New York State
Office of Children &
Family Services

2007 Annual Report on Child Fatalities

Gladys Carrión, Esq., Commissioner
David A. Paterson, Governor

Table of Contents

Appendices (Starting on Page 26)

I. Introduction

In 2007, the Office of Children and Family Services (OCFS) focused on a number of new strategies to better understand how and why children die in New York State. Such strategies not only serve to reduce preventable child deaths, but support OCFS performance improvement outcomes developed as a response to the Federal Child and Family Services Review (CFSR). Those performance improvement outcomes include reducing recurrence of child maltreatment, preventing placement in foster care and providing supports to the child welfare workforce in their service to children and families in New York State.

In accordance with Social Services Law (SSL)§ 20(5) a, [1]OCFS reviews child deaths within the mandated context of child welfare services:

- Deaths reported to the Statewide Central Register of Child Abuse and Maltreatment (SCR) that allegedly occur as the result of abuse or maltreatment,
- deaths that occur while the child is in foster care[2], or,
- deaths that occur while the child is receiving protective or preventive services.

It is important to note, however, that the majority of child deaths in New York State, do not require review by OCFS, but rather are tracked through the New York State Department of Health (http://www.health.state.ny.us/vital_records/). While OCFS's review of child fatalities occurring within the child welfare system fulfills statutory requirements, it is evident that prevention strategies on behalf of all children in New York State require a broadened perspective.

II. Strategies

Partnership

To better understand how and why children die in New York State, a working partnership between OCFS and the New York State Department of Health (DOH) broadened in 2007 to include a joint recommendation calling for the creation of a state level child fatality review team as a potential priority outcome. State level Child Fatality Review Teams (CFRTs) exist in 46 states and are typically used by public health agencies to oversee local and regional teams. The state level team is intended to better coordinate and oversee local teams, track and address team recommendations, and to develop systemic, policy and practice recommendations for child fatality prevention.

OCFS and DOH continued their "safe babies" campaign and throughout 2007, 'Babies Sleep Safest Alone' materials were distributed in both English and Spanish through a network of organizations having valuable relationships with families, caregivers and professionals. These relationships allow service providers to emphasize with families the importance of safe sleeping practices and incorporate materials with other

[1] For relevant text, see Appendix B, Social Service Law
[2] Child is in the care and custody or custody and guardianship of an authorized agency

resources and tools for family well being. For example, several NYS municipalities have adopted the practice of mailing out OCFS's materials to all parents of newborns along with birth certificates. To help keep infants safer in homeless shelters, "Babies Sleep Safest Alone" campaign materials were distributed to shelters across New York State.

Child Fatality Review Teams (CFRT)

In 2007, OCFS continued its work to strengthen and expand benefits of the retrospective child fatality review. Limited resources were used to strategically expand local teams to achieve more robust statewide CFRT representation. A Request for Proposals (RFP) was issued in 2006, offering funding for CFRTs. The goal for this RFP was to establish a team review of the death of any child whose care and custody or custody and guardianship had been transferred to an authorized agency, any child for whom child protective or preventive services had an open case, and, in the case of a report made to the Statewide Central Register, involving the death of a child. A CFRT in New York State is also allowed to review any unexplained or unexpected death of any child under the age of eighteen.

Local or regional fatality review teams are required to include, but need not be limited to, representatives from:

- County Child Protective Services (CPS)
- OCFS
- County Department of Health (or if locality did not have County Health Dept., 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 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)

A local or regional fatality review team may also include representatives from: Local Department of Social Services (LDSS), Mental Health agencies, Domestic Violence agencies, Substance Abuse programs, Hospitals, Local Schools and Family Court.

The Request for Proposal issued in 2006 was the first funding opportunity for teams since the legislature expanded confidentiality provisions for members. Persons who present information to a local or regional fatality review team are now provided immunity from civil and criminal liability for all reasonable and good faith actions and from questioning in any civil or criminal proceeding regarding any opinions formed as a result of a meeting of a local or regional CFRT. This would not prevent a person from testifying about information obtained independently of the team, or about information which is public information.

In addition, all meetings conducted, all reports and records made and maintained, all books and papers obtained by a local or regional fatality review team are confidential

and not open to the general public. Exceptions include a court order, an annual report or a fatality report (if the team chooses to complete such a fatality report or annual report). The release of any fatality report prepared by a local or regional fatality review team is governed by the provisions of SSL §20(5). No annual or fatality report can contain any individually identifiable information and must be provided to OCFS upon completion. OCFS continues to forward copies of all such reports as required by SSL § 422-b.

In response to the Request for Proposal issued in 2006, OCFS initiated funding contracts with nine county child fatality review teams: Chemung County, Columbia County, Monroe County, Nassau County, Oneida County/Madison County, Onondaga County, Oswego County, Putnam County, and Schoharie County. Added to the previously funded Westchester, Rensselaer and Oswego teams, the total number of teams funded in 2007 was 12. The Westchester team was the first team to write all required individual child fatality reports in their county in 2007.

OCFS staff have worked with teams in developing mission statement and goals, interagency protocols, confidentiality procedures, meeting requirements and applications for approval as required under §422-b. Program support included such activities as training members on aspects of investigation, writing child fatality reports, preventing child fatalities and recognizing indicators of child abuse and maltreatment.

Data Collection

To increase the utility, depth and clarity of OCFS's child fatality data collection, steps were initiated in 2007 to investigate OCFS's participation in the National Center for Child Death Review (NCCDR), as administered by the Michigan Public Health Institute. Data collection is currently facilitated by NCCDR in 27 states. In September of 2007, the Director of the National Center provided an overview of its data collection system and highlighted the potential benefit of the Case Reporting Tool in child death prevention to NYS CFRT's. The tool structures a more thorough and deliberate death review resulting in more comprehensive and consistent data. Participation with NCCDR would enable OCFS to more easily produce information needed to devise prevention strategies where there is evidence of need. The potential for comparison and collaboration with other states becomes more realistic. A foundation for alignment of data sets between OCFS and DOH finds its greatest possibility in the use of the NCCDR data tracking tool. OCFS is continuing its planning work to accomplish the goal of bringing NCCDR's system to New York State.

Education

To complement and support the "Babies Sleep Safest Alone" practice, another OCFS publication, entitled "Keeping Babies Safer" was finalized in 2007 and posted on the OCFS website. It is also available in OCFS Regional Offices and through New York Loves Safe Babies partners, including DOH. A copy can be found on the internet, at http://www.ocfs.state.ny.us/main/publications/#PreventiveServices.

Each year, the OCFS spearheads The Annual New York Loves Safe Babies event at Crossgates Mall in Albany, New York. This event is widely publicized and promotes techniques to prevent Shaken Baby Syndrome, Sudden Infant Death Syndrome and

Traumatic Brain Injury. The important role of fathers is emphasized at this event through activities and materials.

These strategies, including collaboration, CFRT development, robust data collection and continued community education broaden OCFS's understanding of how and why child deaths occur and create much needed community prevention activities. As strategies for child death prevention become clearer, the potential for proactive strategies for family well being is compounded. Community involvement and tools identifying best practice support our child welfare professionals in the field as they strive to keep children safe, prevent abuse and maltreatment and nourish the family unit to keep children in their own homes. Systemic change supporting the service workforce may result in better outcomes for family health, safety and well being.

III. 2007 Findings

A. Number of Child Deaths

According to DOH Vital Statistics for calendar year 2007, the estimated population of children under the age of 18 in New York State was 4,413,414. There were 2,426 child deaths in NYS in 2007. In accordance with legislative mandate, in 2007, OCFS reviewed investigations and reported its findings of a small subset of these deaths: 266 child fatalities or about 11% of all reported child deaths in New York State.

B. How Did These Deaths Become Known to OCFS?

The data on which this report is based comes from NYS's child welfare information system known as CONNECTIONS. In addition, information is gathered from local departments of social services and OCFS regional offices. Once collected, the information is collated and analyzed for the production of the annual report.

In 2007, OCFS was required to issue individual reports on a total of 266 reported child fatalities. These include 227 deaths alleged to have occurred as the result of abuse or maltreatment and registered as Child Protective (CPS) reports by the New York Statewide Central Register of Child Abuse and Maltreatment (SCR), and 39 child deaths whose families were receiving services from local Departments of Social Services (children in foster care, or with an open CPS or preventive services case).

The SCR registered 153,147 reports of alleged child abuse or maltreatment in 2007. The 227 child fatalities, alleged to have occurred as the result of abuse or maltreatment, comprised .15% of all SCR reports for 2007.

After a CPS investigation, eight of the children reported as fatalities to the SCR were determined to have been stillborn, could not be located or their existence could not be verified, leaving 219 verified deaths reported to the SCR.

Children who died while receiving foster care services in 2007 totaled 20, with six reported to the SCR. Three of the 20 foster care deaths were children

under the age of one, while eight were 12 or older at the time they died. The most frequently noted manner of death in this category was natural causes. In 2006, children who died while in foster care numbered 12, with three of those reported to the SCR.

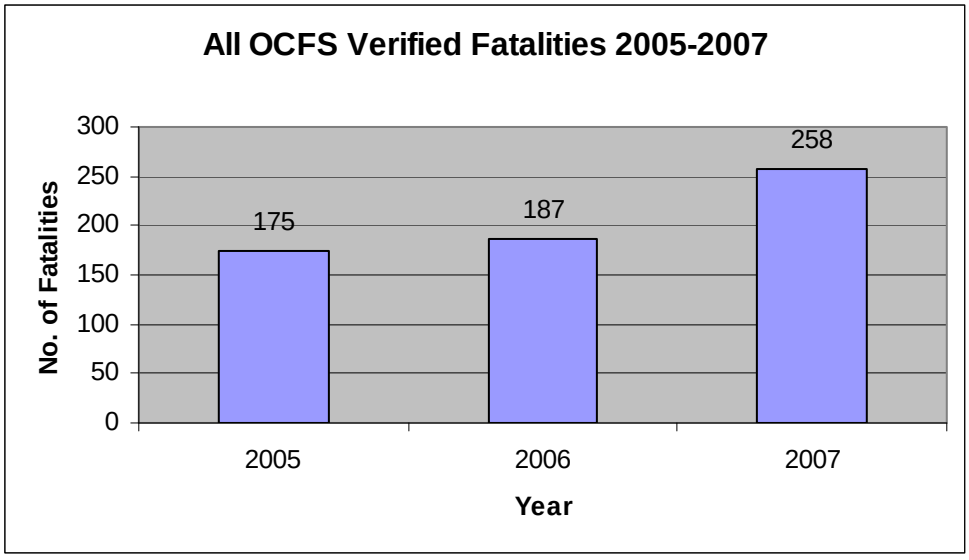
Children who died while their families were receiving preventive or protective services, and whose deaths were not suspected to be the result of abuse or maltreatment, totaled 25, or 11 and 14 respectively.

The number of children who died in 2007 while receiving child welfare services, then, including open protective, preventive and foster care services, but not alleged to have died from abuse or maltreatment, was 39.

The 2007 data reflects a 38% increase in child fatalities over 2006. The statutory change requiring OCFS to issue fatality reports for children with open CPS or preventive cases at the time of death took effect on December 14, 2006. In 2007, OCFS received 25 notifications of such deaths. These additional protective and preventive service case deaths in 2007 comprise 35% of the increase since 2006.

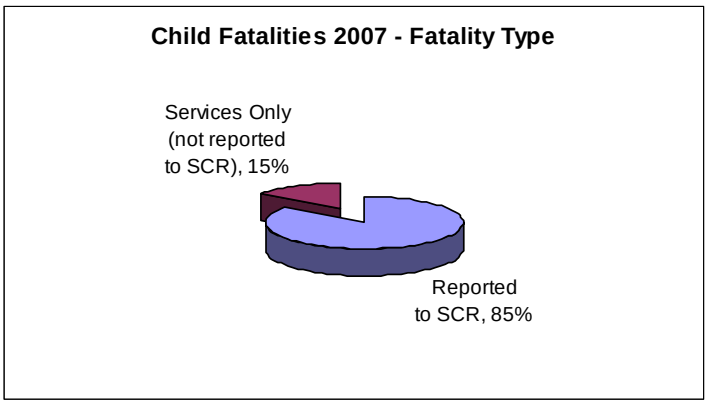
Consistent with shifting the focus from administrative oversight to child death prevention, information in this report will be based on individual child deaths rather than the number of case reviews conducted and individual reports issued.

In 2007, there were five cases in which more than one child's death was reported, and one instance where a single child's death was reported and investigated twice because additional information became available. The data presented here are based on the 219 verified deaths reported to the SCR and the 39 deaths of children in service cases, or a total of 258 child deaths.



Children whose deaths were reported to the SCR because there was a reasonable cause to suspect that the death was due to abuse or maltreatment constituted 85% of all child deaths reviewed by OCFS in 2007.

The children who died while their families were receiving preventive, foster care or CPS, but no report was made alleging that the deaths were the result of abuse or maltreatment, comprised 15% of the child deaths reviewed by OCFS in 2007.



The chart below shows the breakdown by number and type of reviews of verified child fatalities required by OCFS in 2007. The next chart shows a percentage breakdown by type.

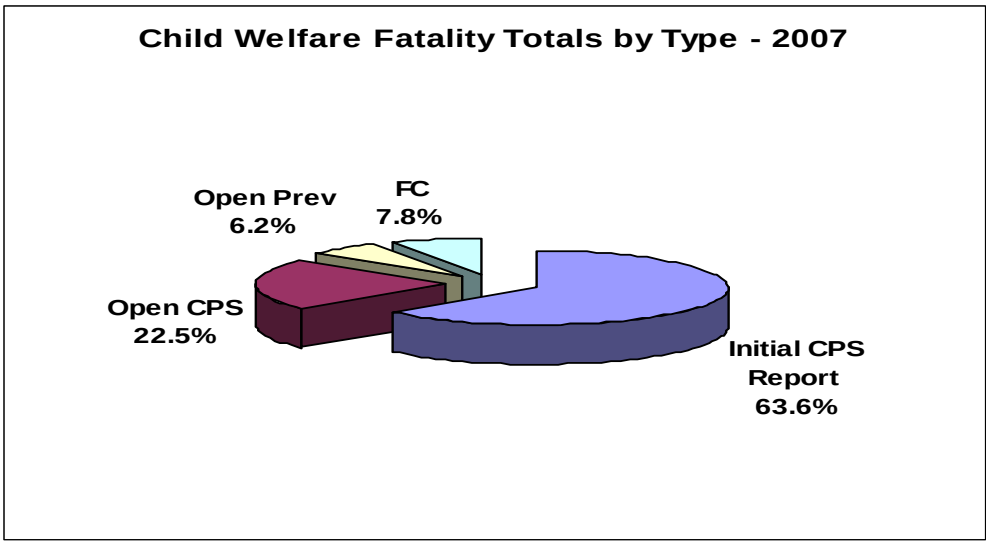
The first chart details that there were 55 instances where a child's death was alleged to have been the result of abuse or maltreatment while that child was either in foster care (6) or receiving preventive (5) or protective (44) services. Or, children were known to a local district and actively in receipt of child welfare services in 25% of the 219 child deaths alleged to have resulted from abuse or maltreatment.

A review of the data shows that in cases where child deaths were reported to the SCR, 87 (39%) had history of one or more prior indicated cases in 2007. Looking backward through 1999, the number with previously indicated cases rises to 48%.

