

# Chapter 11: Child Fatality Reviews

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# Chapter 11: Child Fatality Reviews

## A. Child Fatality Reviews

### 1. Purpose of Child Fatality Reviews

Engaging in a retrospective review of the circumstances around a child death aims to accomplish three key goals:

- Protect the safety and well-being of children, especially surviving siblings and other children in the household of the deceased child;
- Identify actions to help prevent similar fatalities in the future; and
- Identify appropriate and legitimate individual and systemic accountability for child welfare actions taken prior to and subsequent to a child fatality.

### 2. Role of OCFS in Child Fatality Reviews

#### a. Requirements

Under New York State law, the Office of Children and Family Services (OCFS) must prepare and issue a fatality report, except if a fatality report is prepared by an OCFS approved local or regional child fatality review team (CFRT), for all child fatalities in the following categories [SSL §20(5)(a)]:

- A report involving the death of a child is made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR);
- A child who, at the time of their death, is in the care and custody, or the guardianship and custody, of the local department of social services (LDSS) or a voluntary authorized agency (VA), other than a child who is a vulnerable person as defined in SSL §488(15);<sup>1</sup>
- A child for whom the LDSS has an open Child Protective Services (CPS) case at the time of their death. This includes cases in the investigative track and the Family Assessment Response (FAR) track, and cases where protective services are being monitored or provided by CPS; or
- A child for whom the LDSS has an open Preventive Services case at the time of their death.

When a CFRT prepares the fatality report, OCFS does not have to prepare a separate report, but OCFS is ultimately responsible for reviewing and issuing the report developed by the CFRT. Please see **Section A.3, Role of Child Fatality Review Teams in Child Fatality Reviews** [SSL §422-b].

#### b. Responsibilities

SSL §20(5)(a) states that when a child dies under one of the circumstances described above, OCFS is responsible for taking the following actions:

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<sup>1</sup> As per the Protection of People with Special Needs Act (Chapter 501 of the Laws of 2012), OCFS is not responsible for issuing fatality reports involving children in residential facilities or programs. These fatalities are reported to and investigated by the Justice Center for the Protection of People with Special Needs.

- Investigate, or provide for the investigation of, the cause and circumstance surrounding such death. "Provide for the investigation" means overseeing the investigative activities of an LDSS.
- Review the investigation of the cause and circumstances surrounding the death.
- Prepare and issue a report on each death unless such report is issued by an approved CFRT in accordance with [SSL §422-b](#).

As a result of the Protection of People with Special Needs Act [[Chapter 501 of the Laws of 2012](#)], OCFS is no longer responsible for issuing fatality reports involving children in the care of residential facilities or programs licensed, certified, or operated by OCFS. These fatalities are reported to and investigated by the Justice Center for the Protection of People with Special Needs (Justice Center), which is also responsible for issuing the associated reports. Authorized agencies must still notify OCFS within 24 hours of the death of any child in foster care where the investigation of the fatality is under the jurisdiction of the Justice Center, even though OCFS will not be issuing the report [[18 NYCRR 441.7\(c\)\(1\)](#)].

Once an IFCR is finalized, OCFS is responsible for sending the report to:

- The LDSS in the county where the child's death occurred;
- The chief executive officer in the county where the child's death occurred;
- The chairperson of the local legislative body of the county where the child's death occurred; and
- The LDSS that had care and custody, or custody and guardianship, of the child, if different than the LDSS in the county where the death occurred [[SSL §22\(5\)\(c\)](#)].

OCFS also must notify the Temporary President of the State Senate and the Speaker of the State Assembly when a child fatality report is issued. The law provides for certain circumstances in which a report may be released to the public. Please see **Section B.2.b.** of this chapter for a specific discussion of public release.

### **3. Role of Child Fatality Review Teams in Child Fatality Reviews**

[Social Services Law §422-b](#) allows for the establishment of Child Fatality Review Teams (CFRTs). A CFRT may be established at a local or regional level, with the approval of OCFS, for the purpose of investigating child fatalities in any of the categories on which OCFS is required to investigate and report, and for the purpose of preparing a child fatality report for any of those child deaths [[SSL §§20\(5\)\(a\) & 422-b\(1\)](#)]. A CFRT is also authorized to investigate the unexplained or unexpected death of any child under the age of 18 [[SSL §422-b\(1\)](#)].

