# ACCOUNTABILITY REVIEW PANEL REPORT 2015 & 2016

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Administration for Children's Services

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## Introduction

New York City's Administration for Children's Services (ACS) is charged with investigating alleged abuse and neglect among children residing in the city. During 2015 and 2016, ACS conducted over 111,800 investigations of child maltreatment, concerning over 150,000 children, after a report of suspected maltreatment was accepted by the Statewide Central Register (SCR) and forwarded to ACS. Each year, ACS investigates about 100 child fatalities, following a report made to the SCR concerning the death; roughly half of these fatalities concern children in families who have no prior history of contact with ACS. Investigations following a fatality reported to the SCR comprise one-tenth of one percent of the cases investigated by ACS each year.

This report focuses on the work of New York City's Accountability Review Panel during the years 2015 and 2016. The Accountability Review Panel (referred to hereafter as "the Panel") reviews fatalities of children whose families have previously been the subject of a child protective, investigation or have otherwise received services from ACS within the last ten years, or who were receiving services or the subject of an investigation at the time of the fatality. The Panel is a multidisciplinary advisory body composed of experts from the fields of medicine, psychiatry, psychology, social work and public administration. Panel members include representatives from city agencies (including the Department of Education, Health and Hospitals Corporation, Police Department, Department of Homeless Services, Department of Health and Mental Hygiene and the Office of the Chief Medical Examiner), and external experts (including child advocacy center medical directors, child mental health specialists, pediatricians). In addition to the invited external Panel members, participants include ACS senior leadership, clinical staff and, when applicable, representatives from contracted preventive and foster care provider agencies. The Panel's reviews aim to identify systemic issues in ACS practice and policy, to provide expert opinions regarding individual child fatality cases, and to foster inter-agency collaboration and information-sharing regarding high-risk families.

This report outlines how ACS responds to child fatalities, provides context for understanding Panel fatalities, and thematically summarizes Panel case data, systemic recommendations, and ACS initiatives connected to the Panel's review of child fatalities in 2015 and 2016. The findings cannot be used to generalize about ACS case characteristics or practice, as Panel cases are neither a random nor representative sample of families involved in the city's child welfare system, and fatalities are an extremely rare outcome in families known to ACS. Nonetheless, the purpose of the Panel's case reviews and analysis is to identify ways to strengthen overall case practice, safety assessment and supportive services, while addressing individual and structural risk factors, for all families with whom ACS has contact.

This report is published pursuant to Local Law 19 of 2018, which requires ACS to issue a report on the findings and recommendations of 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 previous year;
b. The 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.

This report includes information on fatalities which occurred in both 2015 and 2016.

## New York City's Review of Child Fatalities Alleging Abuse or Maltreatment

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

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 pneumonia. The *manner* of death is based on the findings of the ME's autopsy examination and the circumstances of the death. The ME certifies the manner of death as an accident, homicide, natural, suicide, therapeutic complications, or undetermined. These classifications are administrative and may differ from other jurisdictions, making comparisons across systems difficult. For example, the ME may classify a death as either an accident or a homicide in which a child died in a fire where s/he was left alone without adult supervision. The District Attorney does not always pursue a criminal case following deaths classified a homicide by the ME. Another source of variation in manner of death classifications, as will be discussed in further detail below, relates to deaths in which unsafe sleep conditions may have contributed to the fatality, which are often 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.

When the SCR accepts a report of a child's death in New York City, the report is forwarded to the ACS Division of Child Protection (DCP). DCP investigates all fatalities referred by the SCR, and makes a determination regarding the circumstances of the death. As with child protective investigations for all allegations, when a DCP investigation finds "some credible evidence" that abuse or neglect has taken place in relation to any of the allegations, then the report is "indicated" for those allegations. If there is no evidence of maltreatment, the report is deemed "unfounded." Some investigations result in an indication for some, but not all, of the allegations. Of note, in fatality investigations, which often include additional allegations, allegations of maltreatment may be indicated but the child protective specialist may unsubstantiate the fatality allegation after concluding that the parent did not contribute to the fatality.[1] The New York City Police Department and District Attorney also reviews select child fatalities to determine if there is criminal culpability and whether or not to pursue prosecution.