2007 Child Fatalities
Actual Deaths by Type

Child Welfare Fatalities

Type	Reported to SCR	Services Only (not reported to SCR)	Total	Pct
Initial CPS Report	164	0	164	63.6%
Open CPS	**44**	14	58	22.5%
Open Prev	**5**	11	16	6.2%
FC	**6**	14	20	7.8%
Total	**219**	**39**	**258**	**100%**
Pct	**85%**	**15%**	**100%**	



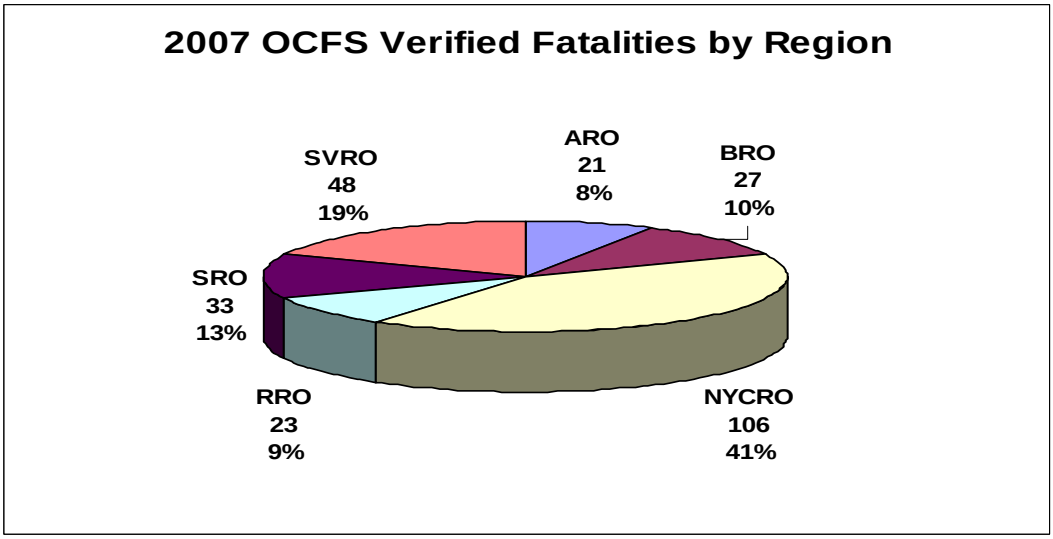
C. Regional Information

Fatalities by County

There were 12 counties statewide where no child deaths were reported to OCFS (See Appendix D-1, Fatalities by Jurisdiction 2007). All six OCFS regional offices covering the remaining 45 NYS counties and all five boroughs of New York City reviewed child deaths and issued reports in 2007. (See Appendix C-2, New York State Counties and Regions).

Fatalities by Region

The graph below shows the distribution of child deaths in the Buffalo (BRO), Rochester (RRO), Syracuse (SRO), Albany (ARO), Spring Valley (SVRO) and New York City (NYCRO) regional offices. [3]



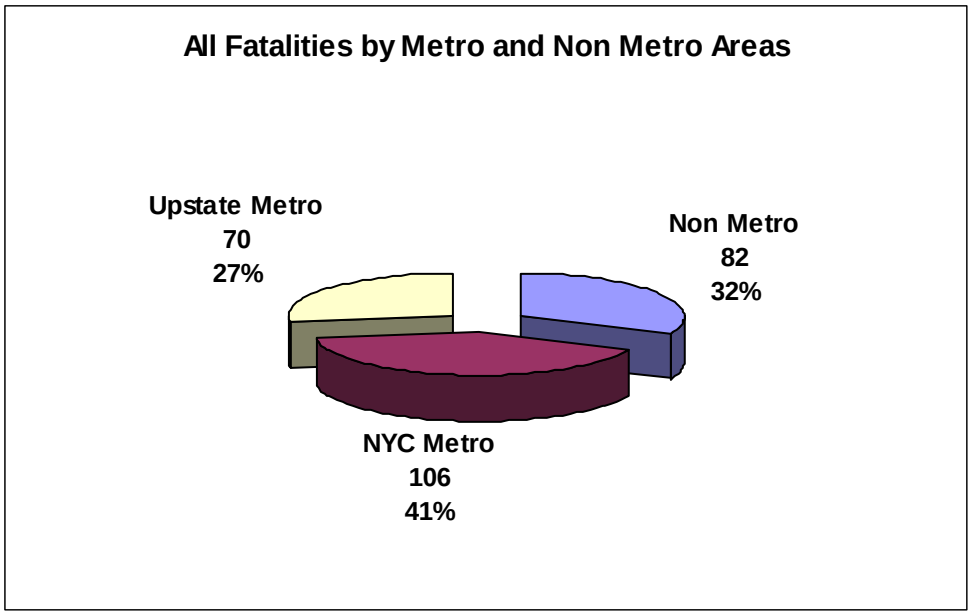
As expected, and consistent with past years, the New York City Region experienced the highest number of child fatalities reviewed by OCFS in 2007. (See Appendix D-1, 2007 Frequency by Jurisdiction.)

[3] Totals do not reflect reports issued on investigations of eight unverified deaths.

Fatalities by Metropolitan and Non Metropolitan Areas

For the purposes of this report, NYS metropolitan areas are defined as the five Boroughs of New York City, and the counties of Erie, Monroe, Nassau, Onondaga, Albany, Rensselaer, Schenectady (tri-county capital region), Rockland; Suffolk, and Westchester. With the exception of Rensselaer, which is included as part of the tri-county capital metropolitan area, counties were considered metropolitan areas if the population density in 2007 was greater than 500 people per square mile.*[4]

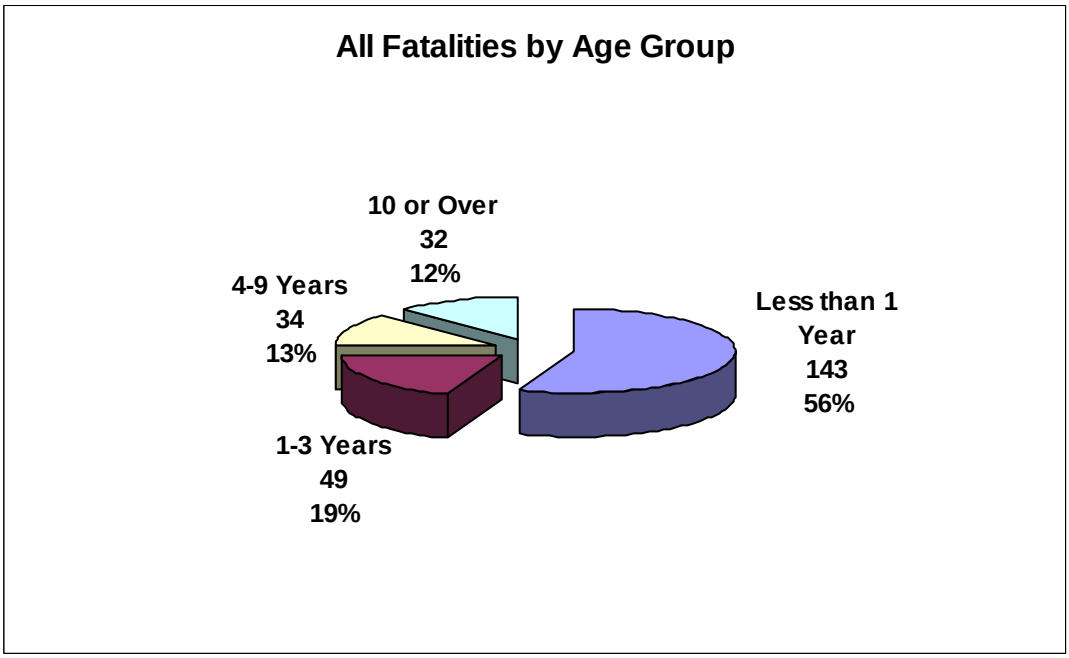
While about 78% of the population in NYS resides in metropolitan areas, just over 68% of the child fatalities reviewed by OCFS occurred in those geographic areas. Conversely, while about 22% of the population resides in non-metropolitan areas, about 32% of child fatalities reviewed by OCFS occurred in those areas. See below.



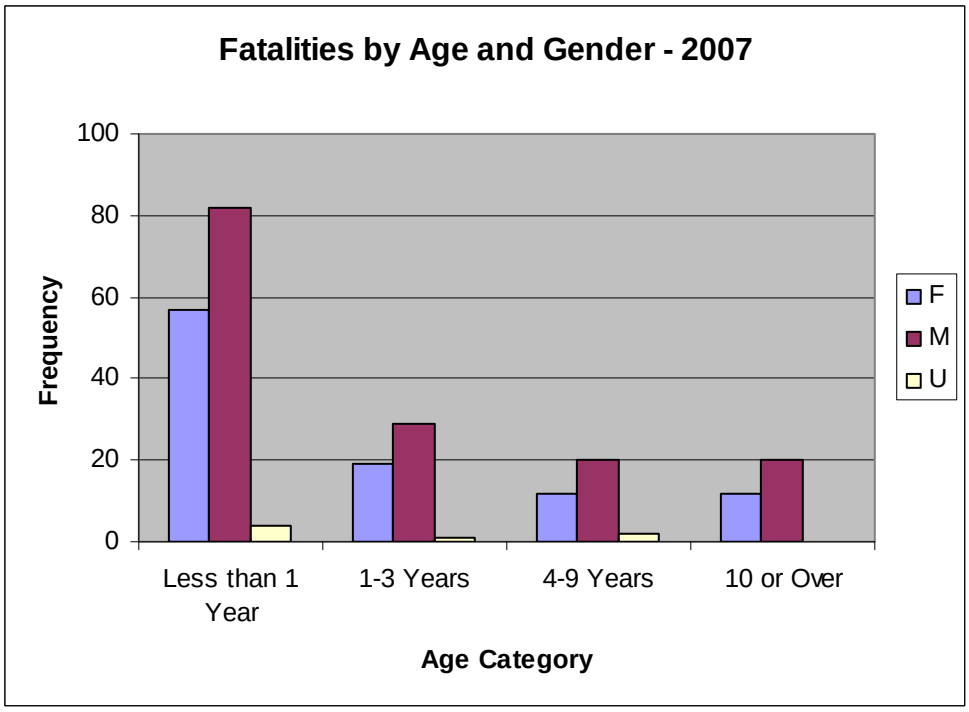
[4] NYS Health Dept. Vital Statistics

D. Age and Gender

The greatest percentage of child deaths, or 56%, occurred when the child was less than one year of age. The next highest age group reflected deaths of children aged 1-3. Together, these children made up 75% of all the verified deaths requiring OCFS review in 2007.

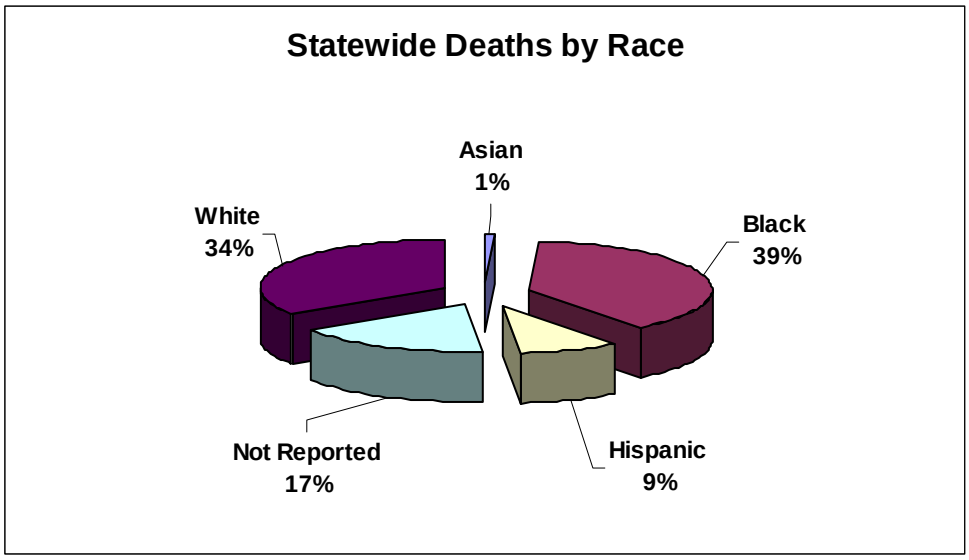


Of the 258 deaths discussed in this report, 151 (58%) were male children and 100 (39%) were female. In seven cases, gender information was not available.

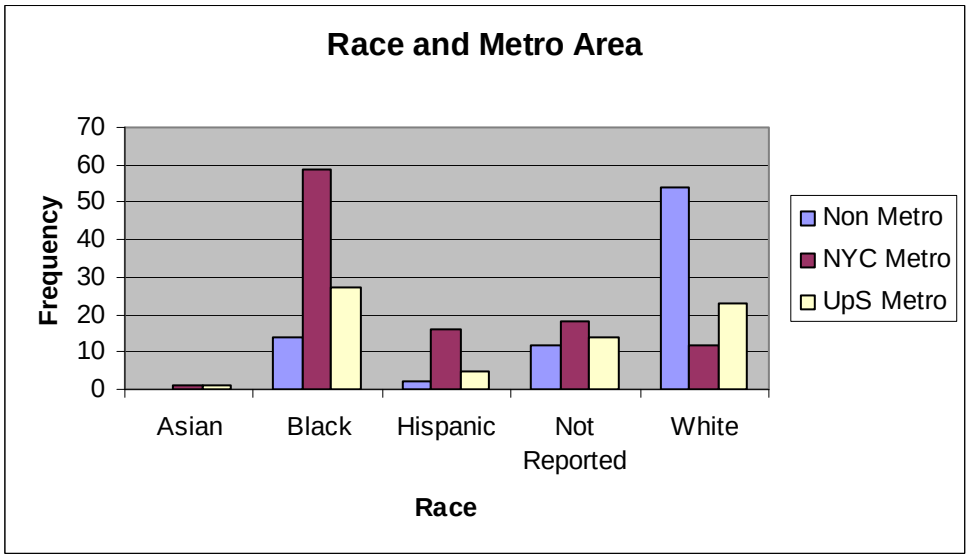


E. Race

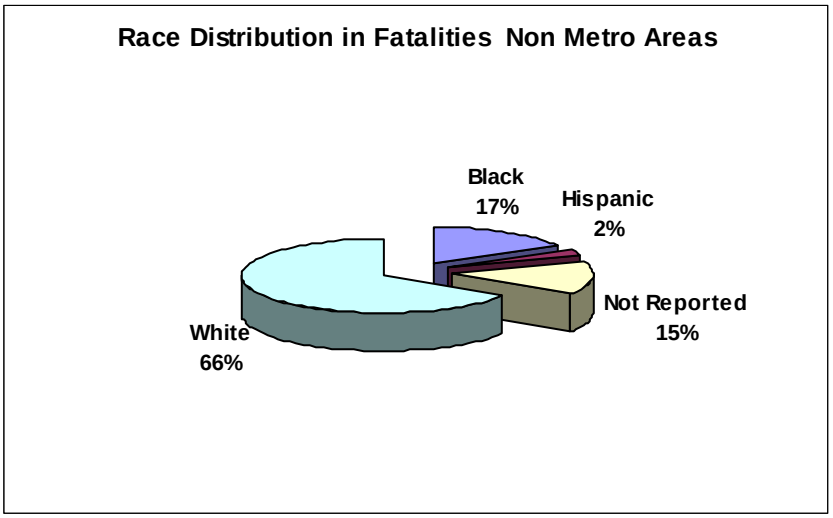
In 2007, New York State continued its inquiry into how the characteristics of race and ethnicity may correspond to families' involvement and experience in the child welfare system. The chart below details race/ethnicity information of verified child deaths in NYS in 2007.

