SYSTEMIC CHILD FATALITY REVIEW
2019 ANNUAL REPORT

Systemic Child Fatality Review - 2019 Annual Report

Table of Contents

Introduction

New York City's Administration for Children's Services (ACS) is mandated to investigate alleged abuse and neglect among children residing in the city. In 2019, ACS investigated almost 65,000 reports of child maltreatment, concerning more than 84,600 children. These reports were consolidated into a total of 54,828 investigations and Family Assessment Response cases. Among these, ACS investigated 101 child fatalities reported to the Statewide Central Register (SCR) of Child Abuse and Maltreatment. Following an ACS investigation, the investigative team concluded in a majority of child fatalities that the circumstances of the fatality were unrelated to abuse or neglect. As noted in prior reports, the occurrence of a child fatality due to abuse or maltreatment continues to be a rare event, comprising about 0.1 percent of all cases investigated. Nonetheless, the death of a child in a family with past ACS contact requires special attention.

This report focuses on child fatalities investigated by ACS that occurred during calendar year 2019. It outlines how ACS responds to child fatalities, summarizes demographic data, and provides systemic findings from cases reviewed. Due to the small number of fatalities when compared to the larger pool of child welfare cases touched by ACS, readers are cautioned against generalizing findings in this report. The child fatality cases examined in this report are neither a random nor a representative sample of all families involved in the city's child welfare system. However, the purpose of the case reviews and analyses is to learn lessons that will help to strengthen the child welfare system for all families with whom ACS has contact.

This report is published pursuant to Local Law 19 of 2018,[1] which requires ACS to issue a report on its child fatality reviews. This is an annual obligation, with a report on fatalities from each calendar year to be issued no later than 18 months after the end of the year. The law requires that this report include, but not be limited to, the following:

a. The number of fatalities of children known to ACS for the applicable year;

b. The manner and/or cause of death in such fatalities;

c. The age, gender, race and ethnicity of children with fatalities for the previous year;

d. Any relevant trends and systemic recommendations, including opportunities for inter-agency collaboration; and

e. A summary of any case practice findings and agency policy changes made in response to child fatalities in the previous 12 months.

The New York State Office of Children and Family Services (OCFS) and the New York City Department of Health and Mental Hygiene (DOHMH) also produce annual reports on child fatalities using other criteria for inclusion.

In 2018, ACS adopted and began piloting a safety science approach to reviewing fatalities, based on innovations in aviation, health care and other industries to improve safety. ACS's Systemic Child Fatality

[1] 2018 N.Y.C. Local Law No. 19, N.Y.C. Admin. Code §§ 21-915

Review (SCFR) process is modeled after systems developed in Tennessee, Arizona, Minnesota, Wisconsin and other jurisdictions around the country.

This approach to reviewing fatality cases carefully examines the complex interplay of systemic factors, such as policies, workloads, availability of resources, supervision and training, among many other issues that may impact case practice and decision-making. Safety science teaches us to produce applied, data-driven learning and insight, and promotes a culture of openness and shared agency-wide accountability, in order to strengthen investigative practice and the child welfare system as a whole. ACS continues to build and implement its Systemic Child Fatality Review process to reviewing child fatalities. This approach emphasizes:

1) a shift from a culture of blame to a culture of system accountability

2) implementing systemic methods of learning and investigation; and

3) addressing underlying systemic issues rather than quick fixes.

Technical assistance to implement the model in ACS was provided by Collaborative Safety LLC, and the Center for Innovation in Population Health at the University of Kentucky through The National Partnership for Child Safety, established in partnership with Casey Family Programs.

This report reviews 57 child fatalities from calendar year 2019 that occurred in families that were “known” to ACS because of active involvement in an ACS investigation or services at the time of the fatality, or because of such involvement in the preceding ten years. The purpose of these reviews is to understand the case-specific and underlying systemic issues that must be addressed to improve practice and service delivery to families. Using a safety science approach, ACS’s goal is to thoroughly investigate child fatalities to learn and ultimately improve the system’s ability to support safe outcomes for children.

New York City's Review of Child Fatalities Alleging Maltreatment

The New York Statewide Central Register (SCR) receives all reports of suspected child abuse and maltreatment for anyone under 18 years old. Reports may come from professionals (e.g., medical staff, school officials, social service workers, police officers), who are mandated by law to report, as well as from the general public. Among the reports the SCR receives are cases of child fatalities in which maltreatment may have been a factor, including reports received from the medical examiner or coroner. Additionally, any fatality that occurs during an open child protective investigation, while a family is receiving prevention services, or while a child is placed in foster care, must be reported to the New York State Office of Children and Family Services (OCFS), even if the circumstances of the fatality did not raise suspicion of abuse and/or maltreatment.