While conducting its investigation, DCP reports each fatality investigation it receives from the SCR to ACS' Accountability Review Unit (ARU), within the ACS Division of Policy, Planning, and Measurement. The ARU assesses the case to determine whether falls within the Panel's purview. The Panel reviews fatalities of children whose deaths were reported to the SCR and whose families are "known to ACS." A family is considered "known" if it meets any of the following criteria:

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

[1]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."

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 preventive services.

If a family is known to ACS, that child's death becomes a "Panel case" and receives a full Panel review. As shown in table 1, just over half (53 percent) of the child fatalities reported to the SCR in 2015 and 2016 occurred in families who were known to ACS, and thus were subject to Panel review. This report focuses on those cases. Table 1, below, provides an overview of all fatalities reported to the SCR and investigated by ACS in 2015 and 2016 (see table 2 in the section that follows for Panel data alone). In 2015 and 2016, the cause and manner of death for fatalities which occurred in families known to ACS when compared to fatalities reported to the SCR in families that were unknown to ACS prior to the fatality were generally similar.[2]

### Table 1: Manners of death for all 2015 and 2016 child fatalities reported to SCR

| | 2015 Panel Cases | | 2015 non-Panel Cases* | | 2016 Panel Cases | | 2016 non-Panel cases | | Total 2015-16 all SCR-reported child deaths | |
|---|---|---|---|---|---|---|---|---|---|---|
| Manner of Death | N | % | N | % | N | % | N | % | N | % |
| Accident | 6 | 14% | 8 | 19% | 8 | 14% | 8 | 18% | 30 | 16% |
| Homicide | 10 | 21% | 8 | 19% | 11 | 20% | 5 | 11% | 34 | 18% |
| Natural | 6 | 14% | 9 | 21% | 17 | 30% | 17 | 39% | 49 | 26% |
| Suicide | 2 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 1% |
| Undetermined | 17 | 40% | 18 | 42% | 19 | 34% | 14 | 32% | 68 | 37% |
| Therapeutic Complications | 1 | 2% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% |
| Pending/No Autopsy | 1 | 2% | 0 | 0% | 1 | 2% | 0 | 0% | 2 | 1% |
| **Total** | **43** | | **43** | | **56** | | **44** | | **186** | |

*Percentages may not equal 100 due to rounding*
*Average age of non-Panel 2015 fatalities was 13 months.

For each Panel case, the ARU staff examines the family's history with ACS as well as autopsy reports and records from service providers that had contact with the family. ARU examines the history of child welfare involvement of adults , such as parents, boyfriends, grandparents, aunts, and uncles, related to the child or known to have had caregiving responsibilities, to understand family and child functioning prior to the fatality.

The Panel convenes monthly to review fatality cases. The Panel reviews the facts of each case, engages in dialogue with ACS staff and representatives from other city agencies about their interactions with the family, makes observations, and offers recommendations. In each review, the Panel makes observations regarding case practice, characteristics of the family in which the fatality occurred, and systemic issues that may warrant exploration. After review and discussion, the Panel may suggest practice or policy changes, which are subsequently reviewed by the relevant divisions.

[2] As described on the preceding page, 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.

## Understanding the Local and National Context

To place the Panel's work in a larger context, data below are presented related to child fatalities in the United States and New York City.

In 2016, the national fatality rate among infants was 5.6 deaths per 1,000 live births[3], slightly down from 5.9 in 2015. Data suggests that infants under one year of age are at greatest risk of death among all children; that rate decreases substantially after the first year of life. Across age groups, death rates for boys are higher than for girls, with the largest percentage difference being among youth aged 15 to 19, where boys were more than three times as likely to die as girls in 2015.[4]