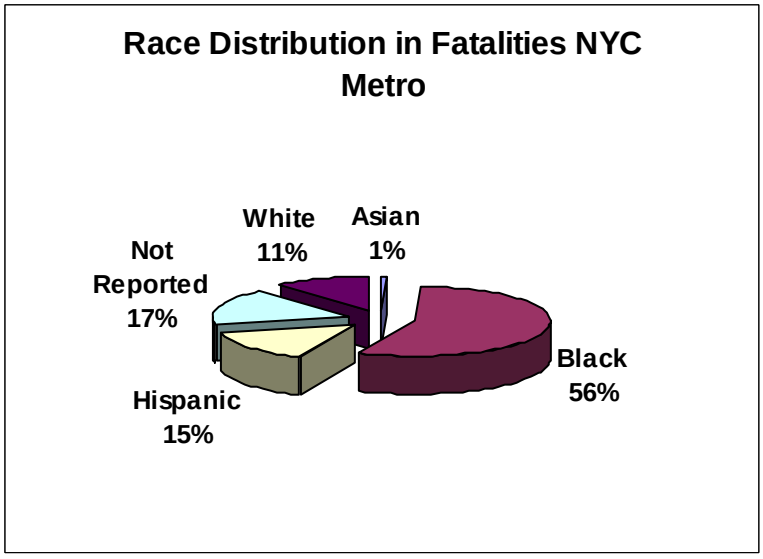


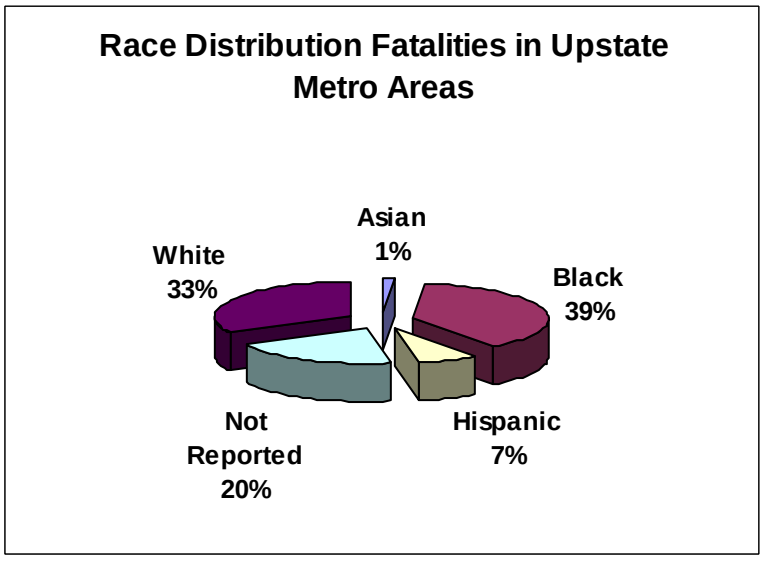
Based on available data, information about the race and ethnicity of the children who died in State metropolitan areas is detailed below.



Race and Metropolitan Areas vs. Non Metropolitan Areas



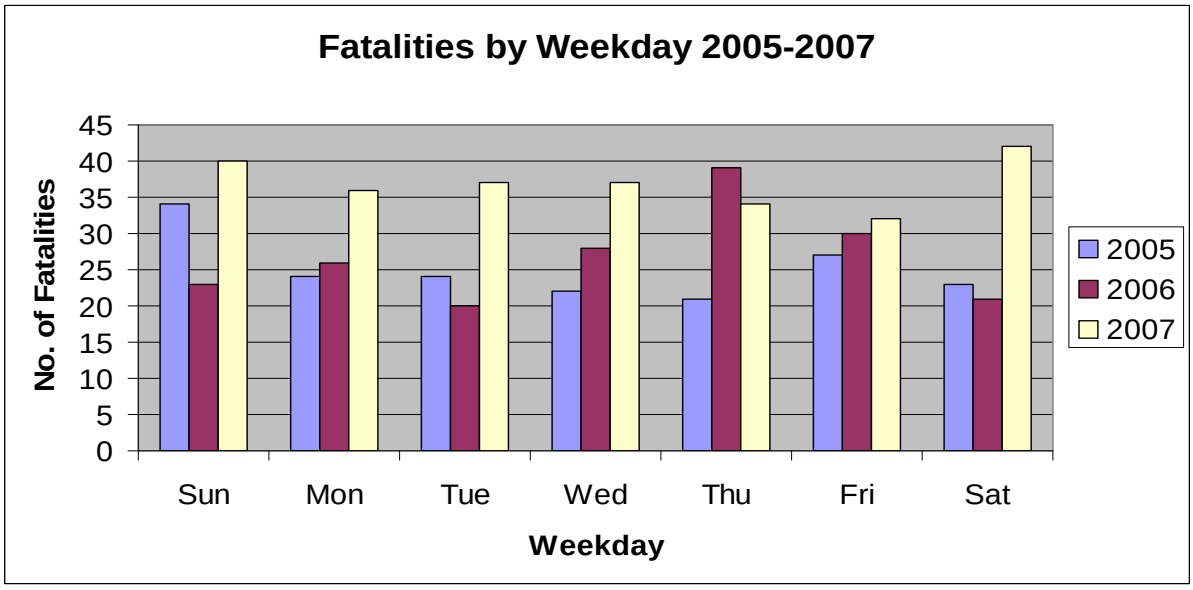




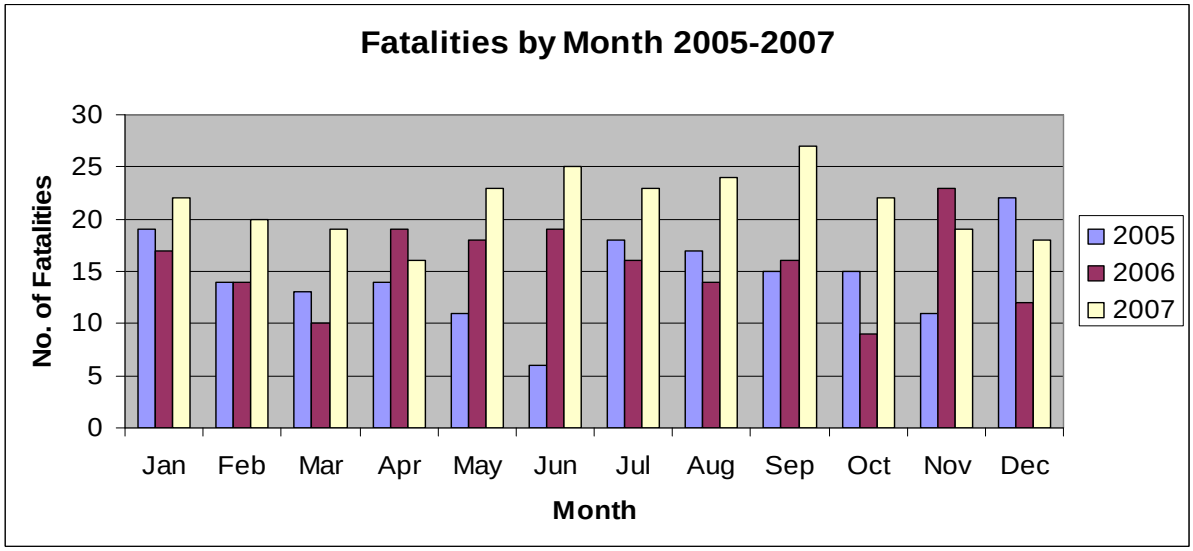
Based on the data collected, there appears to be a disproportionate number of child deaths among the black population, particularly in metropolitan areas. Some of the disparity may be due to the demographic makeup of the general population in these areas. This issue deserves a closer examination. It is hoped that new data collection methods and collaborations with other community agencies will allow for a more comprehensive analysis of the role of race in child fatalities in the future.

F. Weekday & Month

The 2007 data show that the percentage of deaths reported to have occurred on Saturday and Sunday nights is slightly higher than deaths reported to have occurred on other days of the week. This has not been consistent over past years.

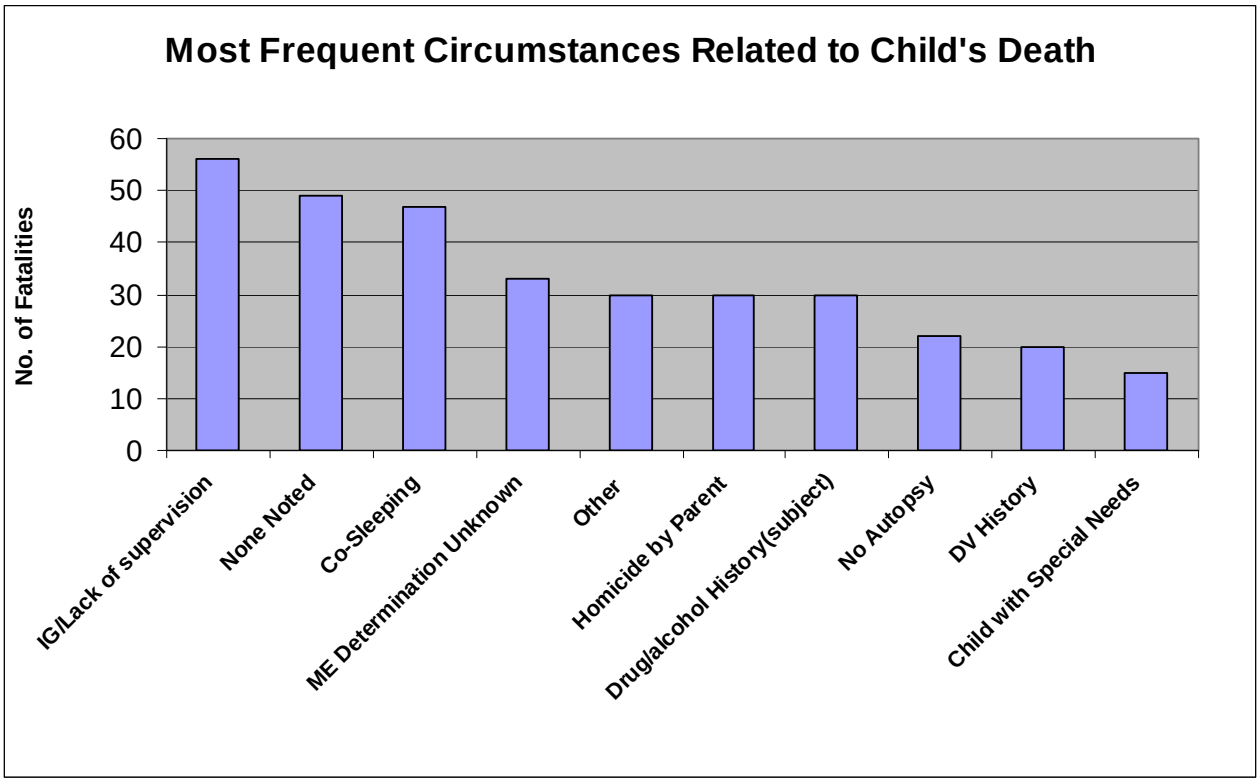


As detailed below, the highest monthly percentage of deaths reported in 2007 occurred between May and September. There does not appear to be consistency with previous years.



G. Circumstances of Death

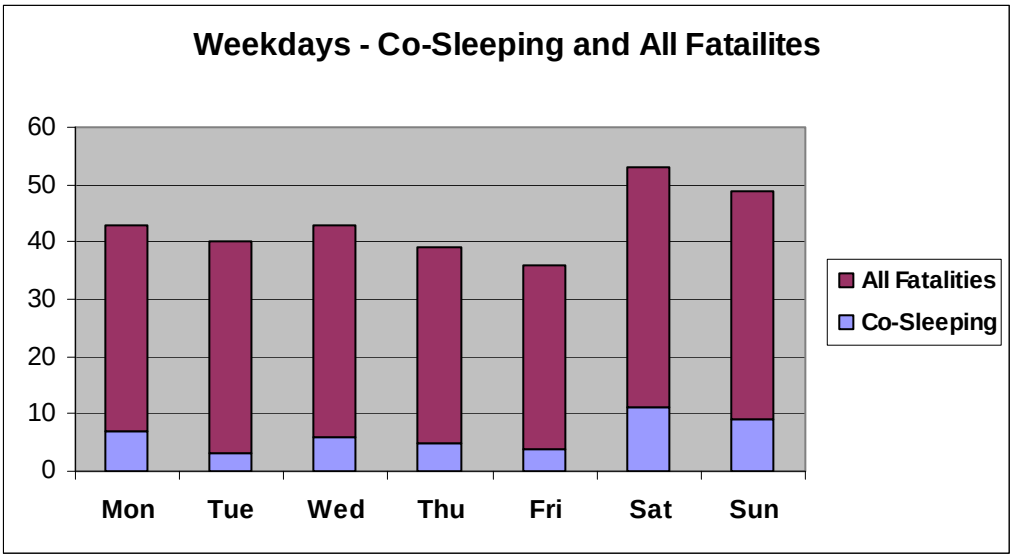
OCFS collects limited data on the circumstances of a child's death during the regional office review. Based on data collected, the most frequently found circumstance related to a child's death was the caretaker's failure to supervise or provide the minimum degree of care that would be expected of a responsible adult. (See definitions, Appendix D-4.) The next most frequently identified circumstance in 2007 was that the child was sharing a bed at the time the death was discovered.



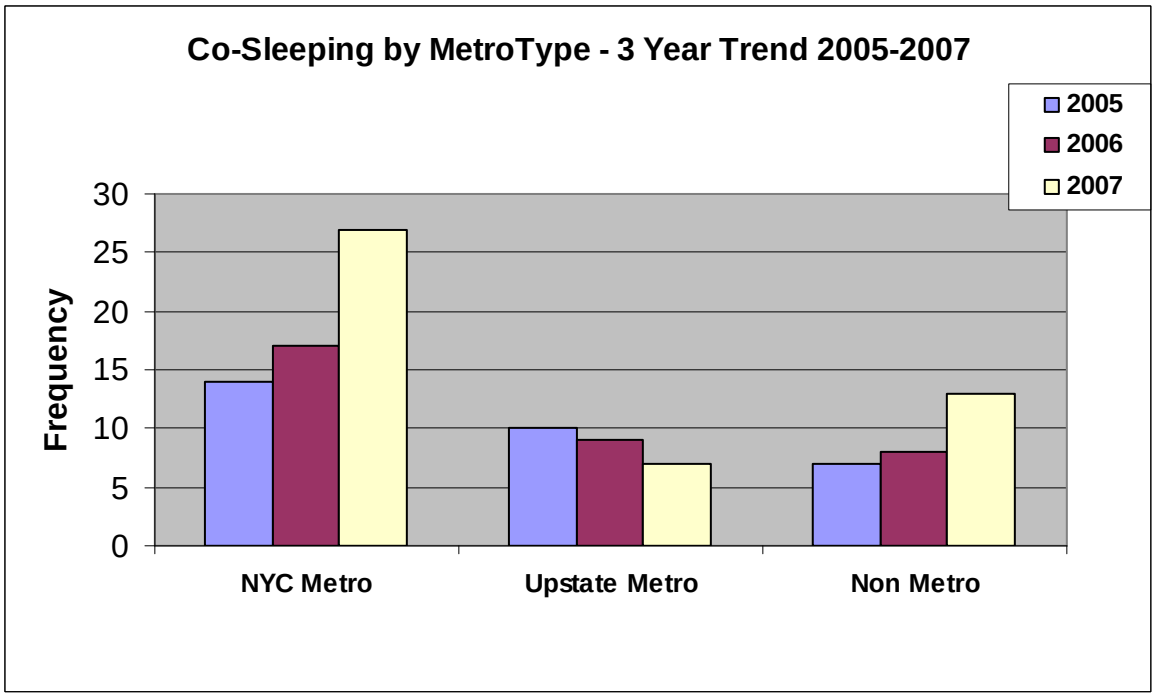
A complete list of data collected about circumstances can be found in Appendix D-5.

