



New York State
Office of
Children & Family
Services

2006 Annual Cumulative Report on Child Fatalities



State of



New York

STATE OF NEW YORK

**2006 Annual
Cumulative Report on
Child Fatalities**

**New York State
Office of Children and Family Services
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Commissioner**

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Foreword

Legislative Background

In 1989, New York State enacted amendments to sections of the Social Services Law (SSL), sections 17(d) and 20(5), pertaining to the investigations of the death of children. Section 20(5) of the SSL requires the New York State Office of Children and Family Services (OCFS), formerly the New York State Department of Social Services, to investigate the cause and circumstances surrounding the death of a child:

- whose care and custody or custody and guardianship has been transferred to an authorized agency (foster care fatality); or
- in the case of a report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR fatality).

In 2006, section 20(5) of the SSL was amended by Chapter 485 of the Laws of 2006, to require OCFS to investigate the cause and circumstances surrounding the death of any child for whom Child Protective Services has an open or pending case and any child for whom the local department of social services has an open or pending Preventive Services case.

Chapter 136 of the Laws of 1999 provided for the creation of local and regional fatality review teams pursuant to section 422-b of the SSL. Such teams may prepare fatality reports for the categories of cases as set forth in section 20 (5) of the SSL. In addition, a local or regional child fatality review team may also investigate any unexplained or unexpected death of any child under the age of eighteen years.

The amendment requiring investigation of deaths of children that occur in open service cases did not go into effect until December 14, 2006. There were no fatalities that met the new criteria during the time the law was in effect in 2006. Therefore, this new category of fatality is not reflected in this report.

When a child dies under one of the circumstances described above, OCFS is responsible for the following:

- investigating or providing for the investigation of the cause and circumstances surrounding such death and reviewing each investigation;
- preparing and issuing a report on each such death except when a report is issued by an approved child fatality review team in accordance with section 422-b of the SSL; and
- preparing and issuing an annual cumulative report concerning such deaths.

Additionally, under statutory authority enacted in 1999, a local or regional child fatality review team approved by OCFS may prepare and issue a report on each death as set forth in section 20(5) of the SSL.

The law requires that the individual child fatality report contain the following information:

- the cause of death, specifically whether from natural or other causes;

- identification of child protective or other services provided or actions taken regarding such child and family;
- any extraordinary or pertinent information concerning the circumstance of the child's death;
- information concerning whether the child's family had received assistance, care or services from a social services district prior to the child's death;
- any action or further investigation taken by OCFS or its social services districts since the death of the child; and
- as appropriate, recommendations for local or State administrative or policy changes.

The law requires that each individual child fatality report must be completed no later than six months after the death of the child and OCFS must send the child fatality report to the following local officials: the commissioner of the social services district, the commissioner of the social services district which had care and custody or custody and guardianship, if different; the chief county executive officer; and the chairperson of the local legislative body of the county where the child's death occurred. Additionally, OCFS must notify the Temporary President of the Senate and the Speaker of the Assembly that a child fatality report has been issued. In New York City, in addition to officials at the Administration for Children's Services (ACS), child fatality reports are sent to the Mayor of the City of New York and the President of the New York City Council. If the report is issued by an approved local or regional child fatality review team, the report must be provided to OCFS upon completion for dissemination by OCFS to the same parties that receive access to OCFS issued fatality reports. OCFS must forward copies of all such reports to all other local or regional fatality review teams established pursuant to this section, to all citizen review panels established pursuant to SSL 371(b), to the Governor, the Temporary President of the Senate and the Speaker of the Assembly.

Further, in 1996, amendments were made to section 20(5) of the Social Services Law (Elisa's Law) that authorizes OCFS to make child fatality reports available to the public. OCFS must respond to a child specific or non-child specific request for a fatality report if OCFS determines that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.

Development of Local and Regional Child Fatality Review Teams

OCFS has made a commitment to foster the development of multidisciplinary teams for the purpose of investigating child abuse and maltreatment. In addition, support continues to be offered for the development of local or regional child fatality review teams. Chapter 485 of the Laws of 2006 expanded the purview, role, and composition of local or regional child fatality review teams, and granted participants immunity from civil and criminal liability for all reasonable good faith actions related to their participation on the teams.

A local or regional fatality review team must include, but need not be limited to, representatives from:

- *County Child Protective Services (CPS)*
- *OCFS*
- *County Department of Health or, if locality does not have County Department of Health, then the local health commissioner or his/her designee, or the local public health director, or his/her designee*
- *Office of the Medical Examiner (ME), or if the locality does not have an ME, then the Office of the Coroner*
- *District Attorney's Office*
- *Office of County Attorney*
- *Local Law Enforcement*
- *State Law Enforcement*
- *Emergency Medical Services (EMS)*
- *A Pediatrician or comparable medical professional, preferably with expertise in the care of child abuse and maltreatment or forensic pediatrics*

Section 422-b of the SSL now states that a local or regional fatality review team may exercise the same authority as OCFS with regard to the preparation of a fatality report. Notwithstanding any other provision of law to the contrary and to the extent consistent with federal law, local or regional fatality review teams have access to client-identifiable records necessary for the preparation of the report. A fatality report prepared by a local or regional fatality review team and approved by OCFS satisfies the obligation to prepare a fatality report. Such report is subject to the same re-disclosure provisions applicable to fatality reports prepared by OCFS.

OCFS will now forward copies of any such report to all other established local or regional fatality review teams, all citizen review panels, the Governor, the Temporary President of the Senate and the Speaker of the Assembly.

OCFS issued a Request for Proposals (RFP) in December of 2006. There was \$825,350 made available for start up and enhancements of child fatality review teams. There were nine awards made through that RFP for start-up or enhancement of teams. The counties that were funded are: Nassau, Putnam, Monroe, Oswego, Oneida, Onondaga, Schoharie, Columbia and Chemung.

Executive Summary

The 2006 Annual Report on Child Fatalities has been prepared in accordance with section 20(5)(c) of the SSL, which requires OCFS to issue an annual report on its review of child fatalities.

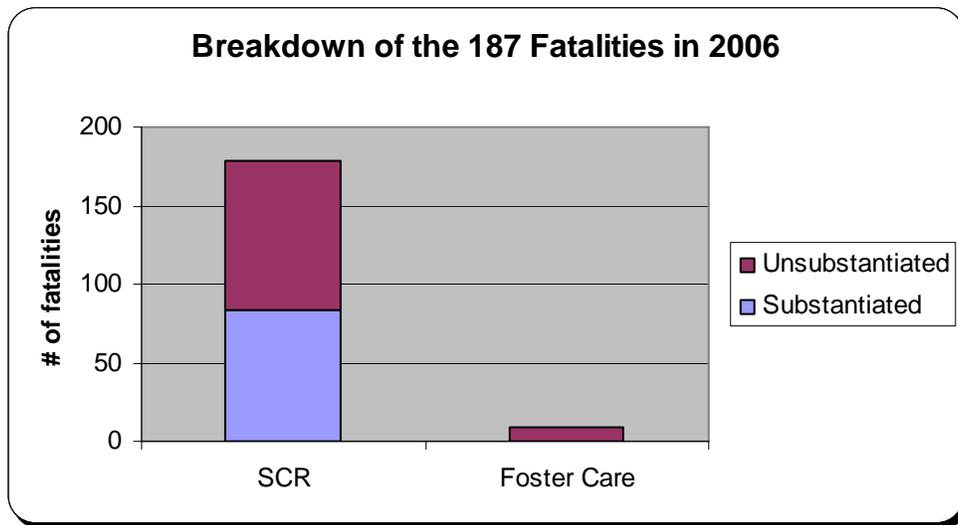
The data in this Annual Report are derived primarily from data submitted by OCFS Regional Offices based on their review of fatality cases.

Overall Data on 2006 Child Fatalities

This report provides data on the 187 fatalities that were tracked in 2006 under provisions of section 20(5) (c) of the SSL. Of the 187 deaths reported in 2006, 179 occurred in 2006. The remaining eight concerned children who died in years prior to 2006 and whose deaths were reported or re-reported to OCFS in 2006.