Child fatality rates also differ across racial and ethnic identities. Nationally, Black children have the highest death rates, followed by American Indian/Alaska Native, Hispanic and white children. Asian/Pacific Islander children have the lowest death rates. In 2015, the infant fatality rates were 11.3 per 1,000 Black infants, 8.3 per 1,000 per American Indian/Alaska Native infants, 6.4 per 1000 for Puerto Rican infants, 5.0 per 1,000 Hispanic infants, 4.9 per 1,000 non-Hispanic white infants, and 4.2 per 1,000 Asian/Pacific Islander infants.[5]

In 2016, the infant mortality rate in New York City was 4.1 per 1,000 live births, the lowest in recorded history, slightly lower than the 4.3 rate in 2015 and lower than the national rate (5.6 per 1,000). Similar to national trends, racial disparities persist in New York City. In 2016, the city's infant mortality rate among non Hispanic Black children was about three times higher than among non Hispanic whites (8.0 per 1,000 versus 2.6 per 1,000). Additionally, infant mortality rates in New York City were 1.9 times higher in areas with very high concentrations of poverty compared to low poverty areas (4.3 per 1,000 versus 2.3 per 1,000). In terms of maternal age, the infant mortality rate in New York City was highest among infants born to women 40 years of age and older (6.3 per 1,000), followed by mothers less than 20 years old (5.3 per 1,000), aged 30 to 39 (3.7 per 1,000), and ages 20 to 29 years of age (3.4 per 1,000).[6] A recent report by the NYC Department of Health and Mental Hygiene found that unintentional injuries were the leading cause of death for NYC children between the ages of one and 12.[7]

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[3] Kochanek KD, Murphy SL, Xu JQ, Arias E. Mortality in the United States, 2016. NCHS Data Brief, no 293. Hyattsville, MD: National Center for Health Statistics. 2017

[4] Murphy SL, Xu JQ, Kochanek KD, Curtin SC, Arias E. Deaths: Final data for 2015. National Vital Statistics Reports; vol 66 no 6. Hyattsville, MD: National Center for Health Statistics. 2017.

[5] Li W, Sebek K, Huynh M, Castro A, Gurr D, Kelley D, Kennedy J, Maduro G, Lee E, Sun Y, Zheng P and Van Wye G, Summary of Vital Statistics, 2015. New York, NY: New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2017.

[6] Li W, Zheng P, Huynh M, Castro A, Falci L, Kennedy J, Maduro G, Lee E, Sun Y, and Van Wye G. Sum¬mary of Vital Statistics, 2016. New York, NY: New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2018.

[7] NYC Vital Signs: Understanding Child Injury Deaths: 2010-2015 Child Fatality Review Advisory Team Report. Please note that this report excluded infants under the age of one.

# Panel Data: 2015 and 2016

## Overall Panel Cases

In 2015 and 2016, the New York City's Accountability Review Panel reviewed 99 child fatalities from 96 reported cases (in 2016, three cases involved deaths of siblings). The most common manner of death as certified by the ME was *undetermined* (*n* = 35), followed by *natural* (*n* = 23 ), *homicide* (*n* = 20 ), *accident* (*n* = 14), and *suicide* (*n* = 2, 2%) (see Table 2) and *therapeutic complications* (*n* = 1, 1%). ME findings remain outstanding for two of the cases.[8]

### Table 2. Manners of death for Panel-reviewed child fatalities from 2015 and 2016

| | 2015 | | 2016 | | Total 2015-16 | |
|---|---|---|---|---|---|---|
| Manner of Death | N | % | N | % | N | % |
| Accident | 6 | 14% | 8 | 14% | 14 | 14% |
| Homicide | 10 | 23% | 11 | 20% | 21 | 21% |
| Natural | 6 | 14% | 17 | 30% | 23 | 23% |
| Suicide | 2 | 5% | 0 | 0% | 2 | 2% |
| Undetermined | 17 | 40% | 19 | 34% | 36 | 36% |
| Therapeutic Complications | 1 | 2% | 0 | 0% | 1 | 1% |
| Pending/No Autopsy | 1 | 2% | 1 | 2% | 2 | 2% |
| **Total** | **43** | | **56** | | **99** | |

*Percentages may not add up to 100 because of rounding*

What follows is a review of case characteristics for all of the Panel fatalities reviewed during the two year period of this report (n = 99). Following the overview of all Panel cases, the data are examined by subsection for three key areas of concern: unsafe sleep, homicide, and medical issues. Each high risk subsection also includes a summary of select Panel recommendations representing recurrent themes across cases from the high risk area as well as examples of relevant ACS initiatives in place to address Panel recommendations.