Co-Sleeping Deaths

OCFS identified 47 cases of infant deaths in 2007 where the child was sharing a bed with someone at the time the child's death was discovered. It appears that co-sleeping was a circumstance noted in a greater percentage of all deaths on the weekends.

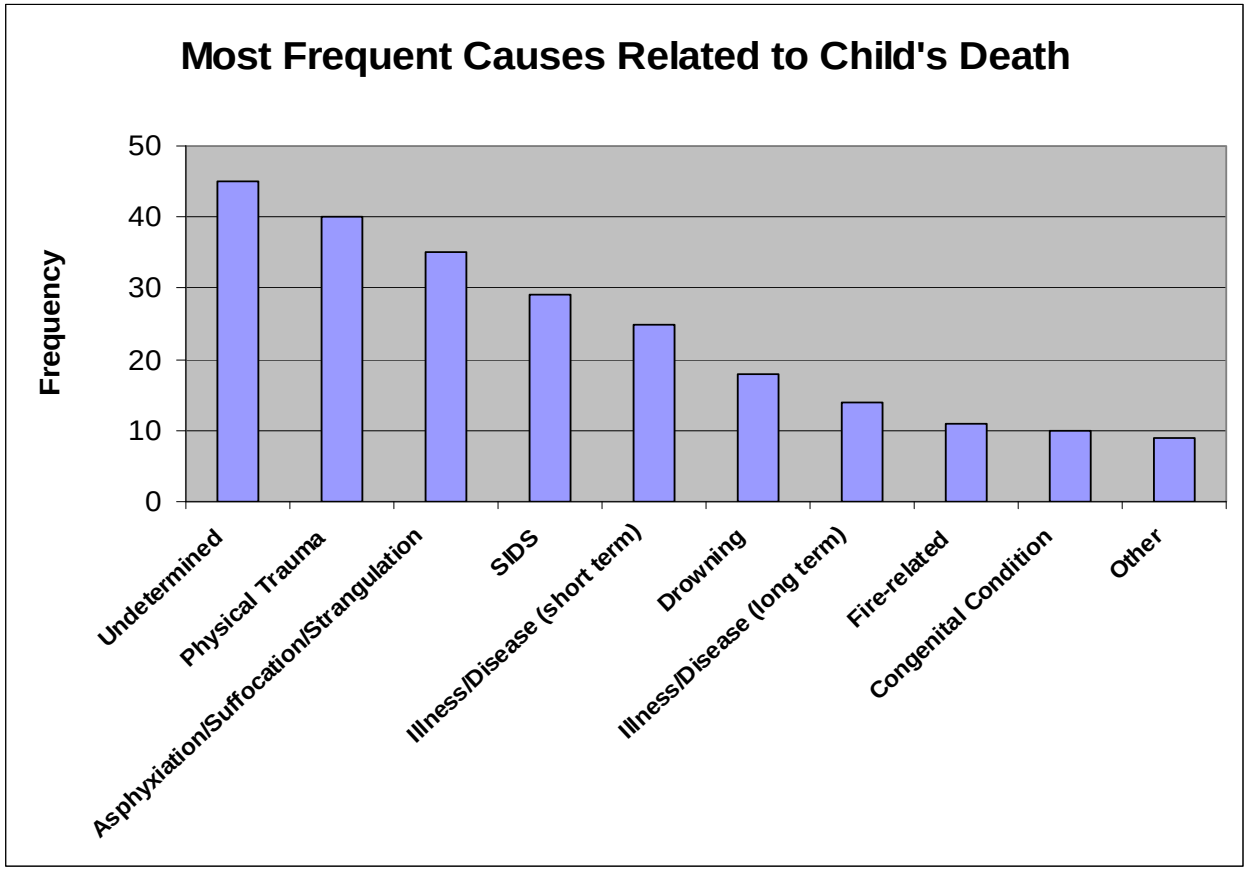


Bed sharing deaths are noted to have occurred more frequently in the NYC metropolitan areas. It is possible that the intensive and ongoing educational campaign in New York City may have resulted in more complete reporting of this circumstance in 2007.



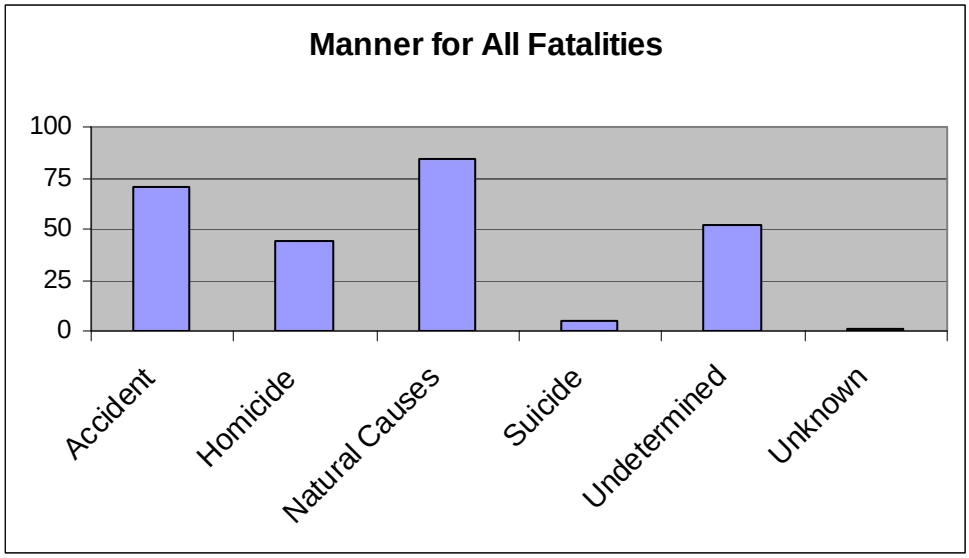
H. Cause and Manner of Death

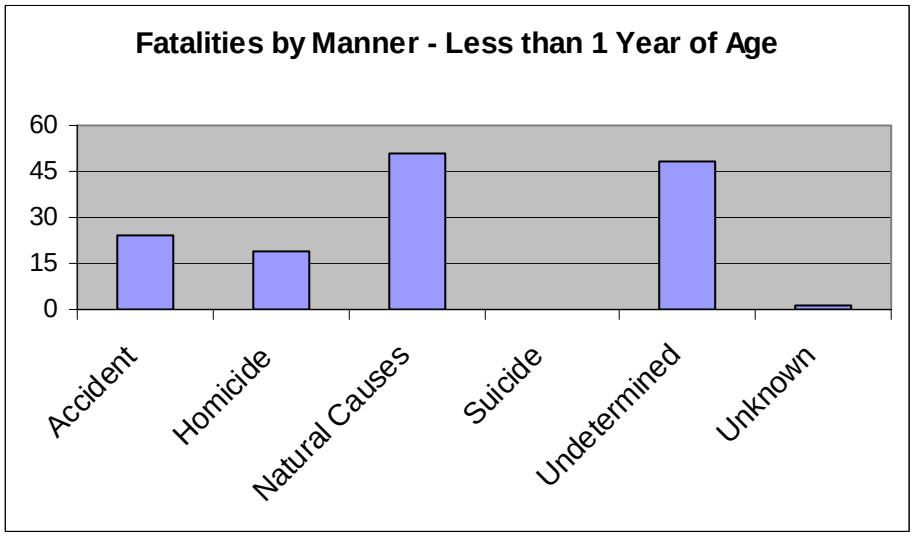
The chart below details the most frequent causes of death identified by the medical examiner or coroner involved in each child death case. The cause of death describes the physical cause, or why the child died, while the manner is a description of how the child came to be in that condition. A comprehensive list of causes of death in the 258 OCFS verified reports can be found in Appendix D-6 at the end of this report.



Manner

Manner of death is generally determined by the medical examiner or coroner charged with review of the child's death, and is limited to six categories, as detailed below.



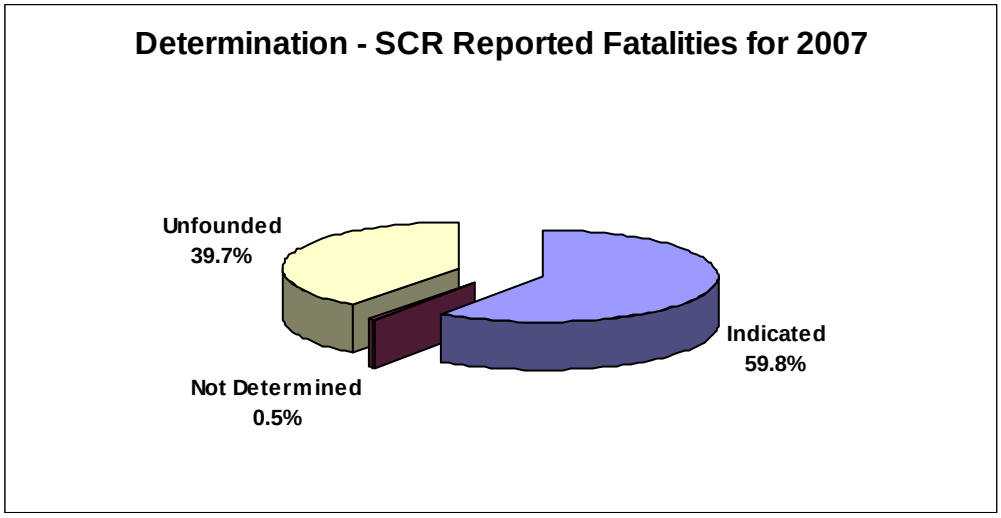


Of the OCFS child deaths occurring in 2007, there were 29 instances when Sudden Infant Death Syndrome (SIDS) was determined to be the cause of death. In 23 of those cases, the manner was determined to be 'natural causes' while in the other six, the manner was 'undetermined.' Such inconsistencies and the high incidence of 'undetermined' cause and manner suggests a need for more consistent information gathering in death scene investigation and review.

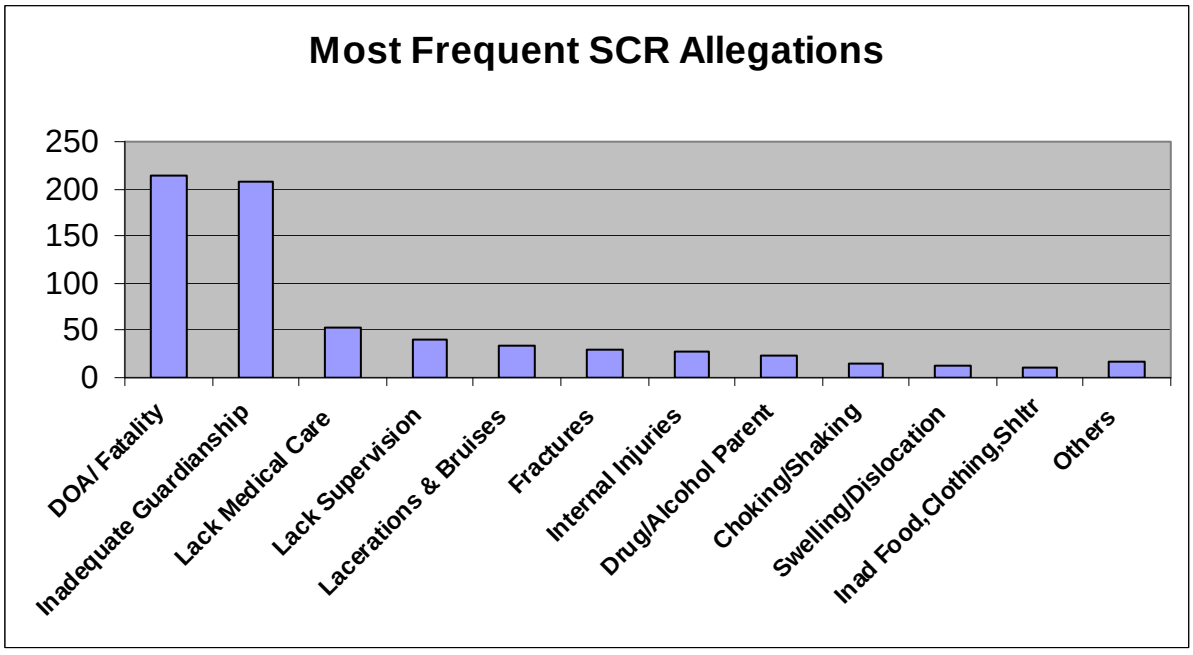
I. Deaths Reported to the SCR

Of the 219 verified deaths that were alleged to have been due to abuse or maltreatment, 131 (59.8%) investigations found some credible evidence to support one or more allegations, and the report was determined to be 'indicated'. These 131 indicated cases included 97 substantiated fatality allegations, and 34 cases where another allegation(s) was substantiated and where no credible evidence was found that the child's death was due to abuse or maltreatment.

Eighty-seven (87) of the SCR fatality reports were completely unfounded in that no credible evidence was found to substantiate either the fatality or any other allegation of abuse or maltreatment. See below.



The most frequently reported allegations associated with these reports are shown below.



A definition of the allegation named Inadequate Guardianship is included in Appendix C, Definitions. A complete list of reported allegations can be found in Appendix D-7 at the end of this report.

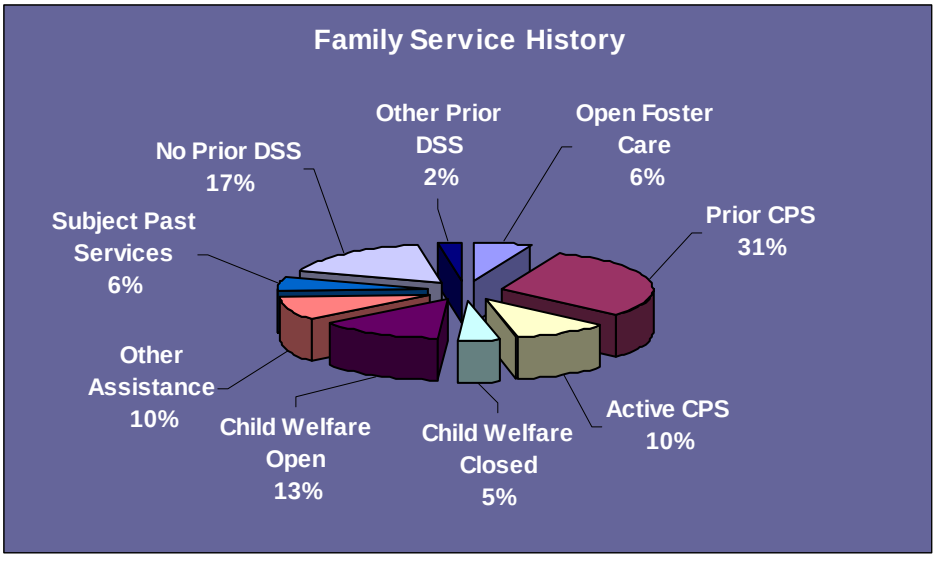
Below is a breakdown of how often a parent was determined to be the responsible party in indicated cases in which a child died.

Role Frequencies per Indicated SCR Fatality		
Role	**Freq**	**Pct**
Mother	**107**	**82.9%**
Father	**48**	**37.2%**
Mother -or- Father -or- both	**119**	**92.2%**
Step Parent -or- Parent Substitute	**11**	**8.5%**
Total No. of Indicated Deaths	**129**	
Frequencies do not add up to the Total and percents do not add up to 100% because in many cases MORE THAN 1 PARENT played a role in a fatality of the same child.		

J. Children Known to Local Departments of Social Services (LDSS)

Many of the families who suffered the death of a child were known to the local district department of social services before the death occurred. Some had been investigated previously by CPS; others had received preventive services or some other form of assistance.

In addition to the cases that were open and receiving services at the time the child died, families may have received some level of child welfare services in the past but their case was closed. In 180 cases (70%), the family had been known to child welfare services in at least one capacity before the child died. (See Appendix D-6.)

