinated with the county's department of health (DOH) to include information on safe sleep, bathtub-drowning prevention, and choking prevention as part of DOH's routine mailings.

- Niagara County CFRT engaged in education activities supported by the Cribs for Kids program and partnered with the P3 Center for Teens, Moms and Kids (P3 stands for planning, pregnancy and parenting) to distribute 90 cribs to low income families. P3 staff set up the cribs in the family's home and conducted short-term in-person and telephone follow-ups to encourage proper use of the crib. The CFRT also created an informational piece for a local publication, *Buffalo Healthy Living,* to further communicate the infant safe sleep message.

- Oneida County CFRT continued with outreach to individuals and families by streaming child safety related information on two smart TVs located in the waiting/reception areas for two Oneida County Department of Social Services locations. CFRT members also contacted various community agencies to promote safe sleep, fire safety, and Spot the Tot information. Spot the Tot is a prevention campaign to raise awareness about protecting kids in and around vehicles.

- Onondaga County CFRT presented safe sleep education in three high schools and is listed as a resource for the Syracuse City School District health classes for presentations. The CFRT educated soon-to-be mothers attending the Prenatal Centering Group for their prenatal care. Monthly, the CFRT educated female inmates at the Justice Center, an interim jail facility, on safe sleep for infants. The CFRT also developed a "Safe Sleep Syracuse – Just for Men" Facebook page where bimonthly safe sleep messages are posted to the site.

- Ontario County CFRT coordinated with the Suicide Prevention Coalition to prevent child suicides. Safe sleep outreach was provided to local hospitals and through Healthy Families NY.

- Orange County CFRT distributed educational materials on child safety and safe sleep through local community events, outreach, and education initiatives.

- Oswego County CFRT collaborated with the EMS coordinator to increase access to fire and C02 detectors. The team also conducted internet safety classes with middle-school aged youth to address suicidal feelings that result from bullying and online exploitation/shaming. The CFRT participated with local community partners to help the community become trauma informed and to be aware of the Kaiser Permanente Adverse Childhood Experiences Study (ACES).

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

- Rensselaer County CFRT coordinated a presentation to women in recovery living with their infants at Hope House. This was a collaborative effort between the CFRT coordinator, a nurse, and a home visiting program specialist where information was shared, and questions answered on infant safe sleep practices.

- Schoharie County CFRT partnered with the local law enforcement agencies and the Schoharie County Health Department to provide information and bike helmets to children in the community. The CFRT partnered with the Cobleskill Police Department in conducting car seat safety checks for children. The CFRT also promoted keeping children safe with the proper disposal of medications by sharing information and disposal bags. The CFRT also participated in the Drug Take Back Day held in the county.

- Westchester County CFRT provided outreach to local parent/teacher organizations and school boards to encourage safe sleep messaging at health fairs and after-school babysitting certification programs. Also, in response to the choking death of a child, the CFRT successfully partnered with the federal Consumer Product Safety Commission to promote broader and more immediate public communication about unsafe products.

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 2016 to 2018, 57 percent involved infants

under the age of 1. 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] than mothers in the study's control group (when the target child was 7 years old). For mothers involved in a substantiated CPS report prior to entering the program, HFNY significantly reduced the rate of subsequent substantiated CPS investigations and generated even greater reductions in the rate of cases required to be 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 of mothers and children and expects to provide findings in 2019.

Safe Sleep Education

In 2018, OCFS distributed 1,250 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,

[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 and Neglect, 22, 249-270.

and a *Sleep Baby: Safe and Snug* board book. The kit also includes a Sleep Sack for the baby. In addition, OCFS distributed over 500 Pack 'n Plays with the safe sleep kits to local department of social services, community-based organizations and CFRTs. To 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 that were implemented 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 began work on a web-based safe sleep training to be incorporated into the newly designed skills-based training for child welfare workers and supervisors of local social services districts and voluntary agencies. The safe sleep training will be incorporated into OCFS's Foundational Training, which will be offered to all new child welfare workers, and into the Child Protective Services Response Training specifically designed for child protective workers.

OCFS continuously 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 on an ongoing basis

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 these 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. CFRTs will continue to collaborate and conduct child fatality reviews to inform OCFS of 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, including a one- page tip sheet for parents and caregivers. OCFS will continue to purchase and disseminate safe sleep kits and Pack 'n Plays.

- **Statewide Child Fatality Review Team** - OCFS is in the process of developing and implementing a statewide child fatality review team. The team will serve as an advisory committee with leadership from multiple state agencies. The team will work collaboratively on statewide child fatality prevention efforts. The team plans to focus on many areas related to child fatalities, such as substance use, domestic violence, parent substitutes and/or other caregivers, suicides, and unsafe sleep.