The New York City Office of the Chief Medical Examiner ("the ME") determines the cause and manner of a child's death. The cause of death is the injury, disease, or condition that resulted in the fatality, such as blunt trauma or acute and chronic bronchial asthma. The manner of death is determined by the findings of the ME's autopsy examination and the circumstances of the death. The ME certifies the "manner" as having been an accident, homicide, natural, suicide, therapeutic complications, or undetermined.[2] These classifications are administratively determined and may differ from other jurisdictions, which can make comparisons across systems challenging. For example, the ME may classify a death as "homicide" in which a child died in a fire where s/he was left alone without adult supervision. Yet another source of variation in "manner of death" classifications relates to sleep-related injury deaths where the child's sleeping conditions or surface may have contributed to the fatality. These deaths are oftentimes classified as "undetermined" by the ME in New York City, though this classification varies for similar cases both within New York City and in other state and county systems.

Table 1, below, shows that over one-half (56%) of the child fatalities reported to the SCR in 2019 alleging maltreatment in association with a child's death occurred in families that were "known"[3] to ACS in the past 10 years. Subsequent sections of this report focus only on those fatalities. Table 1 also provides an overview of all fatalities reported to the SCR and investigated by ACS in 2019 (see Table 2 for data on cases known to ACS).

[2] As noted, the manner of death is an administrative distinction made by the Office of the Chief Medical Examiner. In New York City, the Medical Examiner uses the undetermined category when the manner or cause of death cannot be established with a reasonable degree of medical certainty. Deaths are determined to be from "therapeutic complications" when a medical device failure caused the death. Please see Appendix 1 for additional details.

[3] See Case Review Criteria section of this report for full definition of "known to ACS."

Table 1. Manners of death for all 2019 child fatalities reported to SCR

	2019 Cases in Families Known* to ACS		2019 Cases Not Known to ACS		Total 2019 - All child deaths reported to the SCR	
Manner of Death	**N**	**%**	**N**	**%**	**N**	**%**
Accident	8	14	9	20	17	17
Homicide	11	19	2	5	13	13
Natural	11	19	9	20	20	20
Suicide	3	5	0	0	3	3
Undetermined	15	26	15	34	30	30
Therapeutic Complications	0	0	0	0	0	0
Pending ME determination	9	16	9	20	18	18
Total	57	99	44	99	101	101

Percentages may not equal 100 due to rounding

- A family is considered "known" to ACS if an adult in the household has been the subject of an allegation of child abuse or maltreatment reported to the NY State Central Register within the last 10 years.

When the SCR receives a report of a child's death in New York City, the report is forwarded to the ACS Division of Child Protection (DCP) to investigate and make a determination regarding the circumstances of the deaths. When a DCP investigation finds "some credible evidence" that abuse or neglect may have taken place in relation to any of the allegations, the report is defined as "indicated." Alternatively, if there is no credible evidence of maltreatment, the report is classified as "unfounded." Some investigations result in an indication for some, but not all, of the allegations. Fatality investigations often include other allegations of maltreatment which may be "substantiated," but the child protective team may have "unsubstantiated" the fatality allegation after concluding that the parent or caretaker did not contribute to the fatality.[4] Such cases, then, may involve an allegation of educational neglect being "substantiated" for the deceased child and/or a sibling, but the fatality allegation may be "unsubstantiated." In addition to DCP investigations, the New York City Police Department and District Attorney also investigate child fatalities to determine if there might have been criminal culpability, and whether or not to pursue criminal prosecution.

[4] A child maltreatment allegation is either "substantiated" or "unsubstantiated" based on the evidence gathered. The child maltreatment report is deemed "indicated" if one or more of the allegations are "substantiated." The child maltreatment report is deemed "unfounded" when all of the allegations in the report are "unsubstantiated." Therefore, an allegation may be "unsubstantiated" with respect to the fatality itself, but the report "indicated" if other allegations within the same SCR report are "substantiated."