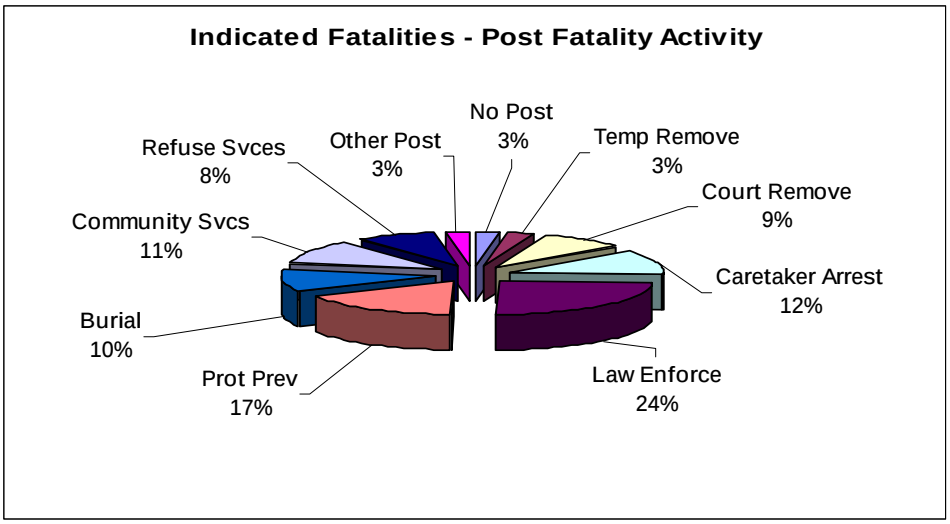


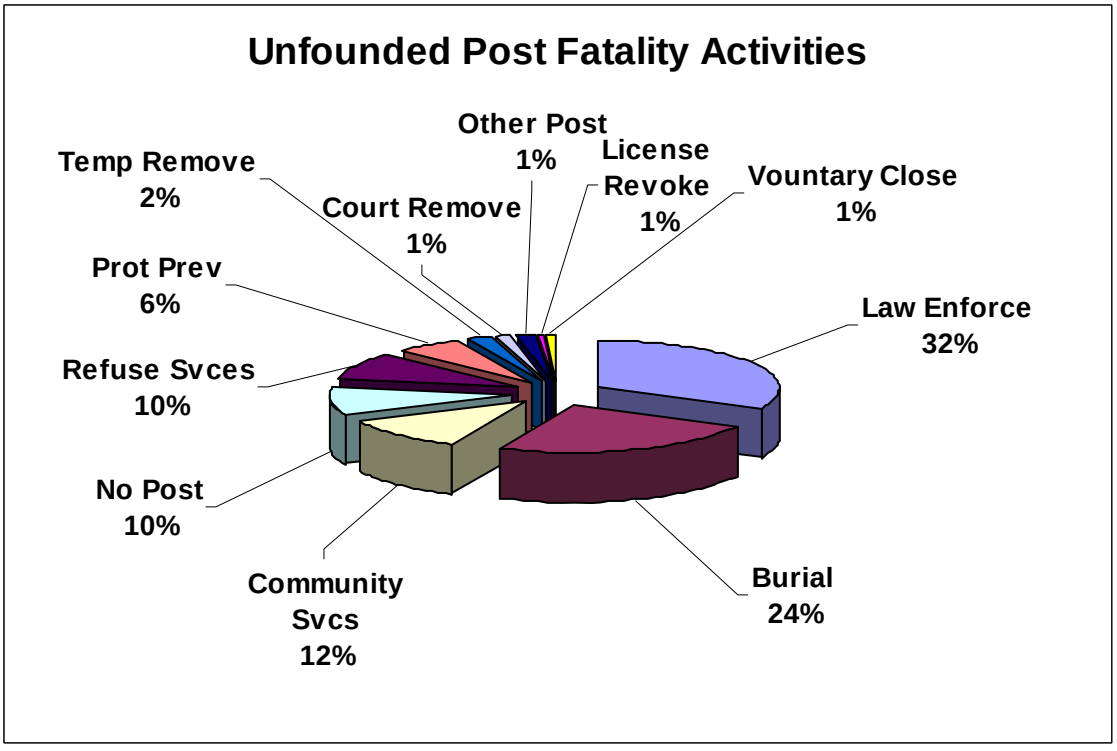
K. Post-Fatality Activities

When OCFS is notified that a child has died, an investigation is conducted and the safety of all surviving children is assessed. State law (SSL§424 (5-a) requires that local Child Protective Services coordinate a fatality investigation with law enforcement in the absence of a local multi disciplinary team; it may be determined that surviving children would be safer in another home for awhile or services may be offered to the family.

In cases where a child dies in a foster home or in a daycare or institutional setting, a review of regulations and licensing issues occurs.

Below is a snapshot of 2007 post fatality activities. (See Appendix D-7 for more detail.)





Use of community services by families in unfounded cases was marginally greater than that in indicated cases. However, in indicated cases, acceptance of protective or preventive services was more frequent.

On December 14, 2006, SSL § 424(5-a), as added by Chapter 494 of the Laws of 2006 took effect to add the requirement for a local CPS to provide notice to and jointly investigate with law enforcement, where a report of suspected child abuse or maltreatment alleges physical abuse, sexual abuse or death of a child. The data show that this occurs only 24% of the time for cases that are indicated, and 32% of the time when unfounded, far less then the required 100% of reported child fatality cases.

L. Required Actions

Once an investigation into the death of a child has been conducted by the responsible agency, usually the local department of social services, the corresponding OCFS regional office or approved CFRT reviews the steps taken in the investigation and issues the fatality report.

This retrospective review allows for identification of areas where community agencies may be in need of training or support. Where child fatalities are reviewed by CFRTs, corrective actions may be required of any participating community stakeholder.

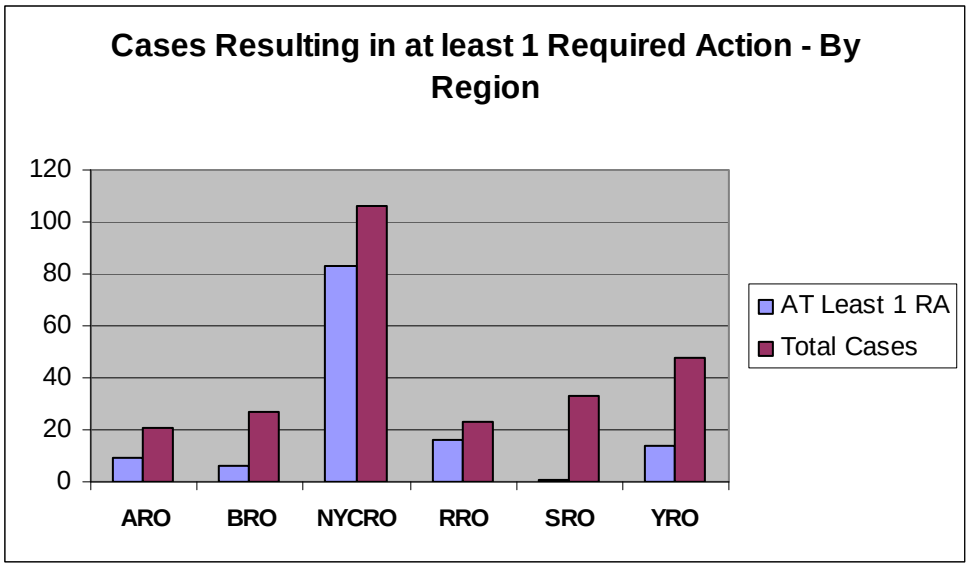
OCFS Regional offices are limited in their authority to make recommendations for administrative or policy changes for other agencies after reviewing a fatality investigation. As the supervising agency of the local departments of social services, OCFS may only require actions identified to improve practice of the local department of social services, voluntary authorized agencies and preventive programs under contract with the local department of social services.

New York State varies a great deal in geography and population, as well as in issues that affect the well being of children and families. Since children and family services are administered at the county level and supervised by the State, there are some variations in oversight style that develop within different regions.

The dense population and high frequency of reported child deaths in New York City has resulted in a partnership between the Administration for Children's Services and OCFS's NYC regional office that consistently documents ongoing efforts in pursuit of improvements. In less populous regions, improvement interventions can often be made during the course of the investigation or review, resulting in less frequently documented required action plans.

In 2007, there were 129 cases where no such required action was identified and 129 where some action was required. Required actions may include improvements to timeliness of actions or quality of investigations, staff training, development of protocols to address systemic issues, or other improvements as needed.

The most commonly noted findings were in regard to timeliness of investigation determinations and case recording, incomplete investigation activities and supervisory direction to the caseworkers. For a complete list, see Appendix D-26 Findings by Region.



IV. Recommendations

The 2007 child death data available for analysis by OCFS recommends the following actions to better position NYS to reduce preventable child deaths, prevent future child abuse or maltreatment, to support child welfare caseworkers in the field and to ultimately result in cost savings.

- Continue development of the OCFS/DOH partnership.
- Continue safe sleep and other educational campaigns.
- Establish a state-level Child Fatality Review Team. A statewide team can work, for example, to develop systemic intervention for the identified issue of parental substance abuse while caring for children and improper administration of over-the-counter treatments for young children by their caretakers.
- Pursue implementation of the NCCDR data collection system using the Child Death Review Case Reporting tool in order to provide the knowledge for effective prevention strategies. A body of consistent data will establish a baseline from which future courses of prevention can be implemented, and against which progress can be measured.
- Continue and increase support for the development and monitoring of local CFRT's and Multi-disciplinary teams.
- Strengthen the systemic network and oversight needed to address the 2006 mandate for a joint investigation of child fatalities by CPS and Law Enforcement.
- Enlist the participation of already established local multidisciplinary and child fatality review teams to collect required information to improve

death scene investigations and strengthen targeted interventions for families.

- Collaborate with DOH to facilitate training for Medical Examiners and Coroners for more consistent identification of the cause and manner of child deaths.
- Provide first responder training and field support for child death investigations to improve the recording and consistency of information related to the investigations. Consistency of the data supports development of preventive intervention strategies for child welfare caseworkers and the social service and law enforcement network.
- Investigate efficacy of an educational campaign for parents, death scene investigators and medical examiners on the inappropriate use of over the counter medication.
- In conjunction with the transformation of CONNECTIONS, the New York State system of record for child welfare cases, develop a mechanism for the automated tracking of all child welfare deaths including those that occur in cases where families are already receiving services.
- In addition to determining that mandates for investigation and review are satisfied, this automated tracking and collection of information can prove informative for service provision and planning. Evaluation of risk factors in such cases can prove effective particularly when a family has a child younger than one, the age where majority of unexpected child deaths occur.
- Support OCFS Regional Office review and monitoring of the cause and circumstance of each child fatality to determine the safety and well being of children, including surviving siblings.
- Support OCFS Regional Office monitoring of actions taken to prevent similar fatalities in the future by a review of individual and systemic accountability for actions taken prior and subsequent to the child's death. Establish a mechanism for referral to OCFS Ongoing Monitoring and Assessment unit to determine that these actions and recommended actions are not only identified but reviewed and coordinated across the state for action.

Appendices

Appendix A: Statutory Background

New York State enacted amendments in 1989 to SSL §§17(d) and 20(5), pertaining to reporting to the governor and the legislature on the findings of investigations of the death of children in New York State. In 2006, SSL §20(5) was again amended by Chapter 485 of the Laws of 2006 with regard to the investigation of child fatalities, to expand the categories of deaths for which fatality reports are required.

SSL §20(5) of the SSL now requires OCFS 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, i.e., the child is in foster care, (1989); or,
- in the case of a report made to the New York Statewide Central Register of Child Abuse and Maltreatment (1989); or,
- for whom Child Protective Services has an open or pending case (2006); and,
- for whom the local department of social services has an open or pending Preventive Services case (2006).

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

- 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 SSL §422-b (see below); and,
- preparing and issuing an annual cumulative report concerning such deaths.

Chapter 136 of the Laws of 1999 provided for the creation of local and regional fatality review teams pursuant to SSL §422-b of the SSL to do a retrospective review of the fatalities detailed above. 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. Such teams may prepare, and are not required to prepare, fatality reports for the categories of cases as set forth in SSL §20 (5) of the SSL.

The law requires that the individual child fatality report, whether authored by a CFRT or by OCFS, 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 be completed no later than six months after the death of the child. OCFS must send the child fatality report to the following local officials: the commissioner of the social services district, (and 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 and the Public Advocate of the City of New York. 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.

Amendments made to section 20(5) of the Social Services Law in 1996, 'Elisa's Law,' authorize 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.

Appendix B:
New York Social Services Law/County Law[1]

A. Social Services Law

§20(5)(a) In the case of a death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency, or the death of a child for whom any local department of social services has an open child protective services or preventive services case, or in the case of a report made to the state central register involving the death of a child, the office of children and family services shall (i) investigate or provide for the investigation of the cause and circumstances surrounding such death, (ii) review such investigation, and (iii) prepare and issue a report on such death, except where a report is issued by an approved local or regional fatality review team in accordance with section four hundred twenty-two-b of this chapter.

§20(5)(b) Such report shall include (i) the cause of death, whether from natural or other causes, (ii) identification of child protective or other services provided or actions taken regarding such child and his or her family, (iii) any extraordinary or pertinent information concerning the circumstances of the child's death, (iv) whether the child or the child's family had received assistance, care or services from the social services district prior to the child's death, (v) any action or further investigation undertaken by the department or by the local social services district since the death of the child, and (vi) as appropriate, recommendations for local or state administrative or policy changes.

Such report shall contain no information that would identify the name of the deceased child, his or her siblings, the parent or other person legally responsible for the child or any other members of the child's household, but shall refer instead to the case, which may be denoted in any fashion determined by the department or a local social services district. In making a fatality report available to the public pursuant to paragraph (c) of this subdivision, the department may respond to a specific request for such report if the commissioner determines that such disclosure is not contrary to the best interests of the deceased's child siblings or other children in the household, pursuant to subdivision five of section hour hundred twenty-two-a of this chapter. Except as it may apply directly to the cause of death of the child, nothing herein shall be deemed to authorize the release or disclosure to the public of the substance or content of any psychological, psychiatric, therapeutic, clinical or medical reports, evaluations or like materials or information pertaining to such child or the child's family.

§20(5)(c) No later than six months from the date of the death of such child, the department shall forward its report to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child's death occurred and the social services district which had care and custody or custody and guardianship of the child, if different. The department shall notify the temporary president of the senate and the speaker of the assembly as to the issuance of such reports and, in addition to the requirements of section seventeen of the chapter, shall submit an annual cumulative report to the governor and legislature incorporating the data in the above reports and including appropriate findings and recommendations. Such reports concerning the death of a child and such cumulative reports shall thereafter be made available to the public after such forwarding or submittal.

[1] Bolded text represents 2006 updates.

§20(5)(d) To enable the office of children and family services or a local or regional fatality review team to prepare such report, the office of children and family services or a local or regional fatality review team may request and shall timely receive from departments, boards, bureaus or other agencies of the state, or any of its political subdivisions, or any duly authorized agency, or any other agency which provided assistance, care or services to the deceased child such information as they are authorized to provide.

---

§418 Mandatory Reporting to and Post-mortem Investigation of Deaths by Medical Examiner or Coroner**.** Any person or official required to report cases of suspected child abuse or maltreatment, including workers of the local child protective service, as well as an employee of or official of a state agency responsible for the investigation of a report of abuse or maltreatment of a child in residential care, who has reasonable cause to suspect that a child died as a result of child abuse or maltreatment shall report that fact to the appropriate medical examiner or coroner. **The medical examiner or coroner shall accept the report for investigation and shall issue a preliminary written report of his or her findings within sixty days of the date of death,** absent extraordinary circumstances and his or her final written report promptly, absent extraordinary circumstances, to the police, the appropriate district attorney, the local child protective service, the office of children and family services, and, if the institution making the report is a hospital, the hospital. The office of children and family services shall promptly provide a copy of the preliminary and final reports to the statewide central register of child abuse and maltreatment.