#### **a. Members / Structure**

A CFRT must include representatives from [[SSL §422-b\(3\)](#)]:

- Child Protective Services
- OCFS
- County Department of Health, health commissioner (or designee), or public health director (or designee)
- Medical Examiner or Coroner's office
- District Attorney's office
- County Attorney's office

- Local and State law enforcement
- Emergency Medical Services
- A pediatrician or comparable medical professional, preferably with expertise in child abuse and maltreatment or in forensic pediatrics

While not statutorily required to do so, a CFRT may also include representatives from:

- Units of the local department of social services other than CPS
- Domestic violence agencies
- Mental health agencies
- Substance abuse programs
- Hospitals
- Local schools
- Family Court

Each CFRT has a team coordinator who engages in administrative and programmatic work to support the team's missions. For example, the team coordinator determines which cases to review according to the team's protocols and organizes team meetings.

The team coordinator must submit an annual child fatality report to OCFS summarizing:

- The number of deaths reviewed;
- The number of team meetings;
- The number of Section 20(5) Child Fatality Reports prepared by the CFRT, if any;
- Data from team reviews, including patterns, trends, findings, and recommendations for improved practice;
- Community interventions; and
- The practices and functioning of the team.

### **b. Responsibilities**

Approved CFRTs may investigate the death of any child who dies under any of the circumstances cited in [SSL §20\(5\)\(a\)](#). (See **Section A.2.a, Requirements.**) A CFRT also may review the unexplained or unexpected death of any child under the age of 18 [[SSL §422-b\(1\)](#)]. A CFRT may prepare an (ICFR) for any investigation and review conducted by the CFRT of a child fatality falling under the circumstances set forth in [SSL §20\(5\)\(a\)](#). A CFRT that chooses to investigate and review of a child fatality and prepare a fatality report has the same authority as OCFS regarding the preparation of fatality reports [[SSL §422-b\(2\)](#)].

CFRTs are authorized by law to access the confidential information in pending or indicated SCR reports [[SSL §§422\(4\)\(A\)\(w\)](#) and [422-b\(2\) & \(4\)](#)]. State law also authorizes CFRT members access to legally sealed unfounded reports for the purpose of preparing such a fatality report [[SSL §422\(5\)\(a\)\(ii\)](#)]. CFRTs also have access to any other information, including confidential information (other than information protected by a statutory privilege or information not available pursuant to federal law), that they need to prepare a fatality report [[SSL §§20\(5\)\(d\); 422-b\(2\)](#)]. Accordingly, a CFRT that is investigating and/or reviewing a child fatality under [SSL §20\(5\)\(a\)](#), but that does not issue a report on that fatality, has access to pending and indicated SCR reports, but not to unfounded reports, FAR reports, or

other confidential information. LDSSs, authorized voluntary agencies (VAs), and any other agencies are required to provide a CFRT with requested information they are authorized to provide within 21 days of receipt of the request [SSL §422-b(4)].

In addition to reviewing those child fatalities specified in statute [(SSL §20(5)(a))], CFRTs may also choose to review near-fatalities and “expected” or “explained” fatalities. CFRTs cannot be given access, however, to confidential information for such reviews and OCFS does not fund such reviews.

When a CFRT prepares a child fatality report, OCFS is not obligated to prepare a separate fatality report. OCFS is responsible, for reviewing and physically issuing the CFRT-prepared report [SSL §422-b(2) & (6)]. OCFS has the final authority to make any needed modifications to the report prepared by the CFRT.

CFRTs must abide by the same confidentiality and re-disclosure provisions as OCFS regarding child fatality reports [SSL §422-b(6)]. It is imperative that CFRTs strictly protect the confidentiality of the sensitive material they access as part of their duties. Members must sign confidentiality agreements as a condition of their membership on the team.

Each OCFS-approved CFRT must use a written protocol to guide its work and assist team members in their mission. OCFS provides a model protocol that CFRTs can use. (See Appendix L in the OCFS *Child Fatality Review Practice Guidance Manual*.) It is important that each team’s protocol include the team’s mission and the specific information outlined in the protocol template that describes how the team plans to fulfill its mission. Strong protocols promote the protection of confidentiality and optimize the work of the CFRTs.