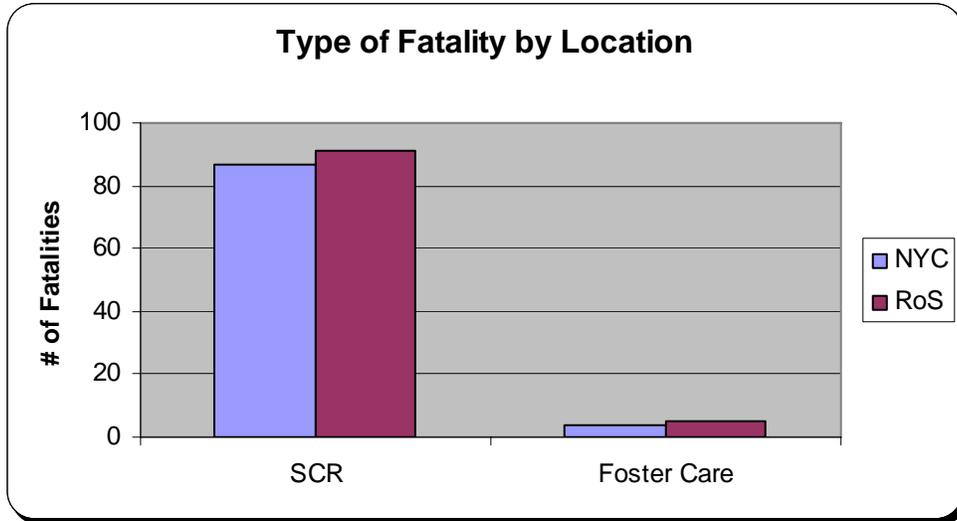
The data in this report distinguishes between fatalities that were reported to the SCR and fatalities of children in foster care that were not reported to the SCR. Most foster care deaths involve children who die of natural causes and/or whose deaths do not involve reasonable cause to suspect abuse or maltreatment. As a result, these foster care deaths are not reported to the SCR.

The breakdown of the 187 fatalities for 2006 is as follows:

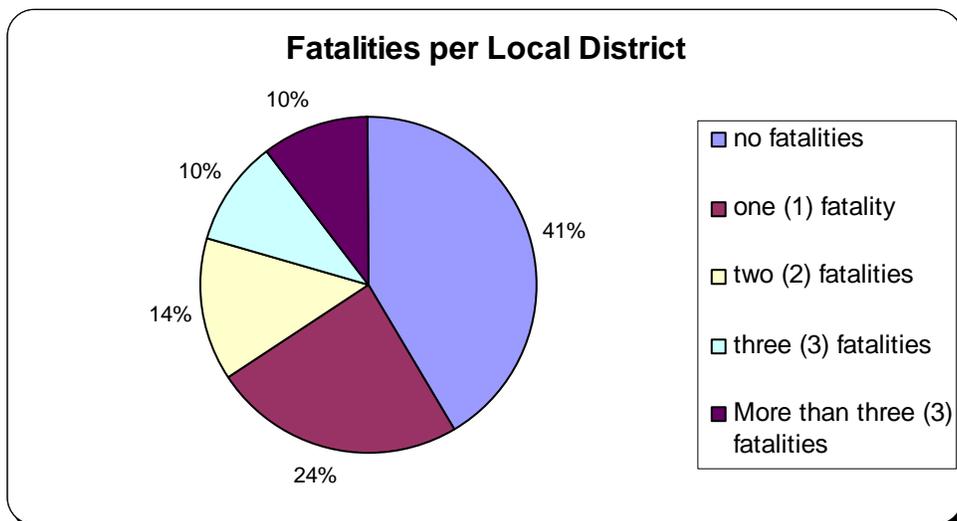


- One hundred and seventy-eight (178) were child fatalities reported to the SCR. The child’s death was substantiated as having involved abuse or maltreatment in 83 (47 percent) of these fatalities. All of the fatalities reported to the SCR were investigated by local departments of social services except for two Institutional Abuse (IAB) investigations. One unsubstantiated IAB report was investigated by the NYS Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) in a facility in Westchester County and has been included in the Westchester County total. Another substantiated IAB report was investigated by the OCFS Albany Regional Office and has been included in the Fulton County total.
- Nine (9) foster care fatalities did not involve suspicion of abuse or maltreatment and were, therefore, not reported to the SCR.

In 2006, 87 (49 percent) of the fatalities reported to the SCR occurred in New York City (NYC), and 91 (51 percent) occurred in counties outside of NYC (“Rest of State” counties). Of the nine foster care fatalities not reported to the SCR, four (44 percent) were of children in the custody of NYC and five (56 percent) were in the custody of a “Rest of State” local department of social services.



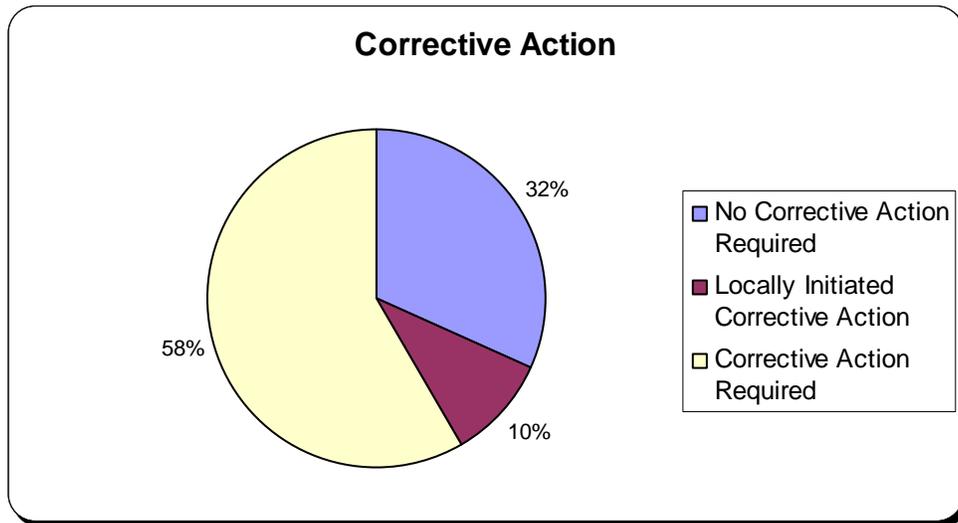
Most jurisdictions outside of NYC had few or no fatalities. The breakdown of number of fatalities per jurisdiction is as follows:



- No fatalities reported in 2006: 24 local departments of social services (including the St. Regis Mohawk Tribe jurisdiction);
- One (1) fatality reported in 2006: 14 local departments of social services
- Two (2) fatalities reported in 2006: 8 local departments of social services;
- Three (3) fatalities reported in 2006: 6 local departments of social services;
- More than three (3) fatalities reported in 2006: 6 departments of social services, including NYC.

Thirty-five (35) jurisdictions had no substantiated fatalities, that is no fatalities in which it was determined that abuse or maltreatment contributed to the child's death. Only eight (8) local departments of social services had more than one substantiated fatality.

After reviewing a fatality case, OCFS draws conclusions about the adequacy of the performance of local departments of social services, voluntary agencies, and other service providers throughout the history of the case. Such conclusions are based on law, regulation, and policy promulgated by OCFS, supplemented by generally accepted standards of good practice. If OCFS concludes that the performance of such a department or agency was deficient, that department or agency may be required to take action to correct the deficiency, unless the local department of social services or voluntary agency had already initiated action to correct the problem uncovered by the review. Action was required and/or had been locally initiated to correct deficiencies uncovered during the review of the fatalities as follows (individual cases could be counted in more than one category):



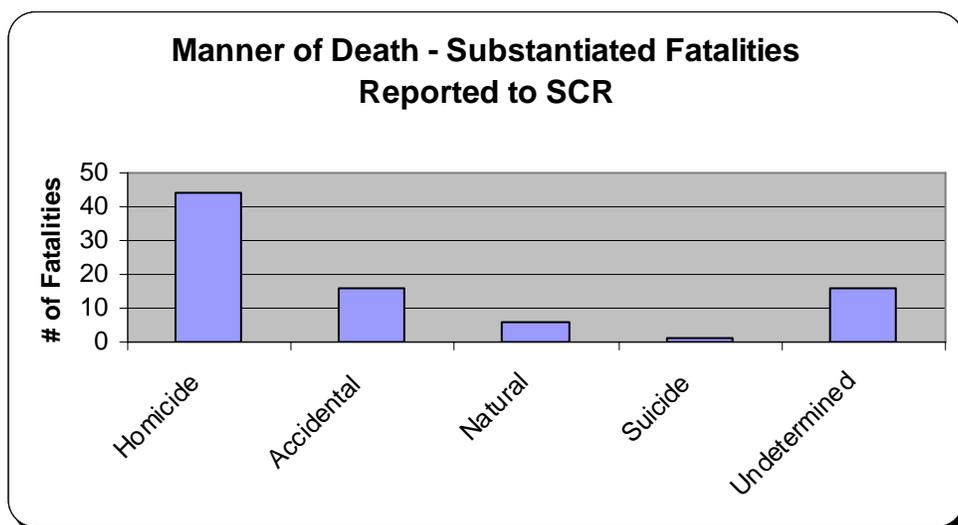
- **No Corrective Action Required:** In 60 (32 percent) of the 187 cases overall, there was no required action in the OCFS fatality report. Fifty-two (29 percent) of the 178 fatalities reported to the SCR had no required action. Only one of the nine non-reported foster care fatalities had required action.
- **Locally Initiated Corrective Action:** In 19 SCR fatalities, the local department of social services or voluntary agency initiated its own corrective action prior to the issuance of the OCFS fatality report.
- **Corrective Action Required:** In 111 (59 percent) cases overall, the OCFS fatality report contained some form of required corrective action.