**Overall Panel Case Characteristics.** As in previous years, and consistent with national and citywide statistics, young children are at greatest risk of fatality. The average age of the Panel children was 3.1 years (SD = 5.3), and the median age was 5.2 months. Children's ages ranged from newborn to just under 18 years old. Sixty-three percent of the fatalities were of infants under the age of one. Including infants, children under the age of five comprised 82 percent of reviewed fatalities. Five fatalities were of children between the ages of 5-12, and 13 percent were of teenagers over the age of 12. A larger proportion of the children were male (55 percent) than female (44 percent).[9]

Families in which a Panel fatality occurred were disproportionately Black/African American (58 percent) and Hispanic/Latino (25 percent).[10] Eight of the fatalities occurred in white families. The remaining nine fatalities occurred in families of other, multiple or unknown race/ethnicity. When a fatality occurred in a family of a race/ethnicity of which fewer than six families were represented, the data are not disaggregated to protect anonymity.

[8] Appendix 1 provides descriptions of what the Medical Examiner considers when making a manner of death determination.
[9] In one case, the child's sex was unknown.
[10] This data was based off of the race and ethnicity information available in CONNECTIONS, which was most often entered for the child's mother. When information was available about the race/ethnicity of the child's father, it is reflected in the data presented here.

As described above, a fatality investigation concludes with the child protective investigative team's determination on each of the allegations made in the SCR report that included the fatality allegation, but may also have included additional allegations, such as inadequate guardianship or lack of supervision. Almost two-thirds of the fatality investigations reviewed in this report resulted in an indication for at least one allegation (*n* = 62, 63 percent), of these just over a third were indicated for the fatality itself. Most Panel children lived with their families at the time of death (91%), though 9 percent were living in out of home family based settings (i.e., foster or kinship care) or institutional settings (i.e., hospital or nursing facility, which includes deaths which occurred shortly after birth). Fewer than half (44%) of the fatalities occurred among families with open ACS cases at the time of death.

Panel families share many characteristics of other families with whom ACS has contact. As with families who interact with ACS in any capacity, families in which a fatality occurred were disproportionately families of color. Many families faced multiple challenges, including recent or ongoing homelessness, experienced by 29 percent of Panel families, and a known history of domestic violence, which was noted in 45 percent of the reviewed cases. Slightly more than a half of the mothers (54 percent) had histories of ACS involvement as children; of those, 27 percent had a history of foster care placement as children.

Of the fatalities reviewed in 2015 and 2016, nearly one in three (29%) occurred in families who had experienced homelessness within four years prior to their child's fatality. Of these, one in six (*n* = 16, 17%) of the families reviewed by the Panel were residing in a shelter at the time of the fatality; less than half of these families (*n* = 6, 38%) had an active ACS case at the time of the fatality. The manners of death for homeless children occurred at similar rates to the overall group of Panel children. In 2015, all four fatalities were unsafe sleep- related and the Medical Examiner certified the deaths as undetermined. In 2016, the manner of death varied, ranging from homicide (*n* = 3, of which two occurred in one family), accident (*n* = 3, including two siblings who died in the same accident), undetermined (*n* = 4) to natural (n = 2).

ARU reviewers examine the child welfare case record of each family in which a fatality occurred, and track the prevalence of family characteristics and presence of pre-identified risk factors for each case, including:

a. Number of children in the family;

b. The age of the mother when her first child was born, as well as the age of the mother at the time of the fatality;

c. Whether the child had any documented developmental, medical or mental health conditions;

d. Whether the family had a history of homelessness and whether the family was residing in shelter at the time of the fatality;

e. 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;

f. Identification in the case record of parent or caregiver mental health condition;

g. Identification in the case record of parent or caregiver substance use;

h. Identification in the case record of household domestic violence within the last four years; and

i. Whether the family had an open case at the time of the fatality.