## B. Individual Child Fatality Review reports

### 1. Contents of the Individual Child Fatality Review report

#### a. *Structure of the report*

An ICFR is prepared by OCFS or an OCFS approved CFRT, and must contain the following [SSL §20(5)(b)]:

- The cause of death, whether from natural or other causes
- Any extraordinary or pertinent information concerning the circumstances of the child's death
- The identification of child protective or other services provided, or actions taken regarding the child and their family (this includes historical information)
- Information concerning whether the child or the child's family had received assistance, care or services from an LDSS prior to the child's death
- Any action or further investigation taken by OCFS or the LDSS since the death of the child
- As appropriate, recommendations for local or state administrative or policy changes
- Written comments provided by any LDSS referenced in the report. The comments must protect the confidentiality and privacy of the deceased child, the child's family and household members, and the source of any report to the SCR; be relevant to the fatality; and be factually accurate.<sup>2</sup>

The ICFR must **not** include:

- Any information that would identify the deceased child, their siblings, the parent(s) or other person legally responsible for the child, or any other members of the deceased child's household;
- The identity of the source of a report made to the SCR, if one was made;
- Any psychological, psychiatric, therapeutic, clinical or medical reports, evaluations, or like materials or information not directly related to the cause of the child's death.

#### b. *Assessment of the investigation*

Important purposes of the child fatality review process are to determine whether the LDSS or VA complied with applicable statutes, regulations, and OCFS policies and consistent with that assessment, to reach conclusions about the adequacy of the actions taken and decisions made regarding the subject child, siblings, and other children residing in the household [SSL §§20(2)(b) and 34(3)(d)].

To make these judgments, the reviewer, either OCFS or the CFRT, refers to relevant statutes, regulations, and OCFS policies and applies them to case facts. The reviewer assesses the adequacy of the actions and decisions by considering them in the context of the facts that were available to the LDSS or voluntary agency when the actions took place, and the decisions were made.

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<sup>2</sup> OCFS. (2015). "The Inclusion of Local Social Services District Comments in Child Fatality Reports" ([15-OCFS-INF-09](#)).

In this manner, the reviewer identifies the LDSS's or VA's case practice strengths and needs. The information in the case record is weighed against standards for good practice, regarding such elements of case practice as:

- Purposeful information gathering;
- Solution focused interviewing;
- Family engagement;
- Quality of case contacts; and
- Collaboration and coordination activities with other professionals.

This assessment of actions and decisions may lead the review team to make relevant recommendations for improvements that fall within the scope of New York State laws, regulations, and OCFS policies. This assessment of case practice strengths and needs is then used to inform the development and implementation of strategies to improve practice.

## 2. Sharing the Individual Child Fatality Report

### a. *Requirements*

While a CFRT may write an IFCR, OCFS has final responsibility for the report and its contents, and only OCFS can issue the report [SSL §§20(5)(c) & 422-b(6)].

#### **LDSS Review Prior to Finalizing the Report**

Prior to issuance of a report, OCFS must submit a draft copy of the proposed report to each LDSS referenced in the report for review and comment.<sup>3</sup> A purpose of this sharing is to provide the LDSS the opportunity to correct factual errors or to supply missing information.

In addition, the LDSS may submit comments on the draft report. Any such comments must be submitted within ten days of the receipt of the draft. [SSL §20(5)(c)]. These comments must protect the confidentiality and privacy of the deceased child, the child's family and household members, and the source of any report to the SCR; be relevant to the fatality and pertain to one of the factors that must be addressed in the fatality report; and be factually accurate [SSL §20(5)(b)(vii)]. Comments meeting these requirements must be included by OCFS in the final fatality report.

#### **Distribution of the Final Report**

Once the IFCR is final, but no later than six months after the death of the child, OCFS issues the report to the following officials [SSL §20(5)(c)]:

- The LDSS Commissioner of the county where the death occurred;
- The LDSS Commissioner who had care and custody, or custody and guardianship, of the child, if different from the LDSS Commissioner in the county where the child's death occurred;
- The chief executive officer of the county (in New York City, the Mayor of the City of New York) where the child's death occurred;
- Outside of New York City, the chairperson of the local legislative body in the county where the child's death occurred; and

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<sup>3</sup> See 15-OCFS-INF-09, [The Inclusion of Local Social Services District Comments in Child Fatality Reports](#).



- If the death occurred in New York City, the president of the New York City Council

OCFS must also notify the Temporary President of the State Senate and the Speaker of the State Assembly when it issues an IFCR.

OCFS also shares reports about fatalities that occur in New York City with the Public Advocate for the City of New York.