Fatalities Reported to the State Central Register

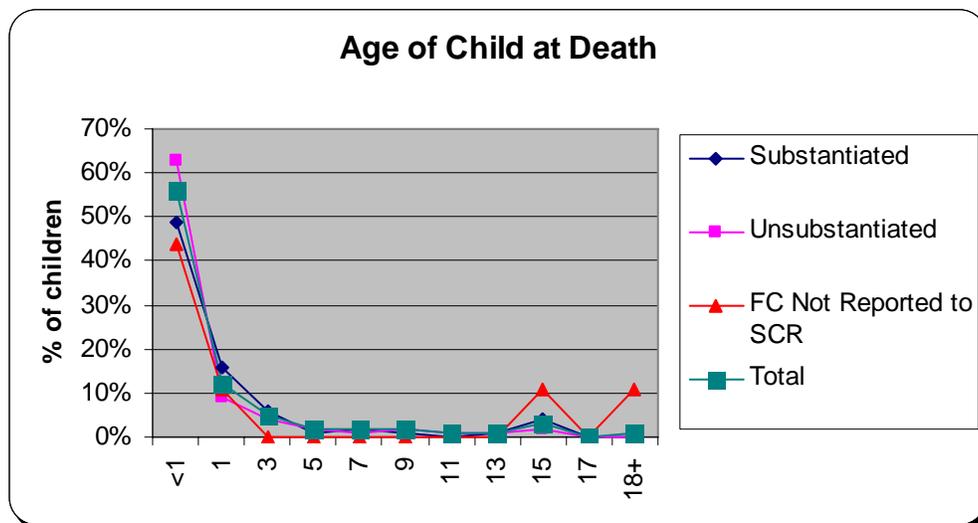
A fatality allegation is considered substantiated if there is some credible evidence that a caretaker's abuse or maltreatment caused or contributed to the child's death. Caretakers who can be subjects of child abuse and maltreatment reports include: parents, guardians, other members of the child's household over the age of 18, day care providers, foster parents, residential child care workers, and certain other people who regularly provide care for the child (see section 412(4) of the SSL). Teachers and other school personnel,

persons under 18 years of age (excluding parents) who reside in the child's home, and other people (such as neighbors, friends and relatives) who do not live with or regularly care for the child cannot be subjects of child abuse and maltreatment reports. Non-homicide deaths, such as those involving accidents or natural causes, may sometimes be substantiated. For example, a fatality might be substantiated if the child's death resulted from a caretaker's failure to provide adequate guardianship or supervision or to obtain timely medical care for the child's illness or injury.

Of the 178 fatalities reported to the SCR, 83 (47 percent) were substantiated. Of the substantiated fatalities reported in 2006, 44 (53 percent) were the result of homicide, and 16 (19 percent) were accidental deaths. In 16 (19 percent) of substantiated fatalities the manner of death was listed as undetermined.



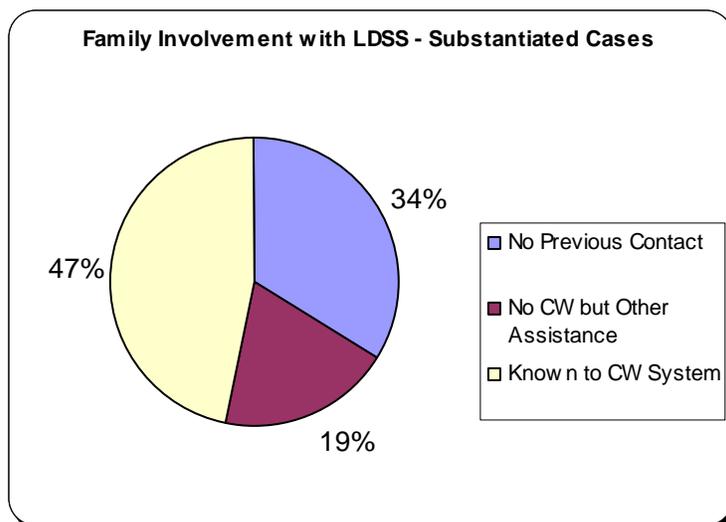
Fifty-four (65 percent) of substantiated fatalities involved a child under the age of two, and 41 (49 percent) of substantiated fatalities involved a child under the age of one.



Three children whose deaths were reported to the SCR were in foster care status when they died. These fatalities are categorized in this report as SCR fatalities. Of the three:

- One NYC foster care fatality was substantiated naming a kinship foster care provider as responsible.
- One “Rest of State” IAB fatality of a foster child in an Office of Mental Retardation and Developmental Disabilities (OMRDD) facility was unfounded.
- One NYC fatality of a child whose custody was transferred to NYC after the child was injured and who died in the hospital, was substantiated naming the child's family of origin as responsible.

Data were collected on any previous involvement the family had with a local department of social services for all SCR reported fatalities. In this context “child welfare services” refers to child protective services (CPS), preventive services, or foster care.



- In 28 (34 percent) of the 83 substantiated fatalities, there was no known previous contact with any local department of social services programs (defined as including income support programs such as Temporary Assistance to Needy Families or Food Stamps, Medical Assistance, and child care, as well as child welfare programs). Included in this figure are cases in which the only prior involvement with services programs was that a subject of the report was involved in an investigation or services case as a child.
- In 16 (19 percent) of the 83 substantiated fatalities, the family had no history with local child welfare services, but had received some other form of assistance (for example, Temporary Assistance to Needy Families, Food Stamps, Medical Assistance) from the local department of social services.
- The family had been known to the local child welfare services prior to, or at the time of, the incident that led to the child's death in 39 (47 percent) of the 83 substantiated fatalities.
- There was an active preventive services case or CPS investigation at the time of the incident that led to the child's death in 18 (22 percent) of the 83 substantiated fatalities.

Non-Reported Foster Care Fatalities

Of the nine foster care fatalities that were not reported to the SCR, four were in the legal custody of the ACS in NYC at the time of death and five were in the custody of a local department of social services from a “Rest of State” county. The most common manner of death among non-reported foster care fatalities was natural causes (6 fatalities). Four of the non-reported foster care children were under the age of one when they died.

Methodology

State Central Register Fatalities

When the SCR registers a CPS report that a child has died as the result of suspected abuse or maltreatment, the CPS report is referred to the appropriate jurisdiction for investigation. Most SCR reports are investigated by Child Protective Services (CPS) in the local department of social services for the county in which the alleged abuse or maltreatment occurred. The local department of social services has up to 60 days to complete its investigation of the allegations made in the report and determine whether the allegations should be substantiated or unsubstantiated. When abuse or maltreatment of a child in certain institutional care settings is reported to the SCR, the case is investigated by a state agency, either OCFS or CQC, rather than by a local department of social services. At the same time the report is referred for investigation, the appropriate OCFS Regional Office is notified of the report's existence. OCFS or a local or regional child fatality review team authorized by OCFS is responsible for reviewing the local

department of social services' investigation into the fatality, the circumstances surrounding the child's death and for issuing a fatality report on that review within six months of the death of the child. Fatality reports may require corrective action on the part of the local department of social services or voluntary agency, if warranted.

Non-reported Foster Care Fatalities

OCFS regulation, 18 NYCRR 441.7 (c), provides that when a child dies while in foster care, the authorized agency with which the child was placed is required to notify the appropriate OCFS Regional Office by telephone within 24 hours of the child's death, regardless of the reason or suspected cause of death. The authorized agency is required to follow-up on this telephone notification with a written notice. In addition, the agency with which the child is placed or the local department of social services having custody of the child must update one of OCFS's child welfare information systems, the Child Care Review Service (CCRS), to show that the child's foster care case has been closed due to the child's death. The Regional Office is responsible for reviewing the circumstances of the child's death and for issuing a fatality report on that review within six months of the death of the child.

Data Collection on Child Fatalities

On-going data to identify and track child fatalities is derived monthly from the CONNECTIONS system for SCR fatalities and from the CCRS for foster care fatalities. Once the child fatality report is approved and issued, the Regional Office sends a copy of the report, along with a completed data sheet, to the OCFS Home Office. Data for the Annual Cumulative Report on Child Fatalities are derived from the data sheets that the Regional Offices complete on each individual fatality and from basic demographic information downloaded from the CONNECTIONS and CCRS databases. CONNECTIONS is the computerized data system on which information about cases reported to the SCR, and the investigation of those cases, is maintained. CCRS is the computerized data system on which foster care and other child welfare services information is maintained.

Most of the data in this report derives from data sheets completed by the OCFS Regional Office upon issuance of the report of its review of the fatality case. Some additional data are derived from information recorded by the local department of social services on the CONNECTIONS or CCRS systems.