---

§422(4)(A)(w) Reports made pursuant to this title as well as any other information obtained, reports written or photographs taken concerning such reports in the possession of the department, local departments, or the commission on quality of care for the mentally disabled, shall be confidential and shall only be made available to….members of a local or regional fatality review team approved by the office of children and family services in accordance with section four hundred twenty-two-b of this title.

§422(5)(a)(ii) Unless an investigation of a report conducted pursuant to this title or subdivision (c) of section 45.07 of the mental hygiene law determines that there is some credible evidence of the alleged abuse or maltreatment, all information identifying the subjects of the report and other persons named in the report shall be legally sealed forthwith by the central register and any local child protective services or the state agency which investigated the report. Such unfounded reports may only be unsealed and made available….to the office of children and family services and local or regional fatality review team members for the purpose of preparing a fatality report pursuant to section twenty or four hundred twenty-two-b of this chapter.

---

§422-b(1) A fatality review team may be established at a local or regional level, with the approval of the office of children and family services, for the purpose of investigating the death of any child whose care and custody or whose custody and guardianship has been transferred to an authorized agency, any child for whom child protective services has an open case, any child for whom the local department of social services has an

open preventive services case, and in the case of a report made to the central register involving the death of a child. A fatality review team may also investigate any unexplained or unexpected death of any child under the age of eighteen.

§422-b(2) A local or regional fatality review team may exercise the same authority as the office of children and family services with regard to the preparation of a fatality report as set forth in paragraphs (b) and (c) of subdivision five of section twenty of this chapter. Notwithstanding any other provision of law to the contrary and to the extent consistent with federal law, such local or regional fatality review teams shall have access to those client-identifiable records necessary for the preparation of the report, as authorized in accordance with paragraph d of subdivision five of section twenty of this chapter. A fatality report prepared by a local or regional fatality review team and approved by the office of children and family services satisfies the obligation to prepare a fatality report as set forth in subdivision five of section twenty of this chapter. Such report shall be subject to the same re-disclosure provisions applicable to fatality reports prepared by the office of children and family services.

§422-b(3) For the purpose of this section, a local or regional fatality review team must include, but need not be limited to, representatives from child protective services, office of children and family services, county department of health, the local health commissioner or his or her designee or the local public health director or his or her designee, office of the medical examiner, or, should the locality not have a medical examiner, office of the coroner, office of the district attorney, office of the county attorney, local and state law enforcement, emergency medical services and a pediatrician or comparable medical professional, preferably with expertise in the area of child abuse and maltreatment or forensic pediatrics. A local or regional fatality review team may also include representatives from local departments of social services, mental health agencies, domestic violence agencies, substance abuse programs, hospitals, local schools and family court.

§422-b(4) A local or regional fatality review team established pursuant to this section shall have access to all records, except those protected by statutory privilege, within twenty one days of receipt of a request.

§422-b(5) Members of a local or regional fatality review team, persons attending a meeting of a local or regional fatality review team, and persons who present information to a local or regional fatality review team shall have immunity from civil and criminal liability for all reasonable and good faith actions taken pursuant to this section, and shall not be questioned in any civil or criminal proceeding regarding any opinions formed as a result of a meeting of a local or regional fatality review team. Nothing in this section shall be construed to prevent a person from testifying as to information obtained independently of a local or regional fatality review team or which is public information.

§422-b(6) All meetings conducted and all reports and records made and maintained, and books and papers obtained, by a local or regional fatality review team shall be confidential and not open to the general public, except by court order and except for an annual report or a fatality report, if the fatality review team chooses to complete such an annual or fatality report. The release of any fatality report prepared by a local or regional fatality review team shall be governed by the provisions of subdivision five of section twenty of this chapter. Any such annual or fatality report shall not contain any

individually identifiable information and shall be provided to the office of children and family services upon completion. The office of children and family services shall forward copies of any such report to all other local or regional fatality review teams established pursuant to this section, to all citizen review panels established pursuant to section three hundred seventy-one-b of this chapter, and to the governor, the temporary president of the senate and the speaker of the assembly.

Chapter 494 of the Laws of 2006 Dual Investigation

Added SSL §424 (5-a) to require a local child protective services (CPS) to provide notice to and jointly investigate with law enforcement, where a report of suspected child abuse or maltreatment alleges physical abuse, sexual abuse or death of a child. The law requires CPS to also consider whether notice to law enforcement also should be made where a report made by a mandated reporter alleges physical harm to a child and two other pending or indicated SCR reports were made in the previous six months involving the same child, a sibling or another child in the same household. CPS is required to jointly investigate these SCR reports with their multi-disciplinary team (MDT) or with law enforcement in counties without a MDT. The law permits CPS and law enforcement to develop local protocols on joint investigation of SCR reports. Such local protocols must be approved by OCFS. **Effective December 14, 2006.**

B. New York County Law

§677(8) The coroner, coroner's physician or medical examiner shall promptly, but in no event later than sixty days from the date of death, absent extraordinary circumstances, provide the office of children and family services with copies of any autopsy report, toxicological report or any report of any examination or inquiry prepared with respect to any death occurring to a child whose care and custody or care and guardianship has been transferred to an authorized agency, a child for whom child protective services has an open case, a child for whom the local department of social services has an open preventive services case, or a child reported to the statewide central register of child abuse and maltreatment. If the toxicological report is prepared pursuant to any agreement or contract with any person, partnership or corporation or governmental agency with the coroner or medical examiner, such report shall be promptly, but in no event later than sixty days from the date of death, absent extraordinary circumstances, provided to the office of children and family services by such person, partnership, corporation or governmental agency. Where the death involves a child reported to the statewide central register of child abuse and maltreatment, the reports referred to in this subdivision shall also be promptly, but in no event later than sixty days from the date of death, absent extraordinary circumstances, provided to the local child protective service investigating the report pursuant to section four hundred twenty-four of the social services law.

Appendix C: Definitions*

Inadequate Guardianship

This term applies to the overall quality of care the parent or other person legally responsible provides the child(ren). Guardianship is inadequate if it fails to meet a reasonable minimum standard of care for the child within commonly accepted societal norms. Inadequate guardianship results in actual physical or developmental harm to the child, or imminent danger of such harm. Inadequate guardianship includes, but is not limited to:

- Continually allowing a child to remain away from home for extended periods of time without knowledge of the child's whereabouts.
- Making demands beyond the child(ren)'s physical or emotional abilities which results in harm or imminent danger of harm to the child.
- Exploitation of the child(ren) by a spouse in marital or custodial disagreements, or litigation disputes which results in specific harm or imminent danger of harm to the child. Litigation itself is not sufficient to show inadequate guardianship.
- Exposing, exploiting or encouraging the child to participate in illegal and/or immoral acts.
- Leaving a child(ren) in the care of another person without establishing a plan for the provision of adequate food, clothing, education or medical care.
- Providing constant surveillance of the child and limiting activities to the extent these actions result in harm or imminent danger of harm to the child.

Immediate Considerations

- What is the condition of the child(ren)? Has the child been harmed or is he in imminent danger of harm?
- What is the age of the child and what capacity does he have to care for himself?
- What is the parental capacity to provide care for the child?
- What are the parents' current child care practices?
- Do these practices meet a reasonable, minimum standard of care for the child?

Other

The allegation categories of child abuse and maltreatment contained here are not all-inclusive. Any other act(s) or omission(s) of a parent or other person legally responsible which harm(s) or create(s) or allow(s) to be created a substantial risk of harm to the child by other than accidental means or which demonstrate(s) a failure

* OCFS CPS Program Manual

to exercise a minimum degree of care to protect the child constitute(s) child abuse or maltreatment.

Lack of Supervision

Lack of supervision is evident if a child is alone or not competently attended for any period of time to the extent that his or her need for adequate care goes unnoticed or unmet, and the child is harmed or exposed to hazards which could lead to harm.

Parents have a responsibility to supervise their children or arrange for proper competent supervision. Proper supervision means that the child's minimum needs for adequate food, clothing, shelter, health, and safety are met. The need for supervision varies with the age and developmental stage of the child.

An infant (0 to 24 months) has some mobility but cannot meet any needs of his own and must be under the constant care of a competent, mature person; toddlers (age 2 to 4) need broader space to explore. Toddlers can walk, climb, have no sense of danger and must be closely watched to keep safe from harm. A preschool child (age 4 to 6) can play independently but cannot be responsible to meet basic needs for adequate food, clothing, shelter, health, and safety.

School-aged children (age 6 to 12 years) may not be ready for the responsibility of being on their own even for short periods of time. A child who cannot be responsible for meeting his or her own needs cannot be a competent caretaker for other children.

Each situation in which there is an allegation of lack of supervision must be carefully assessed to determine the basic needs of the child(ren), the child's capacity to meet those needs on his own, and the role of the parent or other person legally responsible in insuring that the child's needs are adequately met.

Immediate Considerations

- What is the condition of the child(ren)? Has the child been harmed or is he in imminent danger of harm?
- What is the age of the child and what capacity does he have to care for himself?
- What basic needs of the child have gone unnoticed or unmet?
- At what time of day did the child's needs go unnoticed or unmet and how long did the situation last?
- What was the parent's explanation for this situation? Good note taking is essential. Use direct quotes.
- What degree of planning for adequate child care has the parent shown? Is the caretaker mature and competent to provide a minimum degree of care, given the age and circumstances of the child (ren)?

1. Frequency by Jurisdiction 2007

Jurisdiction	Total	Pct
Albany	5	1.9%
Allegany	2	0.8%
Broome	6	2.3%
Cattaraugus	2	0.8%
Cayuga	4	1.6%
Chautauqua	3	1.2%
Chemung	5	1.9%
Clinton	1	0.4%
Columbia	1	0.4%
CQC (Commission on Quality of Care)	2	0.8%
Dutchess	5	1.9%
Erie	12	4.7%
Essex	1	0.4%
Fulton	1	0.4%
Genesee	1	0.4%
Herkimer	1	0.4%
Jefferson	5	1.9%
Livingston	1	0.4%
Madison	1	0.4%
Monroe	9	3.5%
Nassau	4	1.6%
NYC	107	41.5%
Niagara	4	1.6%
Oneida	3	1.2%
Onondaga	7	2.7%
Ontario	3	1.2%
Orange	10	3.9%
Orleans	2	0.8%
Oswego	1	0.4%
Putnam	1	0.4%
Rensselaer	2	0.8%
Rockland	1	0.4%
Saratoga	1	0.4%
Schenectady	6	2.3%
St. Lawrence	1	0.4%
Steuben	5	1.9%
Suffolk	15	5.8%
Sullivan	1	0.4%
Tioga	1	0.4%
Tompkins	2	0.8%
Ulster	1	0.4%
Warren	1	0.4%
Washington	1	0.4%
Westchester	9	3.5%
Wyoming	1	0.4%
Grand Total	258	100.0%

New York City Boroughs

Bronx	30
Kings	28
New York	24
Queens	17
Richmond	8
Total	**107**

- **Does not include reports of 8 unverified deaths. Counties not appearing had no fatalities.**

- **Frequency by Jurisdiction 3-Year**

Jurisdiction	2007	2006	2005	Total
Albany	5	3	4	12
Allegany	2	0	0	2
Broome	6	3	3	12
Cattaraugus	2	0	0	2
Cayuga	4	1	1	6
Chautauqua	3	2	2	7
Chemung	5	2	2	9
Chenango	0	3	0	3
Clinton	1	1	1	3
Columbia	1	2	0	3
Cortland	0	1	0	1
CQC	2	0	0	2
Delaware	0	0	1	1
Dutchess	5	0	0	5
Erie	12	14	11	37
Essex	1	0	1	2
Franklin	0	0	1	1
Fulton	1	1	0	2
Genesee	1	1	0	2
Greene	0	1	1	2
Herkimer	1	0	1	2
Jefferson	5	1	2	8
Lewis	0	0	1	1
Livingston	1	0	0	1
Madison	1	0	1	2
Monroe	9	6	9	24
Nassau	4	5	4	13
Niagara	4	0	2	6
NYC	107	91	79	277
Oneida	3	2	3	8
Onondaga	7	3	5	15
Ontario	3	1	1	5
Orange	10	1	3	14
Orleans	2	1	0	3
Oswego	1	0	0	1
Otsego	0	1	2	3
Putnam	1	0	0	1
Rensselaer	2	0	1	3
Rockland	1	2	2	5
Saratoga	1	0	2	3
Schenectady	6	0	3	9
Schoharie	0	1	0	1
Schuyler	0	1	0	1
St. Lawrence	1	3	2	6
Steuben	5	1	0	6
Suffolk	15	10	9	34
Sullivan	1	0	2	3
Tioga	1	0	1	2
Tompkins	2	0	0	2
Ulster	1	3	2	6
Warren	1	2	0	3
Washington	1	2	1	4
Wayne	0	2	1	3
Westchester	9	13	7	29

Wyoming	1	0	0	1
Yates	0	0	1	1
Grand Total	**258**	**187**	**175**	**620**

NYC Breakdown	**2007**	**2006**	**2005**
Kings	28	28	28
Bronx	30	24	14
New York	24	18	23
Queens	17	13	11
Richmond	8	8	3
Total	**107**	**91**	**79**

- **Totals do not reflect reported deaths that could not be verified.**

2. Circumstances Related to Child's Death 2007

OCFS 2007 Child Fatality Report *Circumstances related to Child's Death*			
Circumstance	**Frequency**	**Pct of Total**	**Cumulative Pct**
IG/Lack of supervision	56	13.66%	13.66%
None	49	11.95%	25.61%
Co-Sleeping	47	11.46%	37.07%
Cause/MannerUnknown	33	8.05%	45.12%
Other	30	7.32%	52.44%
Homicide by Parent	30	7.32%	59.76%
Drug/alcohol History(subject)	30	7.32%	67.07%
No Autopsy	22	5.37%	72.44%
DV History	20	4.88%	77.32%
Special Needs Child	15	3.66%	80.98%
Inappropriate Sleeping Arrangements	15	3.66%	84.63%
Motor Vehicle Accident	10	2.44%	87.07%
Homicide by Other Household Member	9	2.20%	89.27%
Teen Parent	9	2.20%	91.46%
Lack of Medical Care	8	1.95%	93.41%
Concealed Pregnancy	6	1.46%	94.88%
Homicide by Non-household Member	6	1.46%	96.34%
Drug/alcohol (subject) Contributed to Death	5	1.22%	97.56%
Inadequate Food/clothing/shelter	3	0.73%	98.29%
Bathtub	3	0.73%	99.02%
DV Contributed to Death	1	0.24%	99.27%
Farm Accident	1	0.24%	99.51%
Abandoned Infant	1	0.24%	99.76%
Home Visit	1	0.24%	100.00%
Total	**410**	**100.00%**	

***Some deaths had more than one associated circumstance.**

4. Causes Related to Child's Death 2007

OCFS 2007 Child Fatality Report *Causes Relating to Child's Death*		
Cause	**Frequency**	**Pct of Total**
Undetermined	45	17.58%
Physical Trauma	40	15.63%
Asphyxiation/Suffocation/Strangulation	35	13.67%
SIDS	29	11.33%
Illness/Disease (short term)	25	9.77%
Drowning	18	7.03%
Illness/Disease (long term)	14	5.47%
Fire-related	11	4.30%
Congenital Condition	10	3.91%
Other	9	3.52%
Gunshot	5	1.95%
Shaken Baby Syndrome	4	1.56%
Drug/Alcohol Consumption (child)	3	1.17%
Hanging	3	1.17%
Falling	2	0.78%
Poisoning	1	0.39%
Scalding	1	0.39%
Dehydration/Malnutrition/Starvation	1	0.39%
Total	**256**	**100.00%**

***Individual deaths may have more than one associated cause, and not all causes are available at the time the review is conducted.**

5. All Allegations 2007

Allegation Type	Substantiated	Unsubstantiated	Grand Total
DOA/ Fatality	140	73	213
Inadequate Guardianship	183	25	208
Lack of Medical Care	36	16	52
Lack of Supervision	37	4	41
Lacerations, Bruises, Welts	23	11	34
Fractures	20	9	29
Internal Injuries	22	6	28
Parents Drug/ Alcohol Misuse	22	1	23
Choking/ Twisting/ Shaking	10	5	15
Swelling/ Dislocation/ Sprains	6	6	12
Inadequate Food, Clothing, Shelter	8	2	10
Burns, Scalding	4	1	5
Excessive Corporal Punishment	2	1	3
Other	1	2	3
Poisoning, Noxious Substances	2	1	3
Sexual Abuse	2	1	3
Emotional Neglect	1		1
Grand Total	**519**	**164**	**683**

*Every reported fatality report contains more than one allegation.