For reports prepared by a CFRT, OCFS must also forward copies of the report to all other CFRTs established under [SSL §422-b](#), as well as to all citizen review panels established pursuant to [SSL §371-b](#), and to the Governor.

### **b. Confidentiality / Release to the Public**

When OCFS receives a request for a specific IFCR to be released to the public, OCFS may release the report if OCFS determines that such disclosure is not contrary to the best interests of the deceased child's surviving siblings or to other children in the deceased child's household [[SSL §20\(5\)\(b\)](#)].

Such a "best interests" determination must be made when there is either a request for the release of an IFCR or a more general, request for multiple reports that is not child specific. With each request, OCFS must consider various factors including, but not limited to, the potential adverse effects of disclosure on the surviving siblings or other children in any deceased child's household.<sup>4</sup> A "best interests" determination must also be made before releasing an IFCR prepared by OCFS to members of a CFRT.

These confidentiality protections do not preclude OCFS, acting in its supervisory role, from issuing a separate report and findings to the appropriate LDSS or VA that specifically identifies the pertinent parties.

## **3. LDSS Program Improvement Plans**

### **a. Development of an LDSS Program Improvement Plan**

When the review of an investigation of a child fatality finds important statutory or regulatory compliance failures and deficiencies in practice, the LDSS must develop a Program Improvement Plan (PIP) and submit it to its OCFS Regional Office.

OCFS pre-fills a PIP template with the identified deficiencies and the applicable statutory or regulatory citations and emails the template and any accompanying information to the LDSS. The OCFS Regional Office informs the LDSS of the timeframe for submission of its PIP.

In New York City, staff from the Regional Office and the Administration for Children's Services (ACS) meet within seven days to clarify the issues raised in the report and to offer technical assistance and guidance in developing the plan.

The objective of a PIP is to correct the behaviors and/or conditions that caused the noncompliance issues identified in the Child Fatality Review. The PIP should describe specific corrective strategies, detailing actions and activities that will help the LDSS resolve the identified issue(s). The PIP should indicate how and when those actions and activities

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(OCFS, 2021) "OCFS Best Interests Determinations Process for Fatality Report Releases" ([21-OCFS-LCM-12](#)).

will occur. The PIP should also describe how the LDSS will demonstrate that the identified noncompliance issues have been corrected.

When applicable, the OCFS Regional Office should initiate discussions with the LDSS about its findings and the need for a PIP as early in the fatality review process as possible. Upon request, the OCFS Regional Office may help the LDSS develop its PIP by:

- Engaging the LDSS's leaders and managers in ongoing discussions about the process for developing, approving, and monitoring the PIP
- Reviewing and providing comments on early drafts of the PIP
- Providing guidance about the types of corrective strategies that have been shown to be successful in correcting the identified noncompliance issues
- Assisting the LDSS to identify existing agency strengths and resources that it can mobilize to meet the PIP's objectives
- Helping the LDSS to determine if technical assistance is needed to implement and complete the PIP
- Identifying and obtaining resources for corrective actions, such as staff training and technical assistance
- Encouraging the LDSS to use, as appropriate, its overall quality assurance process to sustain the improved performance achieved through the PIP

If, after reviewing the PIP, the OCFS Regional Office has concerns that it does not adequately address the identified noncompliance issues and required actions, then Regional Office staff will meet with the LDSS to discuss these concerns and negotiate changes or additions to the PIP.

When the OCFS Regional Office determines that the LDSS's plan is adequate, it issues an approval letter to the LDSS.

In New York City, the OCFS New York City Regional Office also sends a copy of the approval letter to the New York City Citizen Review Panel.

### ***b. Monitoring LDSS Program Improvement Plans***

The OCFS Regional Office is responsible for monitoring the implementation and completion of PIPs. The OCFS PIP template is the working document for the monitoring process, with the focus on the columns filled out by the LDSS, describing the corrective actions that will be taken and their timeframes.

The LDSS should notify the OCFS Regional Office when it has completed the corrective actions specified in the PIP. If a completion date passes without such notification, the OCFS Regional Office will contact the LDSS to determine whether the plan is being implemented. If a PIP is amended, this should be recorded in the Regional Office's records maintained for PIPs.

The Regional Office determines the effectiveness of the Program Improvement Plan through its ongoing case review process and site visits by the Regional Office liaison. The OCFS Regional Office will indicate in its PIP records when the LDSS has completed all corrective actions.