Case Review Criteria

The ACS Child Fatality Review Team, consisting of specially trained Case Reviewers, screens each child fatality case reported to the SCR for ACS history to determine whether the family was "known" to ACS.[5] A family is considered "known" if it meets any of the following criteria:

a. Any adult in the household has been the subject of an allegation of child abuse or maltreatment to the SCR within 10 years preceding the fatality;

b. When the fatality occurred, ACS was investigating an allegation against an adult in the household; OR

c. When the fatality occurred, a household family member was receiving ACS services such as foster care or prevention services.

If the family is "known," the Case Reviewers assess the case to determine the appropriate review track. There are two possible tracks:

1. There is an open investigation or an open case with prevention and/or foster care services; or there was a prior ACS case within the past 3 years; or the ACS Office of the Commissioner requested a review.

2. A prior ACS case was closed more than 3 years ago but within 10 years.

Cases that fall within category one receive a summary and are eligible for the ACS Systemic Child Fatality Review Process, while cases in category two receive a case summary only.

[5] Although the family may have prior history, it does not mean that the decedent was the maltreated child or alive during the prior ACS involvement.

ACS Systemic Child Fatality Review (SCFR) Process

Upon notification of a child fatality from the SCR, the Division of Child Protection (DCP) takes immediate action, in accordance with OCFS guidelines, to initiate the investigation and ensure the safety of any surviving siblings and/or family members. Throughout the investigation, as more information becomes available, DCP may take additional actions to assure child safety. The Child Fatality Review Team (CFRT), within the ACS Division of Policy, Planning, and Measurement, also receives notification of each fatality. The CFRT assesses the fatality to determine whether it falls within the review criteria. If it does, the team implements the Systemic Child Fatality Review (SCFR) process.

Once a child fatality is determined to fall within the review purview, for each SCFR case the Child Fatality Review Team examines the family's history with ACS as well as available autopsy reports and records from service providers that had contact with the family. Additionally, in order to understand family and child functioning prior to the fatality, the team examines the child welfare histories of all adults known to be related to or involved with the child, such as parents, significant others, grandparents, aunts/uncles, and others with known caregiving responsibilities.

The Child Fatality Review Team completes a case summary which includes a review of the case history from available databases. Upon summary completion, the case is discussed with the ACS Interdivisional Team (IDT), consisting of cross divisional ACS staff, to identify whether a more comprehensive analysis of the case would likely generate key learning points or areas for study of internal and external systems. When cases are selected for a full review, staff involved with the corresponding learning points are invited to participate in a "human factors debrief." In 2019, there were 42 cases eligible and selected for a full review.

Human factors debriefings are facilitated opportunities for staff to share and process their experiences working with the family, and an opportunity to explore critical decisions and interactions throughout the case. Debriefings are voluntary and typically involve direct service staff and their supervisors, but may include other staff where necessary. During debriefings, all efforts are made to create a safe and supportive environment for staff to identify opportunities for learning and improvement.

Cases selected for a full review are mapped, a process whereby borough-based multidisciplinary teams (Mapping Teams) made up of staff from the borough offices and other ACS divisions discuss local, regional and regulatory conditions or processes that affect case practice and decision making. Information gathered from the completed case summary review, human factors debriefs, and mapping sessions is analyzed to identify systemic influences and key findings which are used to produce recommendations that will lead to system improvements.

2019 Cases Reviewed

Manner of Death

In 2019, there were 57 fatalities of children in 56 families (two deceased children were in one family) that had been the subject of an investigation or otherwise received services from ACS within the last 10 years, or who were receiving services or were the subject of an investigation at the time of the fatality. The most common "manners" of death as certified by the ME were "undetermined" (n = 15, 26%), followed by "natural" (n = 11, 19%), "homicide" (n = 11, 19%), "accident" (n = 8, 14%), and "suicide" (n = 3, 5%) (See Table 2).[6] There were nine cases with pending autopsies at the writing of this report.

Table 2: Manners of Death for Systemic Child Fatality Cases in 2019

	Total 2019	
Manner of Death	**N**	**%**
Accident	**8**	**14%**
Homicide	**11**	**19%**
Natural	**11**	**19%**
Suicide	**3**	**5%**
Undetermined	**15**	**26%**
Therapeutic Complications	**0**	**0%**
Pending ME Determination	**9**	**16%**
Total	**57**	**99%**

Case Demographics and Family Characteristics

The Child Fatality Review Team examined the child welfare case record of each family in which a fatality occurred and for each case collected information on family demographics, characteristics, and the presence of potential risk factors, including:

a. Race and/or ethnicity of the parents/caretakers
b. Number of children in the family;
c. Whether the mother was under eighteen when her first child was born, as well as the ages of the mother and father/male involved at the time of the fatality;
d. Whether the child had any documented developmental, medical or mental health conditions;