6. Family Service History 2007

Family Service History	
Open Foster Care	20
Prior CPS	99
Active CPS	33
Child Welfare Closed	15
Child Welfare Open	43
Other Assistance	32
Subject Past Services	20
No Prior DSS	56
Other Prior DSS	8
	326
At Least 1	180

***In family history of all 258 verified deaths that were reviewed, 180 cases were known in at least one capacity prior to the fatal incident. Some were known in more than one capacity listed.**

7. Post Fatality Activities 2007

For Unfounded Fatalities

Significant Activities Following the Fatality		
Activity	**Frequency**	**Pct**
Law Enforcement	44	32.4%
Burial	33	24.3%
Community Services	16	11.8%
No Post Investigation Activity	13	9.6%
Refused Services	13	9.6%
Protective/Preventive Services provided	8	5.9%
Temporary Removal Surviving siblings	3	2.2%
Court Ordered Removal Surviving siblings	2	1.5%
Other Post Fatality Activity	2	1.5%
License Revoked (Day Care/Foster Care)	1	0.7%
Voluntary Close (Day Care/Foster Care)	1	0.7%
Total	136	100.0%

For Indicated Fatalities

Significant Activities Following the Fatality		
Activity	**Frequency**	**Pct**
No Post Investigation activity	7	2.6%
Temporary Removal Surviving siblings	7	2.6%
Court Ordered Removal Surviving siblings	24	8.9%
Caretaker Arrest	33	12.2%
Law Enforcement	65	24.1%
Protective/Preventive Services	46	17.0%
Burial	28	10.4%
Community Services	31	11.5%
Refuse Services	22	8.1%
Other Post Fatality activity	7	2.6%
Total	270	100.0%

8. All Fatalities Age & Gender 2007

Age Category	Gender			
	F	M	U	Grand Total
Less than 1 Year	57	82	4	143
1-3 Years	19	29	1	49
4-9 Years	12	20	2	34
10 or Over	12	20		32
Grand Total	**100**	**151**	**7**	**258**
Percentage of Gender within Age Category				
Less than 1 Year	40%	57%	3%	100%
1-3 Years	39%	59%	2%	100%
4-9 Years	35%	59%	6%	100%
10 or Over	38%	63%	0%	100%
Grand Total	39%	59%	3%	100%
Percentage of Age Category within Gender				
Less than 1 Year	57%	54%	57%	55%
1-3 Years	19%	19%	14%	19%
4-9 Years	12%	13%	29%	13%
10 or Over	12%	13%	0%	12%
Grand Total	100%	100%	100%	100%

9. All Fatalities Age & Race 2007

Age Category	Race					
	Asian	Black	Hispanic	Not Reported	White	Grand Total
Less than 1 Year	1	55	14	26	47	143
1-3 Years		19	5	9	16	49
4-9 Years	1	13	3	4	13	34
10 or Over		13	1	5	13	32
Grand Total	**2**	**100**	**23**	**44**	**89**	**258**
Percentage of Race within Age Category						
Less than 1 Year	*1%*	*38%*	*10%*	*18%*	*33%*	*100%*
1-3 Years	*0%*	*39%*	*10%*	*18%*	*33%*	*100%*
4-9 Years	*3%*	*38%*	*9%*	*12%*	*38%*	*100%*
10 or Over	*0%*	*41%*	*3%*	*16%*	*41%*	*100%*
Grand Total	*1%*	*39%*	*9%*	*17%*	*34%*	*100%*
Percentage of Age Category within Race						
Less than 1 Year	50%	55%	61%	59%	53%	55%
1-3 Years	0%	19%	22%	20%	18%	19%
4-9 Years	50%	13%	13%	9%	15%	13%
10 or Over	0%	13%	4%	11%	15%	12%
Grand Total	100%	100%	100%	100%	100%	100%

10. All Fatalities Age & Region 2007

	Region						
Age Category	**ARO**	**BRO**	**NYCRO**	**RRO**	**SRO**	**SVRO**	**Grand Total**
Less than 1 Year	12	14	66	14	20	17	143
1-3 Years	3	7	18	4	7	10	49
4-9 Years	3	3	12	2	4	10	34
10 or Over	3	3	10	3	2	11	32
Grand Total	**21**	**27**	**106**	**23**	**33**	**48**	**258**
Percentage of Region within Age Category							
Less than 1 Year	8%	10%	46%	10%	14%	12%	100%
1-3 Years	6%	14%	37%	8%	14%	20%	100%
4-9 Years	9%	9%	35%	6%	12%	29%	100%
10 or Over	9%	9%	31%	9%	6%	34%	100%
Grand Total	8%	10%	41%	9%	13%	19%	100%
Percentage of Age Category within Region							
Less than 1 Year	57%	52%	62%	61%	61%	35%	55%
1-3 Years	14%	26%	17%	17%	21%	21%	19%
4-9 Years	14%	11%	11%	9%	12%	21%	13%
10 or Over	14%	11%	9%	13%	6%	23%	12%
Grand Total	100%	100%	100%	100%	100%	100%	100%

11. All Fatalities Age & Weekday 2007

All Fatalities by Weekday

Category	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Grand Total
Less than 1 Year	23	22	24	16	16	16	26	143
1-3 Years	5	6	6	9	8	4	11	49
4-9 Years	8	3	5	2	4	8	4	34
10 or Over	4	5	2	10	6	4	1	32
Grand Total	**40**	**36**	**37**	**37**	**34**	**32**	**42**	**258**

Percentage by Weekday within Category

Less than 1 Year	16%	15%	17%	11%	11%	11%	18%	100%
1-3 Years	10%	12%	12%	18%	16%	8%	22%	100%
4-9 Years	24%	9%	15%	6%	12%	24%	12%	100%
10 or Over	13%	16%	6%	31%	19%	13%	3%	100%
Grand Total	16%	14%	14%	14%	13%	12%	16%	100%

Percentage by Category within Weekday

Less than 1 Year	58%	61%	65%	43%	47%	50%	62%	55%
1-3 Years	13%	17%	16%	24%	24%	13%	26%	19%
4-9 Years	20%	8%	14%	5%	12%	25%	10%	13%
10 or Over	10%	14%	5%	27%	18%	13%	2%	12%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%

12. Monthly Breakdown All Fatalities Metro Type 2007

Month	Non Metro	NYC Metro	Upstate Metro	Grand Total
Jan	4	12	6	22
Feb	6	10	4	20
Mar	6	6	7	19
Apr	1	9	6	16
May	11	8	4	23
Jun	10	10	5	25
Jul	7	5	11	23
Aug	6	10	8	24
Sep	13	4	10	27
Oct	7	12	3	22
Nov	8	9	2	19
Dec	3	11	4	18
Grand Total	**82**	**106**	**70**	**258**

13. All Fatalities Age & Month 2007

Age Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Less than 1 Year	14	12	13	9	17	11	7	9	15	10	14	12	143
1-3 Years	4	2	2	2	3	6	8	6	7	6	2	1	49
4-9 Years	1	2	3	2	1	4	2	7	3	4	1	4	34
10 or Over	3	4	1	3	2	4	6	2	2	2	2	1	32
Grand Total	**22**	**20**	**19**	**16**	**23**	**25**	**23**	**24**	**27**	**22**	**19**	**18**	**258**
Percentage by Month within Age Category													
Less than 1 Year	10%	8%	9%	6%	12%	8%	5%	6%	10%	7%	10%	8%	100%
1-3 Years	8%	4%	4%	4%	6%	12%	16%	12%	14%	12%	4%	2%	100%
4-9 Years	3%	6%	9%	6%	3%	12%	6%	21%	9%	12%	3%	12%	100%
10 or Over	9%	13%	3%	9%	6%	13%	19%	6%	6%	6%	6%	3%	100%
Grand Total	9%	8%	7%	6%	9%	10%	9%	9%	10%	9%	7%	7%	100%
Percentage by Age Category within Month													
Less than 1 Year	64%	60%	68%	56%	74%	44%	30%	38%	56%	45%	74%	67%	55%
1-3 Years	18%	10%	11%	13%	13%	24%	35%	25%	26%	27%	11%	6%	19%
4-9 Years	5%	10%	16%	13%	4%	16%	9%	29%	11%	18%	5%	22%	13%
10 or Over	14%	20%	5%	19%	9%	16%	26%	8%	7%	9%	11%	6%	12%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

14. All Fatalities Cause & Region 2007

Cause and Region							
Cause	**ARO**	**BRO**	**NYCRO**	**RRO**	**SRO**	**SVRO**	**Total**
Undetermined	2	2	26	7	5	5	47
Physical Trauma	2	3	17	7	9	6	44
Asphyxiation/Suffocation/Strangulation	1	3	15	2	5	9	35
SIDS	3	9	5	2	4	6	29
Illness/Disease (short term)	3	1	12	1	1	7	25
Drowning	1	2	4	1	4	6	18
Fire-related	2	1	9	1	1	1	15
Illness/Disease (long term)	1	2	10		1	1	15
Congenital Condition	1	2	4	1	2	1	11
Other		1	2	1		5	9
Gunshot		2	2			1	5
Shaken Baby Syndrome		1	2	1			4
Drug/Alcohol Consumption (child)			1		1	1	3
Hanging			1	1		1	3
Falling			2				2
Dehydration/Malnutrition/Starvation	1						1
Poisoning			1				1
Scalding			1				1
Total	**17**	**29**	**114**	**25**	**33**	**50**	**268**

*Some cases may have more than one associated cause.

15. All Fatalities Age & Manner 2007

All Fatalities by Manner

	Manner						
Category	Accident	Homicide	Natural Causes	Suicide	Undetermined	Unknown	Grand Total
Less than 1 Year	24	19	51		48	1	143
1-3 Years	20	17	10		2		49
4-9 Years	13	3	17		1		34
10 or Over	14	5	7	5	1		32
Grand Total	71	44	85	5	52	1	258

16. All Fatalities Cause by Manner, Region and Metro 2007

Cause and Manner							
Cause	**Accident**	**Homicide**	**Natural Causes**	**Suicide**	**Undetermined**	**Unknown**	**Total**
Asphyxiation/Suffocation/Strangulation	21	9	2	2	1		35
Congenital Condition	1		9		1		11
Dehydration/Malnutrition/Starvation			1				1
Drowning	16	2					18
Drug/Alcohol Consumption (child)	2	1					3
Falling	2						2
Fire-related	13	1			1		15
Gunshot		4		1			5
Hanging	1			2			3
Illness/Disease (long term)			15				15
Illness/Disease (short term)			25				25
Other	5	1	3				9
Physical Trauma	18	26					44
Poisoning	1						1
Scalding		1					1
Shaken Baby Syndrome		4					4
SIDS			23		6		29
Undetermined			6		40	1	47
Total	**80**	**49**	**84**	**5**	**49**	**1**	**268**

***Some cases may have more than one associated cause or manner.**

Cause and Region							
Cause	**ARO**	**BRO**	**NYCRO**	**RRO**	**SRO**	**SVRO**	**Total**
Undetermined	2	2	26	7	5	5	47
Physical Trauma	2	3	17	7	9	6	44
Asphyxiation/Suffocation/Strangulation	1	3	15	2	5	9	35
SIDS	3	9	5	2	4	6	29
Illness/Disease (short term)	3	1	12	1	1	7	25
Drowning	1	2	4	1	4	6	18
Fire-related	2	1	9	1	1	1	15
Illness/Disease (long term)	1	2	10		1	1	15
Congenital Condition	1	2	4	1	2	1	11
Other		1	2	1		5	9
Gunshot		2	2			1	5
Shaken Baby Syndrome		1	2	1			4
Drug/Alcohol Consumption (child)			1		1	1	3
Hanging			1	1		1	3
Falling			2				2
Dehydration/Malnutrition/Starvation	1						1
Poisoning			1				1
Scalding			1				1
Total	**17**	**29**	**114**	**25**	**33**	**50**	**268**

***Some cases may have more than one associated cause.**

Cause and Metro				
Cause	**Non Metro**	**NYC Metro**	**Upstate Metro**	**Total**
Asphyxiation/Suffocation/Strangulation	12	15	8	35
Congenital Condition	1	4	6	11
Dehydration/Malnutrition/Starvation			1	1
Drowning	4	4	10	18
Drug/Alcohol Consumption (child)	2	1		3
Falling		2		2
Fire-related	5	9	1	15
Gunshot	1	2	2	5
Hanging	2	1		3
Illness/Disease (long term)	2	10	3	15
Illness/Disease (short term)	6	12	7	25
Other	4	2	3	9
Physical Trauma	21	17	6	44
Poisoning		1		1
Scalding		1		1
Shaken Baby Syndrome	1	2	1	4
SIDS	12	5	12	29
Undetermined	10	26	11	47
Total	**83**	**114**	**71**	**268**

***Some cases may have more than one associated cause.**

17. Fatalities Jurisdiction & Manner 2007

Count of Rpt_ID	Manner					
Jurisdiction	Accident	Homicide	Natural Causes	Suicide	Undetermined	Unknown
Albany			4		1	
Allegany		1			1	
Bronx	4	6	9	1	10	
Broome	2	2	1		1	
Cattaraugus	1		1			
Cayuga	3		1			
Chautauqua	2		1			
Chemung			1	2	2	
Clinton					1	
Columbia		1				
CQC		1		1		
Dutchess	1	2	1		1	
Erie	2	2	6		2	
Essex	1					
Fulton					1	
Genesee	1					
Herkimer	1					
Jefferson	1	1	3			
Kings	10	6	7		4	
Livingston	1					
Madison	1					
Monroe	1		1		6	1
Nassau	3	1				
New York	3	2	3		4	
Niagara		2	2			
OCI	1		3			
Oneida	1	1	1		1	
Onondaga	1		2		4	
Ontario	2	1				
Orange	1		6	1	2	
Orleans	1				1	
OSI	3		5			
Oswego					1	
Putnam		1				
Queens	5	6	2		4	
Rensselaer			1		1	
Richmond		1	5		2	
Rockland			1			
Saratoga			1			
Schenectady	2		4			
St. Lawrence		1				
Steuben	4	1				
Suffolk	7	2	5		1	
Sullivan			1			
Tioga	1					
Tompkins	1	1				
Ulster			1			
Warren		1				
Washington			1			
Westchester	3	1	4		1	
Wyoming			1			
Grand Total	**71**	**44**	**85**	**5**	**52**	**1**