Reviews of the case records indicated that 27 percent of the mothers had current or prior substance abuse issues noted, and 30 percent had current or ongoing mental health concerns noted in the case record. The mothers' average age was 29.2 years at the time of death, and the median age for mothers was 28 years. On average, mothers had three or more children. An adult male was known to be a part of the family in 72 percent (n = 71) of the cases reviewed. When an adult man was known to be a part of the household and/or in a caregiving role, nearly three quarters (n = 69, 70 percent) were fathers or step-fathers of the deceased child; however, such information was either not available or there was no male involvement disclosed by the family in a significant number of the cases (28 percent). There were only two cases noted where the male was unrelated but had a caregiving role at the time of the fatality.

## Safe Sleep

Forty-two percent of all 2015 and 2016 (n=42) Panel fatalities had notations of unsafe sleep conditions (see Table 3); all but three of these cases concerned an infant less than six months old.

**Table 3. Panel reviewed child fatalities from 2015 and 2016 with unsafe sleep conditions**

| Year of Fatality Review | Panel Fatalities (N) (Children) | Number of Panel Fatalities with Unsafe Sleep | Percent of Panel Fatalities with Unsafe Sleep |
|---|---|---|---|
| 2015 | 43 | 21 | 49% |
| 2016 | 56 | 21 | 38% |
| 2 Year Total | 99 | 42 | 42% |

While unsafe sleep is not a manner or cause of death certified by the ME, the ME may note the presence of contributing unsafe sleep factors when determining the manner of death. The above table represents Panel cases categorized as sleep-related fatalities, as tracked by ARU, who track notations of unsafe sleep conditions when cited by the Medical Examiner's report or documented in the progress notes during the investigation by ACS. Unsafe sleep conditions can include 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. In over half of the 42 sleep related fatalities included in this report (n=24), the Medical Examiner specifically cited sleep-related injuries or an unsafe sleep environment in the manner of death determination. Of those 24 cases, the ME certified more than a two thirds (67 percent) of the cases as having an *undetermined* manner of death, and a third (33 percent) of the cases as having an *accidental* manner of death.[11]

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, which is common in cases where an unsafe sleep condition was present but the role of the hazard in the fatality cannot be determined following an autopsy, such as a fatality in which an infant was found prone in a crib in which soft bedding was present. Cases deemed undetermined by the ME are most common in infants.

[11] Most of the fatalities in which the ARU made note of unsafe sleep conditions for tracking purposes were also classified as undetermined or accidental deaths. Three additional deaths, one classified as therapeutic complications and two as natural, also involved unsafe sleep conditions.

**Unsafe Sleep Case Characteristics.** Similar to sleep related deaths in New York City and nationally, risk of unintentional sleep deaths is greatest among the youngest infants. As noted above, 93 percent ($n$ = 39) of the sleep-related deaths involved infants aged 6 months or younger. Slightly more than half ($n$ = 22, 52 percent) of the children were female and nearly half ($n$ = 20, 48 percent) were male, which varied from the overall group of Panel cases, where more males died ($n$ = 54, 55 percent).

Most (93 percent) of the sleep-related fatalities occurred in the infants' biological home. As in Panel families overall, more than a one-third (38 percent) of the families who experienced a sleep-related fatality had been homeless in the four years prior to the death, though most occurred in a non-shelter setting (10, or nearly a quarter of the sleep-related fatalities, occurred in a shelter setting).

Eleven of the 42 sleep related fatalities (26 percent) occurred in families that had open ACS cases at the time of the death.

### Panel Recommendations and ACS Initiatives

ACS provides cribs and Pack 'n Plays to families with whom ACS has contact who lack a safe sleep environment for their infant, and routinely provides safe sleep information and coaching to families during home visits.

Similar to recommendations made in previous years, the Panel recommends continued support of multi-disciplinary public outreach to parents, families, health providers and professionals about safe sleep practices.