[6] Appendix 1 provides descriptions of what the Medical Examiner considers when making a manner of death determination.

e. Whether the family had a history of homelessness within four years prior to the fatality, and whether the family was residing in shelter at the time of the fatality;
f. Extent of prior history with ACS, including the parents' history with child welfare as a child and the number of previous investigations of the family;
g. Identification in the case record of parent or caregiver mental health condition;
h. Identification in the case record of parent or caregiver substance use;
i. Identification in the case record of household domestic violence within the last four years;
j. Whether the family had an open case at the time of the fatality.

The following is a review of case characteristics for the 2019 fatalities (n = 57); Table 3 provides demographic information for the 56 cases (two deceased children were in one family).

Table 3: Demographics

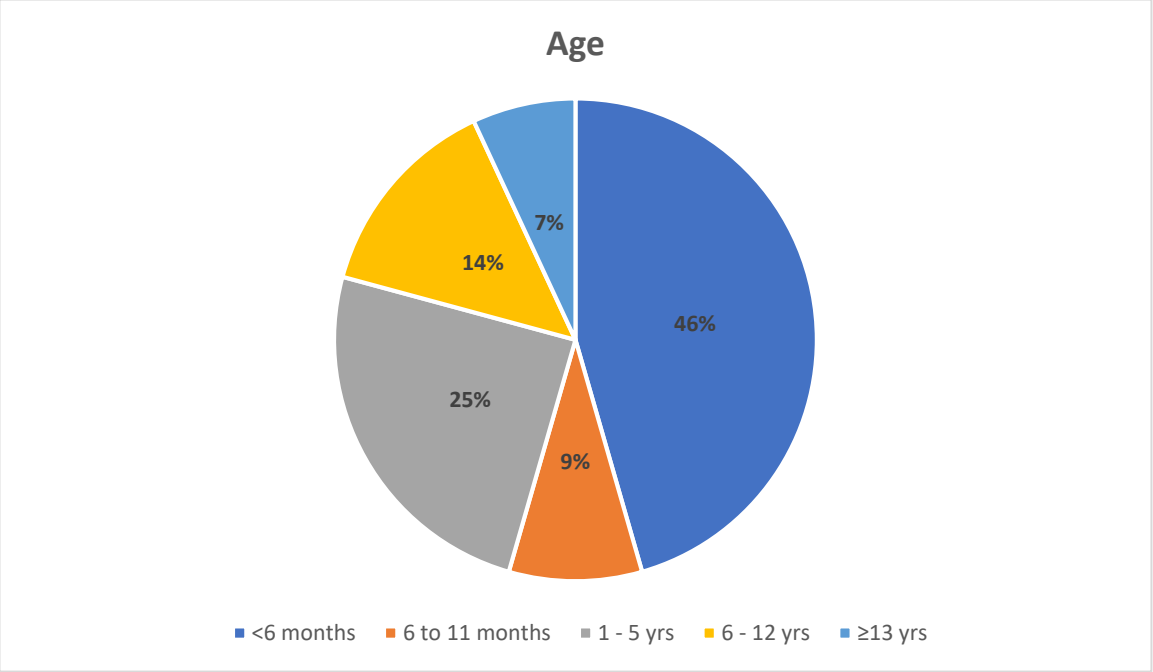
Demographics	n	%
Race (of mother, n = 56)		
Asian	0	0
Black	29	52
Hispanic	18	32
Pacific Islander	0	0
Native American	0	0
Multiracial	1	2
White Non-Hispanic	7	13
Not Available	0	0
Other	1	2
Unknown	0	0
Gender (of child n = 57)		
Female	22	39
Male	35	61
Age (of child n = 57)		
<6 months	26	46
6 to 11 months	5	9
1 to 5 yrs	14	25
6 to 12 yrs	8	14
≥13 yrs	4	7

Percentages may not equal 100 due to rounding

Mothers were disproportionately Black/African-American/non-Hispanic (52%) and Hispanic (32%). Seven of the fatalities occurred in families where the mother was identified as White, in three of those cases the father was Black/African-American/non-Hispanic. When available, data was also collected on the fathers or males involved with the family. Fifty-two percent of the males identified as Black/African