18. Fatalities Manner & Region 2007

Manner by Region

	Manner						
Region	Accident	Homicide	Natural Causes	Suicide	Undetermined	Unknown	Grand Total
ARO	3	3	11		4		21
BRO	7	5	11		4		27
NYCRO	26	21	34	1	24		106
RRO	8	2	2	2	8	1	23
SRO	12	6	8		7		33
SVRO	15	7	19	2	5		48
Grand Total	**71**	**44**	**85**	**5**	**52**	**1**	**258**

19. Co- Sleeping Age & Gender 2007

Co-Sleeping Fatalities by Gender

	Gender		
Category	F	M	Grand Total
Less than 1 Year	19	26	45
1-3 Years		2	2
Grand Total	**19**	**28**	**47**
Percentage by Gender within Category			
Less than 1 Year	42%	58%	100%
1-3 Years	0%	100%	100%
Grand Total	40%	60%	100%

20.Co-Sleeping Age & Race 2007

Co-Sleeping Fatalities by Race

	Race				
Category	Black	Hispanic	Not Reported	White	Grand Total
Less than 1 Year	22	4	6	13	45
1-3 Years	2				2
Grand Total	**24**	**4**	**6**	**13**	**47**
Percentage by Race within Category					
Less than 1 Year	49%	9%	13%	29%	100%
1-3 Years	100%	0%	0%	0%	100%
Grand Total	51%	9%	13%	28%	100%

21. Co-Sleeping Age & Region 2007

Co-Sleeping Fatalities by Region

	Region					
Category	BRO	NYCRO	RRO	SRO	SVRO	Grand Total
Less than 1 Year	3	25	3	10	4	45
1-3 Years		2				2
Grand Total	**3**	**27**	**3**	**10**	**4**	**47**
Percentage by Region within Category						
Less than 1 Year	7%	56%	7%	22%	9%	100%
1-3 Years	0%	100%	0%	0%	0%	100%
Grand Total	6%	57%	6%	21%	9%	100%

21.Co-Sleeping Age & Metro Type

Co-Sleeping Fatalities by Metro Type

	MetroType			
Category	Non Metro	NYC Metro	Upstate Metro	Grand Total
Less than 1 Year	13	25	7	45
1-3 Years		2		2
Grand Total	13	27	7	47

22. Co-Sleeping by Month 2007

Co-Sleeping Fatalities by Month

	Month											
Category	Jan	Feb	Mar	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Less than 1 Year	7	3	2	9	2	5	3	4	3	2	5	45
Pct	16%	7%	4%	20%	4%	11%	7%	9%	7%	4%	11%	100%

23. Co-Sleeping 3-Year

All Co-Sleeping Fatalities Last 3 years

Metro Region	2005	2006	2007
NYC Metro	14	17	27
Upstate Metro	10	9	7
Non Metro	7	8	13
Totals	**31**	**34**	**47**

25. Findings by Region 2007

Numbers Represent the number of Inadequate or No Responses

Findings All Fatalities *	ARO	BRO	NYCRO	RRO	SRO	YRO	Total
Autopsy	1	1	3	2			7
ME	3		3				6
Case Record	4	2	28	10		5	49
Case Management	2		14	1	1	1	19
Services After	1		8	1		1	11
Prior Services	2		12	2	1		17
Case Supervision	1		39	5	2	6	53
Mandated Reports	8				2		10
Subtotal	22	3	107	21	6	13	172

* Some cases may have more than one finding.

Findings SCR Fatalities	ARO	BRO	NYCRO	RRO	SRO	YRO	Total
Investigation was not Timely	5	6	80	8	8	6	113
Investigation Activities	6	2	59	4		8	79
Investigation Safety	2		20	5		3	30
Investigation Determination	2		14			1	17
Investigation Ind/Closed			3				3
Placement Decisions			3	1			4
Law Enforcement	3		2				5
Prior Investigation Activities	3		20	5		4	32
Prior Investigation Safety	3		13	4		1	21
Prior Investigation Ind/Closed			8	3			11
Subtotal	24	8	222	30	8	23	315

Other Findings	ARO	BRO	NYCRO	RRO	SRO	YRO	Total
Report Not Made to Regional Office			4				4
Foster Care Placement	1						1
Monitoring of Child			3				3
Legal Count Activities	1		1				2
FC Training, Licensing, Monitoring			2				2
Subtotal	2	0	10	0	0	0	12

Total of All Findings	48	11	339	51	14	36	499

26. Required Action by Region 2007

Numbers Represent the Frequency where Required Action box was checked

Findings All Fatalities	ARO	BRO	NYCRO	RRO	SRO	YRO	Total
Autopsy			2	1			3
ME	1		1				2
Case Record	1	1	24	6		1	33
Case Management	1		10	1		2	14
Services After			5	2			7
Prior Services	1		10	2			13
Case Supervision	1		35	4	1	2	43
Mandated Reports			7			1	8
Subtotal	5	1	94	16	1	6	123

Findings SCR Fatalities	ARO	BRO	NYCRO	RRO	SRO	YRO	Total
Investigation was not Timely	1	6	70	4		2	83
Investigation Activities	5	2	51	6		5	69
Investigation Safety			14	5			19
Investigation Determination	3		11				14
Investigation Ind/Closed			2				2
Placement Decisions			2	1			3
Law Enforcement							0
Prior Investigation Activities	1		14	5		2	22
Prior Investigation Safety	2		11	4			17
Prior Investigation Ind/Closed			5	4			9
Subtotal	12	8	180	29	0	9	238

Other Findings	ARO	BRO	NYCRO	RRO	SRO	YRO	Total
Report Not Made to Regional Office			4				4
Foster Care Placement	1		1				2
Monitoring of Child			3				3
Legal Count Activities	1		1				2
FC Training, Licensing, Monitoring			2				2
Subtotal	2	0	11	0	0	0	13

	ARO	BRO	NYCRO	RRO	SRO	YRO	Total
Total of ALL Required Actions	19	9	285	45	1	15	374

* Some cases may have more than one required action based on findings. In other cases, there may be findings with no required action, if an issue has already been addressed by the investigating agency.

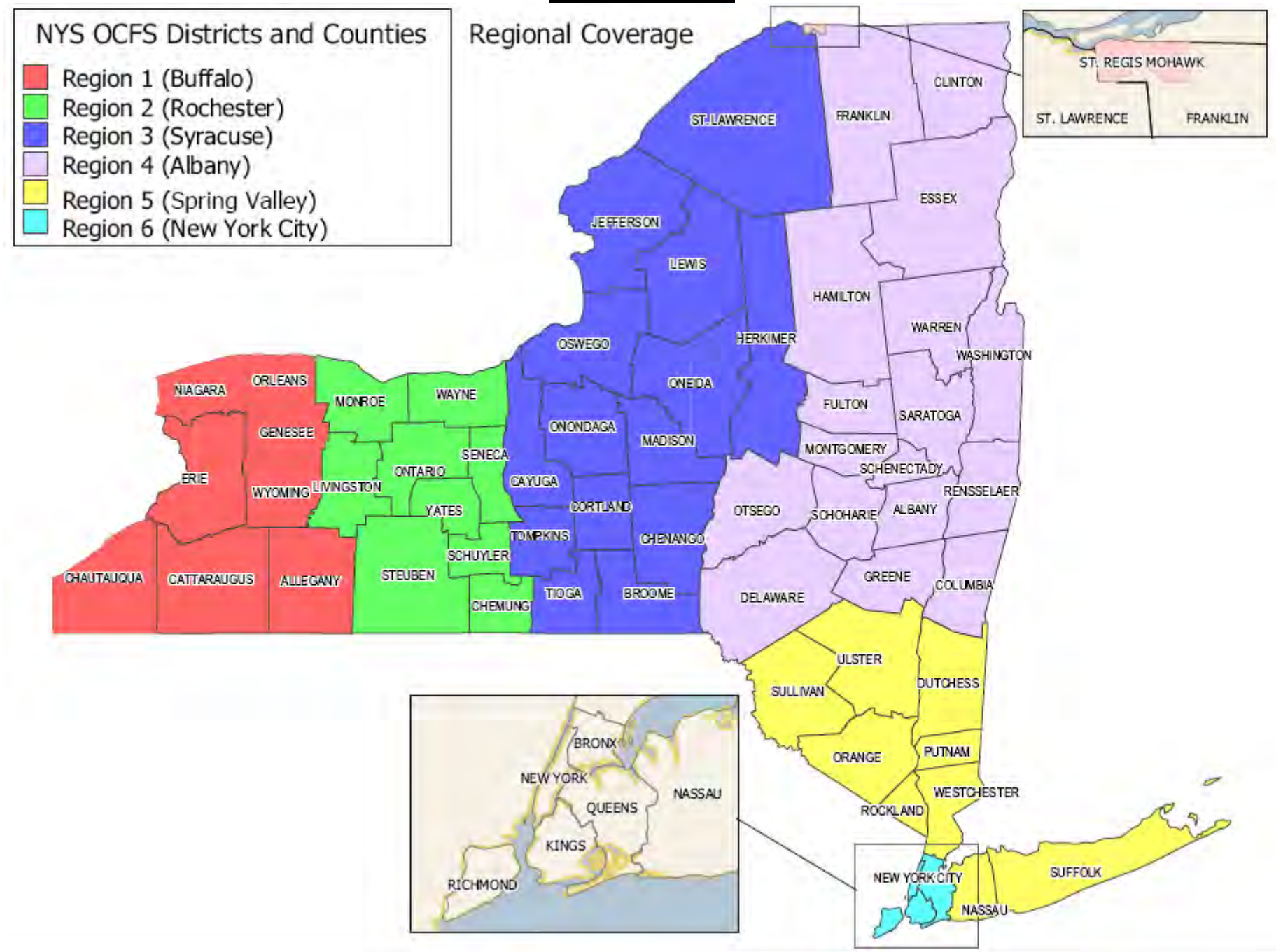
27. All Fatalities 3-Year

All Fatalities by Weekday 2005-2007			
Weekday	**2005**	**2006**	**2007**
Sun	34	23	40
Mon	24	26	36
Tue	24	20	37
Wed	22	28	37
Thu	21	39	34
Fri	27	30	32
Sat	23	21	42
Total	175	187	258

All Fatalities by Month 2005-2007			
Month	**2005**	**2006**	**2007**
Jan	19	17	22
Feb	14	14	20
Mar	13	10	19
Apr	14	19	16
May	11	18	23
Jun	6	19	25
Jul	18	16	23
Aug	17	14	24
Sep	15	16	27
Oct	15	9	22
Nov	11	23	19
Dec	22	12	18
Total	**175**	**187**	**258**

* Totals in reflect all verified deaths

Appendix E-1


NYS OCFS Districts and Counties
Region 1 (Buffalo)
Region 2 (Rochester)
Region 3 (Syracuse)
Region 4 (Albany)
Region 5 (Spring Valley)
Region 6 (New York City)
Regional Coverage
ST. REGIS MOHAWK
ST. LAWRENCE
FRANKLIN
CLINTON
ESSEX
HAMILTON
WARREN
WASHINGTON
FULTON
SARATOGA
MONTGOMERY
SCHENECTADY
RENSSELAER
ALBANY
SCHOHARIE
OTSEGO
DELAWARE
GREENE
COLUMBIA
ULSTER
SULLIVAN
DUTCHESS
ORANGE
PUTNAM
ROCKLAND
WESTCHESTER
NEW YORK CITY
NASSAU
SUFFOLK
BRONX
NEW YORK
QUEENS
KINGS
RICHMOND
NASSAU
JEFFERSON
LEWIS
OSWEGO
HERKIMER
ONEIDA
ONONDAGA
MADISON
CAYUGA
CORTLAND
CHENANGO
TOMPKINS
TIOGA
BROOME
SCHUYLER
CHEMUNG
SENECA
ONTARIO
YATES
WAYNE
MONROE
NIAGARA
ORLEANS
GENESEE
WYOMING
LIVINGSTON
ERIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN

Appendix E-2


OCFS Funded 2007 - 2008 Fatality Review Teams
Fatality Review Teams
* Approved / Not Funded
OSWEGO CAC FOUNDATION
BIVONA CHILD ADVOCACY CENTER
ONEIDA COUNTY DSS
ONONDAGA SUNY RESEARCH
MADISON COUNTY CFRT
START CHILDREN'S CENTER
SCHOHARIE COUNTY CFRT
ALBANY COUNTY CFRT
COLUMBIA COUNTY DSS
CHEMUNG COUNTY DSS
BROOME COUNTY HEALTH DEPT
PUTNAM COUNTY DSS
WESTCHESTER *
NASSAU COUNTY HEALTH DEPT

Appendix F: Resources and Links

Resource	Link
NYS Office of Children & Family Services	www.ocfs.state.ny.us
NYS Department of Health	www.health.state.ny.us
National Safe Kids Campaign	www.safekids.org
Centers for Disease Control and Prevention	www.cdc.gov
Harborview Injury Prevention & Research Center	http://depts.washington.edu/hiprc
Consumer Product Safety Commission	www.cpsc.gov
Red Cross	www.redcross.org
The United States Lifesaving Association (USLA)	www.usla.org
American Academy of Pediatrics	www.aap.org
Children's Safety Network	http://www.childrenssafetynetwork.org/
National Highway Transportation Safety Administration	www.nhtsa.dot.gov
The Think First Injury Prevention Foundation	ww.thinkfirst.org
Harrison's Hope (Formerly Kids 'N Cars)	www.harrisonshope.org
American Academy of Pediatrics Healthy Child Care America: Back to Sleep Campaign	http://www.healthychildcare.org/section_SIDS.cfm
National SIDS/Infant Death Resource Center	www.sidscenter.org
Parents, The Anti-Drug	www.theantidrug.com/drug_info
"Teens & Prescription Drugs, An Analysis of Recent Trend on the Emerging Drug Threat" (February 2007) (and related publications)	www.whitehousedrugpolicy.gov/publications
National Rifle Association: "The Eddie Eagle® Gunsafe Program"	www.nrahq.org/safety/eddie
National Center for the Prosecution of Child Abuse (A program of the American Prosecutors' Research Institute APRI)	www.ndaa.org/apri/programs/ncpca/ncpca_home.html
National Center on Shaken Baby Syndrome *Provides technical assistance, research, expertise to investigation professionals, including scene investigation and suspected incidents, legal professionals, including visual presentation of medical evidence, and medical professionals, including recognizing abusive head trauma*	www.dontshake.org

U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention	www.ojjdp.ncjrs.org
National Center for Missing and Exploited Children	www.missingkids.com
The National Council of Juvenile & Family Court Judges	ww.ncjfcj.org
Publication: Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases The National Youth Violence Prevention Resource Center	www.safeyouth.org
Child Welfare Information Gateway (Formerly the National Clearinghouse on Child Abuse and Neglect Information)	www.childwelfare.gov
National MCH Center for Child Death Review	www.childdeathreview.org
New York City Administration for Children's Services	www.nyc.gov
National Sudden and Unexpected Infant/Child Death Resource Center	www.sidscenter.org
New York State Office of Children and Family Services (Local District Offices)	www.ocfs.state.ny.us/main/localdss.asp
New York State Central Register of Child Abuse and Maltreatment	1-800-342-3720
National Suicide Prevention Lifeline	1-800-SUICIDE (784-2433)
Suicide Prevention Advocacy Network	www.spanusa.org
New York State Office of Children and Family Services Child Abuse Prevention	ww.ocfs.state.ny.us/main/prevention/
New York State Office of Children and Family Services Babies Sleep Safest Alone Campaign	http://www.ocfs.state.ny.us/main/babiessleepsafestalone/default.htm
New York State Kids' Well-Being Indicators Clearinghouse	http://www.nyskwic.org/index.cfm
New York State Department of Health Sudden Infant Death Syndrome	http://www.health.state.ny.us/diseases/conditions/sids/
New York State Department of Health Injury Prevention	http://www.health.state.ny.us/prevention/injury_prevention/