Findings

Note on Categories Used in This Report

Throughout this report, fatalities are grouped in several categories as follows:

Substantiated/Unsubstantiated: A fatality reported to the SCR is considered substantiated if there is some credible evidence to support that at least one of the subjects of the report caused or contributed to the child's death through abuse or maltreatment of the child. The fatality is considered unsubstantiated if there was no credible evidence that any of the subjects of the report caused or contributed to the child's death through abuse or maltreatment.

Foster Care Not Reported: Most foster care deaths are not the result of abuse or maltreatment and are not reported to the SCR. The foster care fatalities in which there was not reasonable cause to suspect abuse or maltreatment, and which were, therefore, not reported to the SCR, are classified as "Not Reported." Fatalities reported to the SCR and involving foster care children are included in the data on substantiated and unsubstantiated fatalities, depending on the determination of the SCR report.

NYC/"Rest of State": Throughout the report, separate totals and percentages are provided for "NYC" and "Rest of State" departments of social services. "Rest of State" departments of social services are the St. Regis Mohawk Tribe and the 57 New York State counties outside the five boroughs that constitute NYC. Foster care fatalities are grouped according to which local department of social services had custody of the child, not according to the county in which the child died.

Voluntary Agency: As used in this report, the term voluntary agency refers to a non-governmental agency with which a local department of social services may contract for the provision of preventive services or foster care.

Note: Fatality cases tracked in this report do not reflect a significant percentage of either foster care cases or SCR cases. Therefore, the data from this report cannot be used to draw statistically valid inferences about the overall performance of child abuse and maltreatment investigations, or the provision of foster care or other child welfare services.

On some occasions, percentages may add up to 99 percent or 101 percent rather than 100 percent. This is the result of rounding.

1. Number of Fatalities

This report contains information about the 187 child fatalities that were reported in 2006. Of these, 178 involved a death that was accepted by the SCR as a CPS report of suspected abuse or maltreatment, and nine involved a child in foster care whose death was not reported to the SCR.

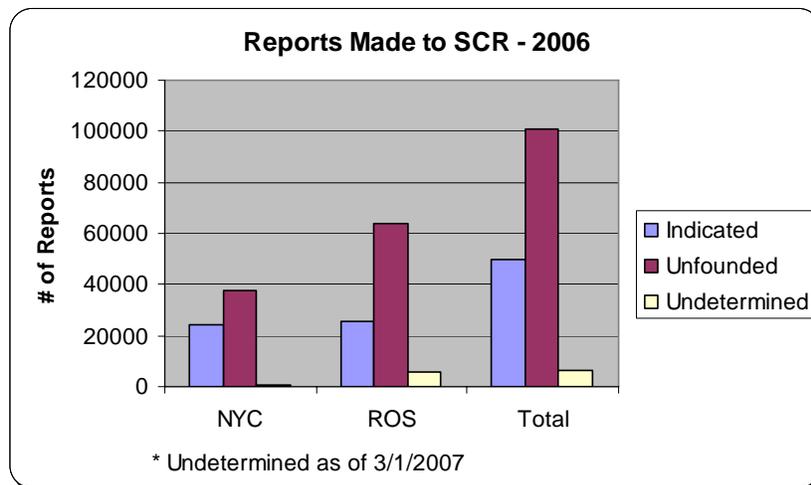
Data in this report are presented in terms of the deaths of individual children. In some instances, an SCR/CPS report involves the death of more than one child. In 2006, six child deaths in three SCR-reported cases involved situations where more than one child died.

Eight fatalities included in this report involve children who died prior to 2006, but whose deaths were reported to OCFs in 2006. Of these, four had been previously reported and investigated, but were re-reported to the SCR in 2006. The remaining four were reported for the first time in 2006. All but one of the eight fatalities from previous years were unsubstantiated. The one substantiated fatality involved a child whose skeletal remains were discovered in 1996, but whose identity was not established until 2006, when the child and the child's parents were identified by law enforcement.

There were four additional cases reported to the SCR as fatalities in 2006 that did not actually involve the death of a child. Data on these four cases are not included in this report. In one of these cases, the local department of social services could not establish that the reported family and/or the child ever existed, in one it was determined that the reported death involved a stillborn fetus, and in two the child reported to have died was found to be alive. In each of these four 'misreported' fatality cases, the OCFs Regional Office determined that the local department of social services had adequately investigated the CPS report and had appropriately determined that the case did not involve the death of a child. Three of these cases were from New York City, and one was from a "Rest of State" county.

State Central Register Fatalities

In calendar year 2006, there were 157,407 CPS reports of alleged abuse and/or maltreatment registered at the State Central Register.



The breakdown of indicated and unfounded and of NYC and “Rest of State” cases in 2006 is shown on Table 1 below. (“Undetermined” in this context refers to reports that were made to the SCR in 2006, but where the investigation was still in progress when the data was compiled in March 2007.)

Table 1 - Reports Made to the State Central Register in 2006¹

	NYC		Rest of State		Total	
	#	%	#	%	#	%
Indicated	24,035	39%	25,785	27%	49,820	32%
Unfounded	37,423	60%	63,534	67%	100,957	64%
Undetermined*	880	1%	5,750	6%	6,630	4%
Total	62,338	100%	95,069	100%	157,407	100%

*Cases undetermined as of 3/1/2007

In 2006, there were a total of 178 fatalities reported to the SCR: 87 (49 percent) from NYC and 91 (51 percent) from “Rest of State” local departments of social services. Three of these fatalities were foster care children whose deaths were also reported to the SCR.

Non-reported Foster Care Fatalities

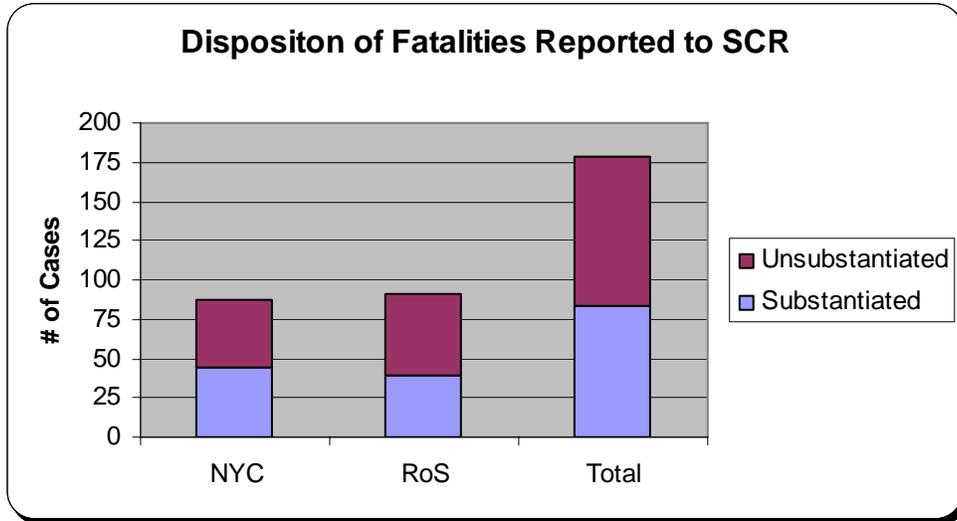
On December 31, 2006, there were a total of 27,191 children in foster care in New York State: 16,790 in the custody of the ACS in NYC, and 10,401 in the custody of a “Rest of State” department of social services². There were a total of 12 fatalities of children in foster care status in 2006, of which three were reported to the SCR and are included in this report in the SCR statistics. Of the nine foster care fatalities that were not reported to the SCR because their deaths raised no suspicions of abuse or maltreatment, four were from NYC, and five from other counties in the state.

2. Disposition

Table 2 shows the number of fatalities and the determination made about whether abuse and/or maltreatment contributed to the child's death. Fatalities reported to the SCR are considered substantiated if the investigating agency found some credible evidence that abuse or maltreatment contributed to the child's death and unsubstantiated if no such credible evidence was found by the investigating agency. A child is considered to be in foster care status if the child was in the care and custody, or custody and guardianship, of a local commissioner of social services or other authorized agency at the time of death. In the chart below, the totals for foster care fatalities are for those deaths of foster care children that were not reported to the SCR because there was no reasonable cause to suspect that abuse or maltreatment contributed to the child's death.

¹ Source: 2006 Monitoring and Analysis Profiles; Data as of 3/1/07

² Source: 2006 Monitoring and Analysis Profiles; Data as of 3/31/07



Three children whose deaths were reported to the SCR were in foster care status when they died. These fatalities are categorized in the report as SCR fatalities. Of the three:

- One NYC FC fatality was substantiated against a kinship foster care provider.
- One “Rest of State” IAB fatality of a foster child in an OMRDD facility was unfounded.
- One NYC fatality of a child whose custody was transferred to NYC after the child was injured and who died before leaving the hospital, was substantiated against the child's family of origin.