American/non-Hispanic while 30% were Hispanic. Males were listed as White in four cases. No race or ethnicity data was available on males in four cases.[7]

Figure 1. Age at Time of Fatality



As in previous years, children at greatest risk of fatality were of the youngest ages. In 2019 cases, the average age of children was 3.2 years, a little higher than 3.1 average in 2018 and slightly lower than 2017 average (3.4 years), while the median age was 6.8 months (slightly higher than the 2018 median age of 6.6 months and younger than the 2017 median age of 9.1 months). Children's ages ranged from newborn to just under 17 years. Fifty-five percent (n = 31) of the fatalities were of infants under the age of one, and of these, eighty-four percent (n = 26) were less than six months of age. In fact, children under the age of six, including infants, accounted for 79% of 2019 fatalities. A significantly larger proportion of the children were male (61%) compared to female (39%).

A fatality investigation concludes with the child protective investigative team making a determination regarding the fatality allegation made in the SCR report, as well as any additional allegations included in the report, such as inadequate guardianship or lack of supervision. Three-fourths of the cases were indicated for at least one allegation (n = 42, 75%), with 36 percent of the cases indicated for the fatality itself. Fifty-two percent of the fatalities occurred among families with open ACS cases at the time of death, while 30 percent of the deaths occurred in families where the case was closed within the three years prior to the fatality.

[7] This data was based on the race and ethnicity information available in CONNECTIONS.

As with other families who interact with ACS in any capacity, families in which a fatality occurred were disproportionately families of color. Many of these families face multiple challenges, including recent or ongoing homelessness (23 percent of families in cases reviewed), and a recent history of domestic violence (within the last four years), which was noted in 41 percent of the cases reviewed. Thirty-four percent (n = 19) of the mothers had histories of ACS involvement as children and of those, 58 percent (n = 11) had a history of foster care placement as children. For the males involved with these families (where information was available, n = 52), 17 percent had histories of ACS involvement as children, and one showed a history of foster care placement. Eleven cases reviewed involved families residing in a shelter at the time of the fatality. Seven had an active ACS case at the time of the fatality.

Reviews of the case records indicated that the average age of mothers was 31.3 years at the time of the child's death; and the median age of these mothers was 32.0 years, both above the 2018 rates, 30.7 and 30.0 respectively, for these data points. On average, as in 2018, mothers had three or more children. A male was involved with the family in 93 percent of the cases reviewed. Fifty percent (n = 28) of the mothers had current or prior substance use issues noted, and 41 percent had current or ongoing mental health concerns (diagnosed or undiagnosed) noted in the case record. Of the identified males, 88 percent (n = 46) were fathers of the deceased child. Where information was available on the male known to be a part of the household and/or in a caregiving role, in 48 percent of the cases, current or prior substance use was noted. Current or past mental health concerns were noted on six of the cases.

Additional Case Characteristics and Related ACS Initiatives

Sleep-Related Injury Deaths

Thirty-six percent (n = 20) of the 2019 fatalities included notations of sleep-related injuries or unsafe sleep conditions either from the Medical Examiner (ME) autopsy findings or from a review of the ACS investigation of the fatality (see Table 5 in Appendix B). The ME often designates and records the manner of death for these cases as "undetermined" or "accident." In New York City, the ME uses the undetermined category when the manner or cause of death cannot be established with a reasonable degree of medical certainty. This is common in cases where an unsafe sleep condition is present but the role of the hazard in the fatality cannot be determined following an autopsy, such as a fatality where an infant is found alone in a crib or bassinet in which soft bedding is present.

While unsafe sleep is not a manner or cause of death certified by the ME, the ME may make note of the presence of contributing unsafe sleep factors when determining the manner of death. These 20 child fatalities were categorized as sleep-related deaths because of unsafe sleep conditions cited by either the ME's report, or documented in the progress notes during an ACS investigation. Unsafe sleep conditions can include factors such as bed-sharing with an adult or sibling; infants sleeping with pillows, blankets, or other objects in the crib, (which can create a risk of entanglement and/or asphyxia); and defective or unsuitable sleeping furniture, such as an air mattress, couch, or car seat. Of the 20 cases with unsafe sleep conditions noted, the ME certified about half (n = 9, 45%) as having an undetermined manner of death. In addition, a review of case records and autopsy findings indicate that the most common unsafe sleep condition was bed-sharing with an adult and/or a sibling.