ACS continues to serve as the lead agency within a coalition of state and city agencies, organizations and other stakeholders, including the city departments of Health and Mental Hygiene (DOHMH), Homeless Services (DHS), Human Resources Administration (HRA), Health and Hospitals and Police Department (NYPD), as well as the New York State Office of Child and Family Services (OCFS) and the American Academy of Pediatrics. This coalition of stakeholders convenes for quarterly meetings. To date, the coalition has focused on developing a uniform safe sleep message, which has been disseminated as part of a citywide public awareness initiative lead by ACS and DOHMH that included messaging in subways and other public locations in areas of the city with the highest rates of unsafe sleep-related fatalities, which launched in May 2017.[12]

ACS also organizes an annual Safe Sleep Summit, with an annual summit held most recently on June 29, 2018. This year's summit will seek to build on the momentum of the safe sleep initiative's ongoing community engagement, training and partnership efforts supported by agencies and professionals that serve children and families, with the aim of moving from awareness to action. The summit will encourage participants to commit to specific strategies, programs and tasks to advance safe sleep practices in the organizations and communities they serve, and will include discussion aimed at the identification of barriers that have impeded implementation of recommended safe sleep practices. ACS will also introduce and distribute its new Safe Sleep Practice Guide.

ACS and DOHMH have also collaborated to create a new video, *the Breath of Life: the How and Why of Safe Sleep,* which explores the potentially fatal risks associated with unsafe sleep practices, provides the medical reasons for recommended safe sleep practices and offers solutions to commonly-cited challenges

[12] See the Safe Sleep page on ACS' public website for additional information and to see examples of the promotional materials distributed as part of this campaign. Information is available in English, Spanish, Chinese, French and Haitian Creole.

parents face when creating safe sleep environments for their infants. The video was filmed in New York City neighborhoods and features diverse families and doctors. The video will be available for use by frontline staff during meetings with families and as a training resource for staff.

In addition, ACS and NYC Health + Hospitals have created a Safe Sleep Toolkit and distribution program, which aims to provide resources, educational materials and supplies to maternity patients and new parents before they are discharged from the hospital. The Toolkit will make it easier for parents, families and caregivers to follow recommended safe sleep guidelines and eliminate risk factors associated with sleep-related fatalities. Fifteen percent of births in NYC annually occur at Health + Hospitals facilities. This initiative will begin in 2018 with the planned distribution of 5,000 Toolkits at four identified pilot sites: Elmhurst Hospital in Queens, Woodhull Hospital in Brooklyn, Jacobi Hospital in the Bronx and Harlem Hospital in Manhattan. The Toolkit will include:

- Protective crib netting;
- An infant sleep sac, for use in place of a blanket;
- An infant onesie, with a printed reminder to practice safe sleep;
- Educational materials; and
- The *Breath of Life* DVD.

## Homicide

Twenty-one percent (*n* = 21) of the Panel cases from 2015 and 2016 were classified as homicides. There were multiple homicides on two cases in 2016 (see Table 4). The Medical Examiner classifies a death as homicide when the fatality results from an act of commission or omission (i.e., seriously negligent behavior) by the perpetrator. During this two year period, the most common cause of death was blunt impact or blunt trauma injury (*n* = 17, 81%).

**Table 4. Panel reviewed child fatalities from 2015 and 2016 with certified homicides**

| Year of Fatality | Panel Fatalities (N) | Number of Homicides | Percent of Panel Fatalities with Homicides |
|---|---|---|---|
| 2015 | 43 | 10 | 21% |
| *2016 | 56 | 11 | 20% |
| 2 Year Total | 99 | 21 | 21% |

*1 autopsy pending

Characteristics and case circumstances in the families in which a homicide occurred were largely indistinguishable from the characteristics of families in which other types of fatalities occurred and the larger population of families who have had contact with ACS.

These commonalities make preventing child homicide challenging, as there are no distinct indications that children are at substantial risk of homicide. This analysis suggests that to prevent child homicide, strengthening violence prevention and striving for continuous quality improvements across the child protective system may be more effective approaches than trying to identify and target individual families that are more susceptible to homicide cases.