Table 2 Disposition	Number			Percent of All Fatalities		
	NYC	Rest of State	Total	NYC	Rest of State	Total
Total SCR Substantiated	44	39	83	48%	41%	44%
Total SCR Unsubstantiated	43	52	95	47%	54%	51%
Total SCR Fatalities	87	91	178	96%	95%	95%
Total FC Not Reported to SCR	4	5	9	4%	5%	5%
Total Fatalities	91	96	187	100%	100%	100%

3. Manner of Death

Table 3 shows the manner of death as determined by the Medical Examiner or Coroner responsible for the autopsy on a child. A case may be listed as having an undetermined manner of death if no autopsy was performed, the autopsy findings had not yet been issued at the time the Regional Office reviewed the case, or the autopsy report listed the manner of death as undetermined.

Table 3 Manner of Death	Number			Percent		
	NYC	Rest of State	Total	NYC	Rest of State	Total
Substantiated Fatalities						
Accident	7	9	16	16%	23%	19%
Homicide	25	19	44	57%	49%	53%
Natural Causes	3	3	6	7%	8%	7%
Suicide	0	1	1	0%	3%	1%
Undetermined	9	7	16	20%	18%	19%
Total Substantiated	44	39	83	100%	100%	100%
Unsubstantiated Fatalities						
Accident	5	22	27	12%	42%	28%
Homicide	0	1	1	0%	2%	1%
Natural Causes	11	21	32	26%	40%	34%
Suicide	3	1	4	7%	2%	4%
Undetermined	24	7	31	56%	13%	33%
Total Unsubstantiated	43	52	95	100%	100%	100%
FC Not Reported to SCR						
Accident	1	0	1	25%	0%	11%
Homicide	0	1	1	0%	20%	11%
Natural Causes	2	4	6	50%	80%	67%
Therapeutic Complications	1	0	1	25%	0%	11%
Total FC Not Reported Fatalities	4	5	9	100%	100%	100%

4. Cause of Death

Table 4 shows the causes of death for fatalities covered in this report. More than one cause of death could be recorded for a fatality. Causes of death are generally those that were listed in the Coroner's/Medical Examiner's report or the autopsy report. In a few instances, such as long-term and short-term illness/disease, Regional Offices were asked to group a specific cause of death into a more general category.

Table 4 Cause of Death	Substantiated	Unsubstantiated	FC Not Reported	Total
Asphyxiation/Suffocation/Strangulation	19	11	1	31
Child Abuse Syndrome	5	0	0	5
Congenital Condition	0	5	2	7
Dehydration/Malnutrition/Starvation	1	0	0	1
Drowning	8	6	0	14
Drug/Alcohol Consumption (child)	3	0	0	3
Falling	0	1	0	1
Fire-related	0	1	0	1
Gunshot	3	1	1	5
Hanging	0	4	0	4
Hyperthermia	0	1	0	1
Illness/Disease (long term)	3	10	2	15
Illness/Disease (short term)	3	10	1	14
Physical Trauma	27	5	0	32
Poisoning	1	1	0	2
Post-surgical Complications	0	0	1	1
Premature Birth	1	5	1	7
Shaken Baby Syndrome	5	0	0	5
SIDS	1	11	1	13
Stabbing	4	0	0	4
Undetermined	11	29	0	40

* More than one cause of death may be recorded for a fatality.

5. Circumstances Related to the Death

Table 5 shows the data for circumstances related to death as recorded by the OCFS Regional Offices for each fatality report. More than one circumstance could be selected for a fatality. Categories that were counted for one or more fatalities included:

- **None Noted:** OCFS indicated that there were no special circumstances of note.
- **Abandoned Infant:** This fatality involved an infant who had been abandoned by the parent or parents.
- **Cause/Manner Undetermined (No Autopsy Results Available):** In these fatalities, no autopsy was performed, or the autopsy or Medical Examiner's/Coroner's report was not available to the local department of social services or the OCFS Regional Office.
- **Cause/Manner Undetermined (Listed as Such By ME/Coroner):** In these fatalities, the autopsy or Medical Examiner's report listed the cause and/or the manner of death as undetermined. In other words, the Medical Examiner/Coroner could not establish an exact cause of death, or the Medical Examiner/Coroner could not come to a conclusion about the manner of death.
- **Bathtub-Related Death:** In these fatalities, the child died while unsupervised in a bathtub or otherwise died while being bathed.

- **Choking:** In these fatalities, the child choked on a foreign object.
- **Concealed Pregnancy/Unattended Birth:** These fatalities involved the death of a newborn infant whose mother had concealed her pregnancy from friends and family members and had given birth at home without medical attendance.
- **Domestic Violence History in Family (did not contribute to death):** In these fatalities, there was a history of domestic violence between adults in the household. However, in these cases the child's death was not directly attributable to the domestic violence.
- **Domestic Violence Contributed to Death:** In these fatalities, a subject's domestic violence actions played some role in the child's death.
- **Subject's Drug/Alcohol Abuse History (did not contribute to death):** In these fatalities, one or more of the caretakers had a history of abusing alcohol or drugs. However, in these cases, the child's death was not directly attributable to a caretaker's use of drugs or alcohol.
- **Subject's Drug/Alcohol Abuse Contributed to Death:** These fatalities involved subjects whose drug or alcohol use was implicated in the child's death.
- **FC Child on Home Visit:** The foster care child was on an approved home visit when he/she died.
- **Homicide by Parent or Primary Caretaker:** These fatalities involved homicide by the child's parent or the person who was the primary caretaker of the child.
- **Homicide by Other Household Member:** These fatalities involved homicide by a household member who was not the child's parent or primary caretaker.
- **Homicide by Non-Household Member or By Person(s) Unknown:** These fatalities involved homicide by an individual who did not reside in the child's household or in which the perpetrator of the homicide could not be identified.
- **Motor Vehicle Related:** These fatalities involved a child who died as the result of a motor vehicle accident or other motor vehicle related incident.
- **Caretaker Psychiatric Problems:** In these fatalities, the caretaker's psychiatric problems played a role in the child's death.
- **Sleeping Arrangements: Infant Co-Sleeping With Others:** These fatalities involved an infant who died while sleeping with one or more other people.
- **Sleeping Arrangements: Other Inappropriate Sleeping Arrangements:** In these fatalities, the child died while sleeping alone in defective or unsafe bedding or furniture.
- **Child With Special Needs:** In these fatalities, the deceased child had serious developmental, psychological or physical problems.
- **Substantiated Fatality: Inadequate Guardianship/Lack of Supervision:** In these fatalities, a parent's or caretaker's inadequate guardianship or lack of supervision of the child was implicated in the child's death. Inadequate

guardianship is the failure of a caretaker to exercise a minimum degree of care to safeguard the child.

- **Substantiated Fatality: Inadequate Food, Clothing, or Shelter:** In these fatalities, a caretaker's failure to provide adequate food, clothing or shelter contributed to the child's death.
- **Substantiated Fatality: Lack of Medical Care:** In these fatalities, there was a determination that a caretaker failed to obtain adequate medical care for the child, or delayed obtaining necessary medical care and that this contributed to the child's death.
- **Teen Parent:** These fatalities involved a parent who was a teenager.

Table 5 Circumstances Related to Death	Sub- stantiated	Unsubstantiated	Not Reported	Total
None Noted	0	25	2	27
Abandoned Infant	2	3	0	5
Cause/Manner Undetermined (No Autopsy Results Available)	5	7	3	15
Cause/Manner Undetermined (Listed as Such By ME/Coroner)	14	26	0	40
Bathtub-Related Death	2	0	0	2
Choking	0	1	1	2
Concealed Pregnancy/Unattended Birth	4	0	0	4
Domestic Violence History in Family (did not contribute to death)	7	8	0	15
Domestic Violence Contributed to Death	5	0	0	5
Subject's Drug/Alcohol Abuse History (did not contribute to death)	6	14	0	20
Subject's Drug/Alcohol Abuse Contributed to Death	9	5	1	15
FC Child on Home Visit	0	0	1	1
Homicide by Parent or Primary Caretaker	31	0	0	31
Homicide by Other Household Member	9	0	0	9
Homicide by Non-household Member or by Person(s) Unknown	4	1	1	6
Motor Vehicle Related	2	2	0	4
Caretaker Psychiatric Problems	7	0	0	7
Sleeping Arrangements: Infant Co-Sleeping With Others	13	21	0	34
Sleeping Arrangements: Other Inappropriate Sleeping Arrangements	4	10	0	14
Child With Special Needs	3	11	2	16
Substantiated Fatality: Inadequate Guardianship/Lack of Supervision	33	4	0	37
Substantiated Fatality: Inadequate Food, Clothing, or Shelter	3	1	0	4
Substantiated Fatality: Lack of Medical Care	10	0	0	10
Teen Parent	3	3	0	6

*More than one circumstance may be recorded for a fatality.