Of the 20 sleep related fatalities, all but four were of children under six months of age. More than half (n = 12, 60%) of the children were male and 40% (n = 8) were female.

ACS Safe Sleep Strategy

The NYC Infant Safe Sleep Initiative aims to prevent sleep-related infant injury deaths and address long-standing disparities to promote and protect the health and well-being of our youngest and most vulnerable New Yorkers. The Initiative's primary prevention focus, collaborations and partnerships aim to achieve equity in infant survival and close the Black/White infant mortality gap.

The ACS Safe Sleep Unit in the Division of Child and Family Well-Being provides free education and resources to help parents and caregivers of babies, child welfare professionals, clinicians and advocates understand the risks, and avoid preventable sleep-related infant fatalities. Our citywide public awareness campaigns, outreach activities, and free training, information and resources educate New Yorkers about potentially fatal practices like bed-sharing or stomach sleeping.

The Safe Sleep team continued its outreach and education in 2019 and throughout 2020, despite the many challenges and limitations associated with the COVID-19 pandemic. In 2020, the work of the Safe Sleep team includes that they:

- Continued to distribute Safe Sleep Toolkits to discharging maternity patients at all 11 NYC H+H facilities.
- Released "Communicating Infant Safe Sleep Practices" – an interactive eLearning course designed for NYC child welfare professionals.
- Captioned our safe sleep video entitled, "The How and Why of Safe Sleep" for the deaf and hard of hearing and translated the Safe Sleep brochure into 10 languages. Made available and promoted electronic links to both the video and brochure for families.
- Transitioned from live, in-person trainings to virtual trainings for parents, caregivers and providers.
- Successfully delivered our third Safe Sleep Summit with over 650 participants across New York and the U.S. Held virtually in October 2020 during Safe Sleep Awareness Month, the Safe Sleep Summit featured weekly presenters focused on the theme: "Closing the Gap: An Intersectional Approach to Reducing Infant Mortality," to examine the intersecting influencers that adversely impact infant survival. During this weekly webcast series, advocates and practitioners shared up-to-date analysis on how institutional racism affect infant mortality, shared outreach strategies, and shared best practices and resources.
- Successfully delivered our fifth annual Safe Sleep Symposium for Expecting and Parenting Youth in partnership with the ACS Division of Family Permanency Services.

In 2021, the Safe Sleep team expanded our virtual training offerings to include support for trainers and coaches. The online *Safe Sleep for All NYC Infants: Train the Trainer Course* (TTT) is preparing 45 experienced trainers from hospitals, City agencies and community-based organizations to train their staff on the core components of safe infant sleep recommendations and background on avoiding sleep-related infant injury deaths. The TTT Course is intended to build a pool of competent instructors who can deliver infant safe sleep training and will conclude in June 2021.

Homicides

In 2019, the Medical Examiner classified 11 cases (19%) as homicides. The ME classifies a death as homicide when the fatality results from an act of commission or omission by the perpetrator. The number of fatalities due to homicide varies from year to year (for a longitudinal view, see Table #6 in Appendix B). Characteristics and case circumstances in the families in which a homicide occurred were largely indistinguishable from those characteristics of families in which other types of fatalities occurred and were also indistinguishable from the larger population of families who have had contact with ACS. Six of the 11 homicide fatalities were of children less than three years of age.

ACS Enhanced Oversight of High-Risk Cases

ACS continues to build on its initiatives to strengthen protection of children who are at the greatest risk of physical abuse, including the Accelerated Safety Analysis Protocol (ASAP) and the Heightened Oversight Process (HOP). These initiatives provide additional levels of consultation, oversight and supervisory support in everyday child protective investigative practice.

The Accelerated Safety Analysis Protocol (ASAP) is a proactive process for evaluating safety practice in the early stages of select investigations, including those in which a child may be at high risk of physical harm. It is one component of a comprehensive quality management program at ACS that includes frequent oversight of outcomes and process data as well as qualitative case reviews. Through ASAP, a quality assurance review team identifies possible safety concerns in potentially high-risk investigations, examines documentation on the case, and, when necessary, meets with the investigative team to provide coaching around appropriate safety practices and interventions.

ACS implemented the Heightened Oversight Process (HOP) in 2017. The HOP provides a structure for collaboration and consultation among child protection investigative teams and the Investigative Consultants, an ACS team of former NYPD detectives. It is initiated when an SCR report contains allegations that include a fatality, a serious injury, or sexual abuse of children three years old or younger, as well as any reports that contain children three years of age or younger where the parent/caregiver named in the report has had one or more children removed and placed in ACS foster care prior to the current investigation, and the child(ren) and parent have not reunified. The HOP team identifies an investigative strategy at the beginning of the investigation and conducts conferences to assess and reassess whether additional investigative steps are needed.

