Informational Letter

| Transmittal: | 10-OCFS-INF-01 |
| To: | Commissioners of Social Services  
Child Fatality Review Team Coordinators (CFRT) and CFRT Partner Organizations |
| Issuing Division/Office: | Division of Child Welfare and Community Services |
| Date: | February 16, 2010 |
| Subject: | New York State participation in the National Center for Child Death Review (NCCDR) |
| Suggested Distribution: | Directors of Social Services |
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| Attachments: | This INF supplies link (below) to NCCDR Child Death Review Case Reporting System 2.1 |
| Attachment Available Online: | Yes, on the NCCDR website:  
http://childdeathreview.org/reports/CDRCaseReportForm2-1-11009.pdf |
I. Purpose

The purpose of this Informational Letter (INF) is to provide social services districts (local districts) and local and regional child fatality review teams (CFRTs) with information about New York State’s participation in the National Center for Child Death Review (NCCDR) Case Reporting System. Participation in NCCDR provides New York State with the opportunity to improve data collection efforts. This will help identify factors that contribute to child deaths, thus enabling targeted prevention interventions at the local, state and national level.

II. Background

In 1989, New York State amended sections 17 and 20 of the Social Services Law (SSL) pertaining to the investigation of the death of children. The new section 20(5) of the SSL originally required New York State, through the predecessor of the Office of Children and Family Services (OCFS), to investigate the cause and circumstances surrounding the death of a child whose care and custody and guardianship had been transferred to an authorized agency (foster care fatality); and in the case of a report of suspected abuse 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 also investigate the cause and circumstances surrounding the death of a child for whom the local district had an open or pending Child Protective Services and/or an open Preventive Services case.

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 CFRT, in accordance with section 422-b of the SSL; and
- Preparing and issuing an annual cumulative report concerning such deaths.

Section 422-b of the SSL authorizes CFRT review of child fatalities. CFRT reviews of child fatalities bring together community agencies to review and share information on child death events and identify risk factors in these deaths, which lead to greater collaborative efforts and improvements in child health and safety.

The NCCDR is a resource center for state and local child death review programs, funded by the federal Maternal and Child Health Bureau of the Health Resources and Services Administration. It promotes, supports, and
enhances child death review methodology and activities at the community, state and national levels. One primary resource of NCCDR is the provision of a comprehensive case reporting system for collecting, analyzing, and reporting child deaths reported to OCFS.

There are currently 27 states that use the NCCDR Case Reporting System to collect and analyze data on child deaths. NYS and two additional states are planning to participate in the near future.

NCCDR provides a Case Reporting System which is a Web-based instrument that will assist OCFS and CFRTs with the collection of comprehensive data on child deaths, including information on:
- The child, family, caretakers, and perpetrator;
- The types of actions taken during the investigation;
- The scene, incident, and background information on the cause of death, including the risk and protective factors;
- The services provided or needed as the result of the death;
- Descriptions of recommendations and the policies, practices, and other actions taken to prevent other child deaths; and
- Factors affecting the quality of a case review.

III. Program Implications

Adoption of the NCCDR data reporting system provides a comprehensive, nationally recognized data set that will expand the pool of knowledge about preventable child deaths at the a) individual fatality, b) local and statewide, and c) national levels.

a) Individual Level Implications: Child Fatality Report (6-month):

As a result of participation in NCCDR, the format of the Child Fatality Report (6-month) required by section 20(5) of the SSL referenced above will be revised to incorporate NCCDR data into the current state-specific requirements. The revised Child Fatality Report format will allow for more comprehensive and diverse information to be collected while significantly reducing time necessary for writing and issuing reports.

b) Local and Statewide Implications: CFRT reviewed fatalities and New York State Annual Report:

Data collection through the NCCDR Case Reporting System will support a stronger community-based approach to child protection. Detailed data related to causes and circumstances of child fatalities will play a vital role in the identification of the following:
- new or improved child health or safety programs
- community education programs
- new or revised agency policies
environmental or product safety modifications

c) National Implications:

Participation from 30 states, nationwide, will provide for the identification of factors contributing to child fatalities, thus increasing the opportunity for national prevention efforts.

Beginning in early February 2010, OCFS and NCCDR will provide a hands-on training program to all CFRT coordinators and regional office staff responsible for the review, writing and issuing of Child Fatality Reports.

OCFS will administer New York State’s participation in NCCDR. Collaboratively, OCFS and NCCDR will provide support services that will include the following:

- Website, protocol manuals, guides to effective reviews, and other printed resources
- Training and help desk support for the standardized NCCDR Case Reporting System
- Technical assistance, strategic planning and training to help implement and sustain prevention-focused CFRT process
- Consultation and connection to expertise in infant and child death investigation, bereavement support and other fatality related services
- Linkage of CFRT team programs to state and national maternal and child health, child abuse and injury prevention programs
- Coordination with other reviews, including fetal and infant mortality, domestic violence, serious injury

/s/ Laura M. Velez

Issued By:
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