6. Age at Death

Table 6 shows the ages at death in years for children whose deaths are covered in this report.

Table 6 Age at Death in Years																				
Number	Under 1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18 or older	Total
Substantiated	41	13	6	5	3	1	0	2	1	1	1	0	2	1	0	3	3	0	0	83
Unsubstantiated	60	9	6	4	2	2	0	1	2	2	0	1	2	1	1	2	0	0	0	95
FC Not Reported	4	1	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	9
Total	105	23	13	9	5	3	0	3	3	3	1	1	5	2	1	6	3	0	1	187
Percent	Under 1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18 or older	Total
% of Substantiated	49%	16%	7%	6%	4%	1%	0%	2%	1%	1%	1%	0%	2%	1%	0%	4%	4%	0%	0%	100%
% of Unsubstantiated	63%	9%	6%	4%	2%	2%	0%	1%	2%	2%	0%	1%	2%	1%	1%	2%	0%	0%	0%	100%
% of FC Not Reported	44%	11%	11%	0%	0%	0%	0%	0%	0%	0%	0%	0%	11%	0%	0%	11%	0%	0%	11%	100%
% of Total	56%	12%	7%	5%	3%	2%	0%	2%	2%	2%	1%	1%	3%	1%	1%	3%	2%	0%	1%	100%

7. Prior Local Department of Social Services Contact with Family

The data collected for SCR fatalities included a number of questions relating to the family's involvement with local department of social services' programs prior to the fatality. The relationship "prior to the fatality" refers to the family's involvement with local services programs at the time of the incident that resulted in the child's death.

In some fatalities where an injured child does not immediately die, an investigation is initiated, custody of the child is transferred, or a services case is opened following the incident, but prior to the child's death. Services and investigations commenced between the incident and the death of the child are not treated as having been active "prior to the child's death."

Table 7 shows prior contacts for substantiated fatalities. A fatality may be counted in more than one category. The categories include:

Prior Article 10 Family Court Proceedings: Article 10 proceedings are Family Court proceedings where judicial intervention is sought because of abuse or neglect.

Other Family Court Proceedings: In these substantiated fatalities, the family had been involved with Family Court proceedings other than Article 10 proceedings prior to the incident that led to the child's death.

Child in Foster Care at Death: The child in a substantiated fatality was in foster care status at the time of the incident that led to his/her death. Only one of the two substantiated foster care fatalities is reflected in this total. The other substantiated foster care fatality involved a child whose custody was transferred to the local social services' commissioner as a result of injuries inflicted by the child's family of origin.

Subject Received Services as a Child: In these substantiated fatalities one or more of the adult subjects of the fatality report had been part of a services case as a child or had been a child in a CPS investigation.

Prior CPS Investigations – Closed at Time of Death: In these substantiated fatalities, there had been another CPS investigation of the family completed (closed) prior to the incident that led to the child's death.

CPS Investigation – Active at Time of Death: In these substantiated fatalities, there was an active CPS investigation in progress at the time of the incident that led to the child's death.

Prior Child Welfare Services – Closed at Time of Death: In these substantiated fatalities, the family had previously received protective, preventive, or foster care services, but the services case was not open at the time of the incident that led to the child's death.

Child Welfare Services – Active at Time of Death: In these substantiated fatalities, the family had active protective, preventive, or foster care services cases open at the time of

the incident that led to the child's death.

Income Support/Medical Assistance: In these substantiated fatalities, the family had never had a services case, but received other assistance from the local department of social services prior to or at the time of the child's death. Such assistance could include programs such as Temporary Assistance to Needy Families, Food Stamps, and/or Medical Assistance.

No Prior Contact With Local Department of Social Services: In these substantiated fatalities, the family had no previous contact with local department of social services programs prior to the incident that led to the child's death.

Active Investigation and/or Active Services at Time of Death: This category includes any substantiated fatality in which there was an active services case or in which there was an open CPS investigation at the time of the incident that led to the child's death.

Prior and/or Active Investigations or Services at the Time of Death: This category includes any substantiated fatalities where the family had a past history of child welfare services, past CPS investigations, an active services case or an active CPS investigation at the time of the incident that led to the child's death. It does not include cases in which the only contact with child welfare services was that one or more of the adults in the family had received services or been part of a CPS investigation as a child.

Table 7 Prior Services and Assistance* (Substantiated Fatalities)	<i>Number</i>			<i>Percent of Substantiated</i>		
	NYC	Rest of State	Total	NYC	Rest of State	Total
Article 10 Family Court Proceedings	9	6	15	20%	15%	18%
Other Family Court Proceedings	4	6	10	9%	15%	12%
Child in Foster Care at Death	1	0	1	2%	0%	1%
Subject Received Svcs. As Child	7	6	13	16%	15%	16%
Prior CPS Investigations - Closed at Time of Death	15	15	30	34%	38%	36%
CPS Investigation - Active at Time of Death	4	5	9	9%	13%	11%
Prior Child Welfare Svcs. - Closed at Time of Death	3	3	6	7%	8%	7%
Prior Child Welfare Svcs. - Active at Time of Death	7	7	14	16%	18%	17%
Income Support/Medical Assistance	14	2	16	32%	5%	19%
No Prior Contact With LDSS	11	17	28	25%	44%	34%
Active Investigation &/or Active Svcs. Case at Time of Death	9	9	18	20%	23%	22%
Prior &/or Active Investigation or Svcs. At Time of Death	19	20	39	43%	51%	47%
Total Substantiated Fatalities	44	39	83	-	-	-

*Fatalities could be counted in more than one category.

8. Type of Out-of-Home Care

Most non-foster care children whose deaths are studied in this report died in their own homes. Children in foster care and a few children whose deaths were reported to the SCR died while being cared for in out-of-home settings by caretakers other than their family of origin. Table 8 shows the setting or type of care these children were in when they died.

Table 8 Type of Out of Home Care				
Children in Foster Care				
Disposition	Type of Care	NYC	Rest of State	Total
Not Reported	Kinship Foster Home	2	0	2
Not Reported	Non-Kin Foster Home	1	2	3
Not Reported	Agency Operated Boarding Home	0	1	1
Not Reported	Absent Without Leave	0	1	1
Not Reported	Other Type of Care	1	1	2
Substantiated	Kinship Foster Home	1	0	1
Substantiated	Other Type of Care	1	0	1
Unsubstantiated	Other Type of Care	0	1	1
Children in Other Out of Home Care				
Substantiated	Family Day Care	1	1	2
Substantiated	Informal Babysitting	2	0	2
Substantiated	Other Out of Home Care	0	1	1
Unsubstantiated	Family Day Care	1	0	1
Unsubstantiated	Other Out of Home Care	0	1	1

Five of the non-reported children in foster care and one non-foster care child were in other types of out-of-home settings, as follows:

Other Foster Care Placements

- Hospital - 1 FC Not Reported, and 1 substantiated fatality.
- Nursing and Rehabilitation Center - 1 FC Not Reported.
- OMRDD Residential Care facility - 1 unsubstantiated FC.

Other Non-Foster Care Placements

- Child in transit from day care provider to home - 1 unsubstantiated fatality.
- OCFS Limited Secure Detention - 1 substantiated non-foster care fatality.

9. Subjects' Relationship in Substantiated Fatalities

The CONNECTIONS system records a relationship for everyone in a report made to the SCR. Table 9 shows the relationship that was recorded for each confirmed subject in the 83 fatalities in which the fatality allegation was substantiated naming at least one of the child's caretakers as responsible. Fatality allegations could be substantiated naming more than one individual in the household as responsible.

Table 9 Subjects' Relationship in Substantiated Fatalities				
Category	Relationship	Female	Male	Total
Parent/Parent Figure	Parent	51	32	83
	Step-Parent	0	1	1
	Parent Substitute	1	22	23
	Guardian	1	0	1
Parent Total		53	55	108
Other Relatives or Household Members	Grandparent	5	2	7
	Other Family Member	1	0	1
	Unrelated Home Member	2	0	2
Other Relatives/Household Members Total		8	2	10
Out of Home Care Provider	Foster Parent	1	0	1
	Day Care Facility/Provider	3	0	3
	Child Care Worker	0	1	1
Out of Home Care Provider Total		4	1	5
Other Relationship		1	0	1

*Source: CONNECTIONS data as of 12/5/07.

10. Post-Fatality Activities and Actions

Table 10 shows the types of post-fatality activities that were pursued for all fatalities.

Temporary, informal removal of children: During the investigation of an SCR fatality, the local department of social services often seeks the caretaker's cooperation in having siblings cared for by a friend or relative while information about their sibling's death is being obtained.

Court ordered removal of children: A court order was obtained removing the surviving children from the custody of the parent/caretaker.