ACS quality management includes collaborative efforts to improve child safety, identify key insights and opportunities for learning and improvement, and inform agency initiatives. Among these is ChildStat, where the ACS Commissioner meets with his executive leadership along with DCP managers and directors from the borough offices to discuss performance metrics and case practice. Each of DCP's 26 zones presents at ChildStat three times during a 15-month cycle. Lessons learned from ChildStat spur recommendations for zone, borough, and system-wide improvements. ACS's continuous quality improvement processes help leadership identify staff development needs and flag challenges to be addressed in management, technology, policies and standards. ACS uses these quality management and continuous quality improvement processes to promote an agency-wide culture of learning and accountability.

Natural Deaths

In 2019, 19 percent (n = 11) of the child fatalities were determined by the Medical Examiner to be natural (see Table #7 in Appendix B). The ME determines the manner of death to be natural when disease or a medical condition is the sole cause of death. Examples of common natural causes in child fatalities include acute and chronic bronchial asthma, pneumonia, and congenital conditions.

Of the 11 natural deaths, 3 had open cases with ACS at the time of death. None of the 11 cases was indicated for the fatality allegation at the conclusion of the investigation; five were indicated for other allegations. The majority of children were female (n= 7), half of the children (n = 6) had chronic medical conditions and/or developmental issues. The children who died of natural causes were slightly older than children who died of non-natural causes. While on average, children who experienced natural deaths were 4.8 years old, almost half the children (n = 5) were less than six months old. Across all fatality types, the average age in 2019 was 3.2 years of age.

Services for Children and Families with Complex Medical Needs

ACS is committed to ensuring quality health care for all children with whom the agency and its contracted providers have contact. The ACS Office of Child and Family Health continues to lead the agency's efforts to provide access to health services and educate staff on assessing whether children and adolescents' medical needs are being met. These efforts include:

- Complex Needs Protocol: In 2019, the Office of Child and Family Health, in collaboration with the Health and Hospitals Medical Consultants stationed in DCP borough offices, developed a protocol for cases in which a child is identified as having a complex medical need (criteria includes diagnosis or suspicion of a significant cognitive delay, neurological disorder, developmental disability, neurosensory limitation, significant neuromotor limitation, or organ system failure). In these cases, the medical consultant is required to schedule a consultation within 1-2 business days, with priority for cases with the most complex and acute medical needs.
- Asthma Mentoring Project (proposed/pending): The Fund for Public Health in New York City (FPHNYC) on behalf of the New York City Health Department, is seeking support to design and implement an initial one-year pilot to support the health needs of foster care youth and other high-risk youth, living in the Bronx and struggling with asthma. The goal of this pilot is to empower these youth to learn self-management skills and to make lifestyle changes to decrease asthma morbidity. This program will be developed as a partnership between the NYC Office of School Health (OSH), a combined program of the New York City Health Department and Department of Education, and the ACS Office of Child & Family Health (OCFH).
- Continued training of new and existing Child Protective Services staff on assessing and addressing medical care, or the lack thereof, during investigations of suspected abuse and/or maltreatment. Initial assessments include gathering the complete medical condition of children in the home and assuring that medical care for children, and the resources and insurance for its provision, is appropriately provided, as well as whether the child's condition warrants special attention or there are developmental concerns. Other topics taught include dental needs, issues contributing to failure to thrive, diabetes, as well as significant disabilities such as autism, Down

Syndrome, hearing or visual impairment, cerebral palsy, and other vulnerabilities. ACS also offers a physician facilitated Medical Issues course where these health conditions and how to assess safety plans and respond, when needed, are discussed. Consultation with the ACS Office of Child and Family Health is also encouraged throughout the life of the case.

System Recommendations

The safety science approach encourages proactively exploring systemic influences that impact decision making in the moment, with the goal of greatly reducing the likelihood of child fatalities. The review process seeks to identify systemic influences within individual cases and trends across multiple cases. The frequency of systemic influences informs recommendations for child welfare system improvement.

The Child Fatality Review Team screens each child fatality case reported to the SCR for ACS history to determine whether the family was "known" to ACS. Cases with current ACS, foster care or prevention services, or cases closed within the past three years or requested by the Office of the Commissioner are eligible for full review which includes producing a case summary and conducting human factors debriefing and mapping sessions, and using a Safety Assessment Tool to score systemic influences. In 2019, there were 42 cases that met the criteria for a full review. Cases closed more than 3 years ago but within 10 years received a case summary, and demographic information is captured for these cases. That information is included in the earlier sections of this report.

In addition to the many specific initiatives detailed in the previous pages, the Systemic Child Fatality Review process identified other recommended actions that were pursued by ACS, including:

- The ACS Division of Child Protection and the ACS Workforce Institute are focusing intensive staff development efforts on strengthening critical thinking, coaching, and modeling skills for supervisors to support the ability of the CPS to holistically assess cases—integrating information from case histories with newly discovered information.
- To strengthen and support engagement of fathers and other adult males involved in families in child protective cases, ACS is using a teaming (collaborative) approach throughout the agency to foster greater communication and partnership across child protection units, zones and boroughs and with other divisions and stakeholders.
- ACS has substantially expanded its use of mobile technology for investigative staff and continues to explore other technologies to support the ability of CPS to fully review families' child welfare history while also completing assessments, home visits and all other necessary tasks.

Appendix A: Manner of Death Definitions

The New York City Office of the Chief Medical Examiner determines both the cause and manner of death for each fatality for which an autopsy is conducted. The cause of death is the injury, disease or condition that resulted in the fatality, such as asthma or blunt trauma. The manner of death is based on the circumstances under which the death occurred. The following are the classifications used by the Medical Examiner:

Homicide: The Medical Examiner determines a death is due to homicide when the death results from an act of commission or omission by another person, or through the negligent conduct of a caregiver.

Natural: The Medical Examiner determines a death to be natural when disease or a medical condition is the sole cause of death.

Accident: The Medical Examiner determines a death to be an accident when the death results from injury caused inadvertently.

Suicide: The Medical Examiner certifies a death as suicide when the death is the result of an action by the decedent with the intent of killing him or herself.

Undetermined: The Medical Examiner certifies a death as undetermined when the manner of death cannot be established with a reasonable degree of medical certainty.

Therapeutic Complications: The Medical Examiner certifies a death from therapeutic complications when the death was due to predictable complications of appropriate medical therapy.

Appendix B: 2019 Data Tables

Table 4. Manner of Death (2010 - 2019)

Manner of Death	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Homicide	10	11	15	6	9	10	10	6	10	11
Undetermined	16	14	15	20	17	16	19	16	20	15
Natural	13	11	15	4	21	7	16	27	19	11
Accident	7	7	4	12	9	6	8	11	8	8
Suicide	0	0	1	2	2	2	0	2	2	3
Therapeutic Complications	0	0	0	0	0	1	1	0	0	0
Pending	0	0	0	0	0	[+]1	[+]*2	*1	0	*9
Total per year	46	43	50	44	58	43	56	63	59	57

[+]In one 2015 case and in 2016 one case, no body was found.

*In two 2016 cases, in one 2017 case, and in nine 2019 cases, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 5. 2019 Sleep-Related Child Fatalities in ACS Known Cases

Year of Child Fatality	Number of ACS Known Sleep Related Fatalities	Total Number of ACS Known Fatalities	Percent of ACS Known Fatalities with Unsafe Sleep Injuries
2015	21	43	49%
2016	21	56	38%
2017	24	63	38%
2018	21	59	36%
2019	20	57	35%

Table 6. Homicides in ACS Known Cases (2010 - 2019)

Manner of Death	2010	2011	2012	2013	2014	2015	2016	*2017	2018	*2019
Homicide	10	11	15	6	9	10	10	6	10	11
Total Fatalities	46	43	50	44	58	43	56	63	59	57
Percent of Fatalities Deemed Homicides	22%	26%	30%	14%	16%	23%	18%	10%	17%	19%

* In one 2017 case and in nine 2019 cases, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 7. ACS Known Cases Certified as Natural Deaths

Manner of Death	2010	2011	2012	2013	2014	2015	2016	*2017	2018	*2019
Natural	13	11	15	4	21	7	17	28	20	11
Total Fatalities	46	43	50	44	58	43	56	63	59	57
Percent of Fatalities Deemed Natural Deaths	28%	26%	30%	9%	36%	16%	30%	44%	34%	19%

*In one 2017 case and in nine 2019 cases, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.