Voluntary closure of foster home: The foster parent voluntarily closed the foster home following the death of the child.

Action taken to de-license, de-certify, or otherwise close day care or foster care facility: Following the fatality, action was taken to close the foster care home or facility or the day care facility in which the child had died.

Coordination of fatality investigation with law enforcement: In many fatalities, it is necessary for the local department of social services' CPS investigator to coordinate the CPS investigation into the child's death with a simultaneous criminal investigation by law enforcement.

Caretaker arrested, indicted or convicted: One or more of the deceased child's caretakers was arrested, indicted or convicted in relation to the death.

Preventive/protective services provided to the family: Protective or preventive services were provided following the child's death on behalf of the deceased child's siblings or other children residing in the household.

Family offered services, but refused: The family was offered services following the death of the child, but refused the offer of services.

Family referred to services in the community: The family was referred to other services in the community.

Family moved outside of NYS following the fatality: The family left the jurisdiction of New York State by moving to another state or another country following the fatality.

Family provided with grief counseling and/or assistance with funeral costs: The family was provided with grief counseling and/or assistance with funeral costs following the death of the child. These services were sometimes provided by the local department of social services or by a voluntary agency with which the deceased child had been placed.

No significant post-fatality services noted: There were no services or activities of note following the child's death and the investigation into that death.

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Chart 10 Post-Fatality Activities	NYC	Rest of State	Total	NYC	Rest of State	Total
Substantiated Fatalities	<i>Number</i>			<i>Percent of Substantiated</i>		
Temporary, informal removal of children.	5	3	8	11%	8%	10%
Court ordered removal of children.	15	12	27	34%	31%	33%
Action taken to de-license, de-certify or otherwise close DC or FC facility.	2	1	3	5%	3%	4%
Coordination of fatality investigation with law enforcement.	32	27	59	73%	69%	71%
Caretaker arrested, indicted or convicted.	12	16	28	27%	41%	34%
Preventive/protective services provided on behalf of surviving siblings and/or other children in household.	17	18	35	39%	46%	42%
Family offered services, but refused.	6	3	9	14%	8%	11%
Family referred to services in the community.	10	12	22	23%	31%	27%
Family provided with grief counseling and/or assistance with funeral costs.	17	12	29	39%	31%	35%
Family moved outside of NYS following the fatality.	2	1	3	5%	3%	4%
No significant post-fatality services noted.	2	3	5	5%	8%	6%
Total Substantiated	44	39	83	-	-	-
Unsubstantiated Fatalities	<i>Number</i>			<i>Percent of Unsubstantiated</i>		
Temporary, informal removal of children.	2	3	5	5%	6%	5%
Court ordered removal of children.	2	2	4	5%	4%	4%
Coordination of fatality investigation with law enforcement.	19	30	49	44%	58%	52%
Preventive/protective services provided on behalf of surviving siblings and/or other children in household.	13	10	23	30%	19%	24%
Family offered services, but refused.	8	9	17	19%	17%	18%
Family referred to services in the community.	10	12	22	23%	23%	23%
Family provided with grief counseling and/or assistance with funeral costs.	19	19	38	44%	37%	40%
Family moved outside of NYS following the fatality.	1	0	1	2%	0%	1%
No significant post-fatality services noted.	2	5	7	5%	10%	7%
Total Unsubstantiated	43	52	95	-	-	-
Not Reported	<i>Number</i>			<i>Percent of Not Reported</i>		
Voluntary closure of foster home	1	0	1	25%	0%	11%
Family offered services, but refused.	0	1	1	0%	20%	11%
Family referred to services in the community.	0	1	1	0%	20%	11%
Family provided with grief counseling and/or assistance with funeral costs.	3	3	6	75%	60%	67%
No significant post-fatality services noted.	1	1	2	25%	20%	22%
Total Not Reported	4	5	9	-	-	-

* More than one category could be chosen for a fatality.

11. Fatality Reports Containing Required Action

Regional Offices recorded information about the overall required action contained in each report on a fatality. Details are provided on Table 11a. More than one category could be selected for a fatality.

- **No Required Action:** There was no corrective action required or taken previously by the local department of social services or voluntary agency.
- **Locally Initiated Action:** The local department of social services or voluntary agency initiated its own corrective action prior to the issuance of the OCFS fatality report, to remedy the issue identified by OCFS.
- **Required Action:** The OCFS fatality report contained some form of required action.

Table 11b shows by category the agency that was required to take action as a result of the findings of the OCFS report on the fatality. Actions could be required of more than one type of agency in any given fatality case. Therefore, percentages do not necessarily add to 100 percent.

Table 11a Overall Required Action*	FC Not Reported to SCR		Reported to SCR (Including FC Reported to SCR)						Total	
			Substantiated		Unsubstantiated		Total SCR			
	#	% of Not Rptd.	#	% of Subst.	#	% of Unsubst.	#	% of SCR	#	% of Total
No Required Action	8	89%	23	28%	29	31%	52	29%	60	32%
Locally Initiated Corrective Action	0	0%	10	12%	9	9%	19	11%	19	10%
Required Action	1	11%	51	61%	59	62%	110	62%	111	59%
Total Fatalities	9	-	83	-	95	-	178	-	187	-

Table 11b Agency Taking or Required to Take Corrective Action*	FC Not Reported to SCR		Reported to SCR (Including FC Reported to SCR)						Total	
			Substantiated		Unsubstantiated		Total SCR			
	#	% of Not Rptd.	#	% of Subst.	#	% of Unsubst.	#	% of SCR	#	% of Total
No Required Action	8	89%	23	28%	29	31%	52	29%	60	32%
LDSS Investigating Fatality	0	0%	55	66%	63	66%	118	66%	118	63%
LDSS With FC Custody	1	11%	2	2%	0	0%	2	1%	3	2%
Vol. Agy. Providing FC	1	11%	1	1%	1	1%	2	1%	3	2%
Other	0	0%	2	2%	0	0%	2	1%	2	1%

*More than one category could be chosen.

12. Areas Requiring Action

When an OCFS review of a fatality report uncovers inadequacies in the performance of either a local department of social services or a voluntary agency, action may be required by the department or agency to correct the deficiency. In doing so, OCFS is exercising its statutory authority over local departments of social services and their contractual agents. Data was collected for fatalities on whether there was required action related to specific areas of concern. The data on the chart in this section indicate the total number of fatalities in which there was a required action in the specific area and the subtotals based on whether at least one of the fatality allegations was substantiated (“Substantiated”), whether all the fatality allegations were unsubstantiated (“Unsubstantiated”), or whether the case involved a foster care fatality that was not reported to the SCR (“Not Reported”).

Some areas are not applicable to all fatality cases. For example, decisions related to indicating and closing an investigation would not be applicable where investigations resulted in unsubstantiated allegations or to those cases where allegations were indicated and cases remained open for services. The number of cases in which the finding area could have been applicable is given in the column headed “Number Where Area Applicable.”

Table 12 Areas Where Corrective Action Was Required	Sub- stantiated	Unsub- stantiated	FC Not Reported	Total	Number Where Area Applicable
1 Were cause and manner of death adequately determined?	1	1	0	2	187
2 Cooperation/coordination with or from the Medical Examiner/Coroner.	1	1	0	2	181
3 Adequacy of case recording.	11	9	0	20	187
4 Adequacy of case management or case coordination of the case at any time.	5	6	0	11	81
5 Adequacy of services following the fatality.	1	2	0	3	60
6 Adequacy of services prior to the fatality.	7	6	0	13	54
7 Adequacy of supervision of caseworkers at any time.	17	13	0	30	187
8 Mandated reporters appropriately reported suspected abuse or maltreatment of the child.	4	2	0	6	176
9 Timeliness of completion of CPS investigation of the fatality.	39	44	0	83	178
10 Adequacy of safety assessments following the fatality.	6	6	0	12	133
11 Appropriateness of the investigation determination.	2	11	0	13	178
12 Appropriateness of indicating and closing the fatality investigation.	1	0	0	1	67
13 Adequacy of CPS investigation of the fatality.	31	30	0	61	178
14 Adequacy of decisions and/or actions related to the placement of surviving minor children.	0	1	0	1	96
15 Cooperation with or from law enforcement.	2	2	0	4	173
16 Adequacy of CPS investigations preceding the fatality.	13	8	0	21	93
17 Adequacy of safety assessments preceding the fatality.	9	9	0	18	93
18 Appropriateness of indicating and closing a prior CPS investigation.	1	3	0	4	51
19 Reporting the foster child's death to the Regional Office.	0	0	1	1	11

13. Local Department of Social Services Listing of Fatalities

Table 13 lists the fatalities by type and disposition for each local department of social services and the St. Regis Mohawk Tribe. One of the fatalities involved an institutional abuse investigation conducted by the CQC on a child not in foster care. This unsubstantiated, non-foster care fatality has been included in the upstate totals. For SCR fatalities, the county assigned is the county in which the investigation of the fatality took place. For foster care fatalities, the county assigned is the local department of social services that had custody of the child, rather than the local department of social services of the county in which the child died.

Of the 58 local departments of social services in NYS, there were 24 in which there were no child fatalities and 35 in which there were no substantiated fatalities. Fourteen local departments of social services had one fatality, eight had two fatalities, and six had three fatalities. Six local departments of social services had more than three fatalities.

Table 13 County Listing of Fatalities	FC Not Reported to SCR	Reported to SCR			Total Fatalities
		Substantiated	Unsubstantiated	Total SCR	
ALBANY	0	3	0	3	3
ALLEGANY	0	0	0	0	0
BROOME	0	3	0	3	3
CATTARAUGUS	0	0	0	0	0
CAYUGA	0	1	0	1	1
CHAUTAUQUA	0	1	1	2	2
CHEMUNG	0	2	0	2	2
CHENANGO	0	3	0	3	3
CLINTON	0	1	0	1	1
COLUMBIA	0	0	2	2	2
CORTLAND	0	0	1	1	1
DELAWARE	0	0	0	0	0
DUTCHESS	0	0	0	0	0
ERIE	1	5	8	13	14
ESSEX	0	0	0	0	0
FRANKLIN	0	0	0	0	0
FULTON	0	1	0	1	1
GENESEE	0	0	1	1	1
GREENE	0	1	0	1	1
HAMILTON	0	0	0	0	0
HERKIMER	0	0	0	0	0
JEFFERSON	1	0	0	0	1
LEWIS	0	0	0	0	0
LIVINGSTON	0	0	0	0	0
MADISON	0	0	0	0	0

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Table 13 County Listing of Fatalities	FC Not Reported to SCR	Reported to SCR			Total Fatalities
		Substantiated	Unsubstantiated	Total SCR	
MONROE	0	1	5	6	6
MONTGOMERY	0	0	0	0	0
NASSAU	0	2	3	5	5
NIAGARA	0	0	0	0	0
ONEIDA	0	1	1	2	2
ONONDAGA	1	0	2	2	3
ONTARIO	0	1	0	1	1
ORANGE	0	1	0	1	1
ORLEANS	0	1	0	1	1
OSWEGO	0	0	0	0	0
OTSEGO	0	0	1	1	1
PUTNAM	0	0	0	0	0
RENSSELAER	0	0	0	0	0
ROCKLAND	0	0	2	2	2
ST. LAWRENCE	0	1	2	3	3
SARATOGA	0	0	0	0	0
SCHENECTADY	0	0	0	0	0
SCHOHARIE	0	1	0	1	1
SCHUYLER	0	0	1	1	1
SENECA	0	0	0	0	0
STEUBEN	0	0	1	1	1
SUFFOLK	1	6	3	9	10
SULLIVAN	0	0	0	0	0
TIOGA	0	0	0	0	0
TOMPKINS	0	0	0	0	0
ULSTER	0	1	2	3	3
WARREN	0	1	1	2	2
WASHINGTON	0	1	1	2	2
WAYNE	0	0	2	2	2
WESTCHESTER	1	0	12	12	13
WYOMING	0	0	0	0	0
YATES	0	0	0	0	0
ST. REGIS	0	0	0	0	0
Total Rest of State	5	39	52	91	96
NYC	4	44	43	87	91
Total Statewide	9	83	95	178	187

Appendices

Appendix A: Child Abuse and Maltreatment Definitions

Subject of the Report

The subject of the report must be one of the following:

- Parent of victim child(ren).
- Guardian of victim child(ren).
- Another person 18 years of age or older responsible for the victim child(ren)'s care at the relevant time.
- A director, operator, employee, or volunteer of a day care center, school-age child care program, family day care home, group family day care home, day services program, or congregate care facility or a foster parent caring for the victim child(ren).

Abused Child

The facts of the case must satisfy the elements of the statutory definition of an abused child as set forth below:

- | | |
|--|--|
| <input type="checkbox"/> Subject of the report inflicts or allows to be inflicted on A CHILD LESS THAN 18 YEARS OF AGE physical injury by other than accidental means. | AND Such action causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ. |
|--|--|

OR

- | | |
|---|---|
| <input type="checkbox"/> Subject of the report creates or allows to be created a substantial risk of physical injury to A CHILD LESS THAN 18 YEARS OF AGE by other than accidental means. | AND Such action would be likely to cause death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ. |
|---|---|

OR

- | |
|--|
| <input type="checkbox"/> The subject of the report: commits or allows to be committed a sex offense as defined in article 130 of the Penal Law; allows, permits or encourages the child to engage in any act described in sections 230.25, 230.30 or 230.32 of the Penal Law; commits any of the acts described in section 255.25 of the Penal Law; or allows the child to engage in acts or conduct described in Article 263 of the Penal Law (the corroboration and age requirements set forth in Article 263 do not apply). |
|--|

Maltreated Child

The facts of the case must satisfy the elements of the statutory definition of a maltreated child as set forth below:

1. The CHILD IS UNDER THE AGE OF 18 YEARS AND HIS OR HER physical, mental or emotional condition must have been impaired or placed in imminent danger of impairment;

AND

2. The subject of the report failed to exercise a minimum degree of care:
- in supplying adequate food, clothing, shelter, education, medical, dental, optometric or surgical care, though financially able to do so or offered financial or other reasonable means to do so; **or**
 - in providing proper supervision or guardianship; **or**
 - by unreasonably inflicting or allowing to be inflicted harm or a substantial risk of harm, including:
 - infliction of excessive corporal punishment; **or**
 - misuse of drugs or alcohol to the extent that the subject loses self-control of his or her actions; **or**
 - other acts of a similarly serious nature.

AND

3. There is a causal connection between 1 and 2 — The failure to exercise a minimum degree of care caused the impairment or imminent danger of impairment.

OR

- The subject of this report demonstrated intent to forego his or her parental rights and obligations as manifested by the subject's failure to visit or communicate with the child UNDER THE AGE OF 18 YEARS although able to do so.

OR

- The subject of the report inflicted serious physical injury upon A CHILD UNDER THE AGE OF 18 YEARS by other than accidental means.

Appendix B: Subject of Report Legal Definition

Subject of a Child Abuse or Maltreatment Report - SSL Section 412 (4)

"Subject of the report" means any parent of, guardian of, custodian of or other person eighteen years of age or older legally responsible for ... a child reported to the central register of child abuse and maltreatment who is allegedly responsible for causing injury, abuse or maltreatment to such child or who allegedly allows such injury, abuse or maltreatment to be inflicted on such child, or a director or an operator of or employee or volunteer in a home operated or supervised by an authorized agency, the division for youth, or an office of the department of mental hygiene or in a family day-care home, a day-care center, a group family day care home or a day-services program, or a consultant or any person who is an employee or volunteer of a corporation, partnership, organization or any governmental entity which provides goods or services pursuant to a contract or other arrangement which provides for such consultant or person to have regular and substantial contact with children in residential care who is allegedly responsible for causing injury, abuse or maltreatment to a child who is reported to the central register of child abuse or maltreatment or who allegedly allows such injury, abuse or maltreatment to be inflicted on such child.

Person Legally Responsible – Family Court Act Section 1012(g)

"Person legally responsible" includes the child's custodian, guardian, and any other person responsible for the child's care at the relevant time. Custodian may include any person continually or at regular intervals found in the same household as the child when the conduct of such person causes or contributes to the abuse or neglect of the child.

Appendix C: Glossary of Abbreviations and Acronyms

ACS	Administration for Children's Services (NYC)
Agy.	Agency
AIDS	Acquired Immune Deficiency Syndrome
AWOL	Absent Without Leave
CCRS	Child Care Review Service – the primary computer system in which case information about foster care, adoption, and child welfare services is maintained.
CONNECTIONS	The primary computer system in which information about CPS Investigations and foster home licensing/certification is maintained.
CPS	Child Protective Services
CQC	NYS Commission on Quality of Care and Advocacy for Persons With Disabilities
DOH	(New York State) Department of Health
FC	Foster Care
IAB	Institutional Abuse Investigation: IAB investigations are child abuse investigations conducted by OCFS and other state agencies on children who have been alleged to have been abused or maltreated in institutional settings.
LDSS	Local Department of Social Services
NYC	New York City
NYS	New York State
OCFS	Office of Children and Family Services
OMRDD	NYS Office of Mental Retardation and Developmental Disabilities
PINS	Person in Need of Supervision
SCR	(New York) State Central Register (of Child Abuse and Maltreatment)
SIDS	Sudden Infant Death Syndrome
SSL	Social Services Law
Svcs.	Services
Voluntary Agency	As used in this report, the term voluntary agency refers to a non-governmental agency with which a local department of social services may contract for the provision of child protective or preventive services or foster care.