**Homicide Case Characteristics.**

For the reported years 2015 – 2016, more homicide victims were male (*n* = 13) than female (*n* = 8); variation within the two years is discussed below.

In 2015, of the 10 homicides, four children were 15 years of age or older and four children were under one. The two remaining children were just under the age of two and just under the age of three. Of the four homicides of teens in 2015, none were perpetrated by a parent. Three of the victims died of gun-shot wounds and the fourth died of stab wounds. Each occurred in a different borough. In contrast, the most common manner of death in the homicides of children under the age of three, was head trauma, characterized as blunt force trauma to the head or abusive head trauma. Of the ten homicides recorded in 2015, eight of the children were male.

In 2016, all of the fatalities classified as homicides were of children between the ages of one and six. The average age of death was 2.3 years. In 2016, slightly more than half (*n* = 6) of the children were female, and in the 2016 cases with multiple homicides where two children died on each case, all the

victims were female children. 2016 included two cases in which the deaths of two siblings in each case were classified as homicides. The deaths of two sisters who died in 2016 of smoke inhalation while left unsupervised in an apartment were classified by the ME as homicides. In another case, two sisters died of stab wounds. The most common cause of death for the remaining 2016 homicides was blunt force injuries, to either the head or torso.

At the time of the fatality, all of the children whose deaths were classified as homicides in 2015 and 2016 were living in the homes of their parent(s), although the fatality may have occurred elsewhere. Panel victims of homicide had negligible rates of chronic medical needs, mental health concerns, or developmental issues when compared with non homicide Panel children. Half of the Panel homicides ($n$ = 10) involved children whose families were not receiving any services from ACS at the time of the fatality. More than half of the perpetrators were related to the child ($n$ = 13, 62%), while the remaining ($n$ = 6) proportion of the perpetrators were unrelated to the child. There were four homicides where the perpetrator was unspecified as there were multiple suspects within the child's household, but none were confirmed as the perpetrator.

A little more than fifty percent (52 percent) of the homicide victims' mothers had been known to ACS as children, including 26 percent with a history of foster care placement. Of note, only three fathers had history as children and only one was placed in foster care as a child. Twenty-six percent of the victims' families had histories of homelessness. Over half of the families in which a homicide occurred were known to have experienced current or recent domestic violence, ($n$ = 10, 52 percent), and a history of domestic violence at any point was present on almost three-quarters of the cases. Almost half (47%) percent of mothers had a history of mental health issues noted in the ACS case record, while seven of nineteen (37%) had substance use history.

### Panel Recommendations and ACS Initiatives

While no case characteristics have been found as predictors of homicide in families with child welfare involvement, characteristics consistent with higher levels of risk for harm and injury have been identified from retrospective analysis of child welfare records and case outcomes. ACS has developed an algorithm to identify open cases with the highest risk of severe harm, in particular the likelihood of physical injury, sex abuse and early childhood abuse based off case characteristics which informs the selection of cases flagged for a new unit dedicated to performing timely quality assurance reviews. The cases are reviewed while the case remains open to verify that child protective teams are adequately serving the family and mitigating risk with appropriate services. When case practice gaps are identified, the quality assurance team immediately notifies the child protective team and holds a conference to review their findings and establish required next steps before the investigation can be closed. This team, which was created in late 2017, has conducted over 700 cases case reviews since its inception and currently conducts an average of 200 reviews each month.

In addition, with the support of the Division of Policy, Planning and Measurement, each borough office zone is working to identify case practice-related targets as a focus for improvement, as part of a new collaborative quality improvement (CoQI) initiative for the Division of Child Protection. The efficacy of the improvement plan at improving the targeted practice is assessed throughout the CoQI cycle, with review and evaluation of progress at regularly scheduled intervals throughout the year.

## Medical Conditions

In 2015 and 2016, one quarter (*n* = 23, 23 percent) of the child fatalities were determined by the ME to be natural (see Table 5).[13] The Medical Examiner determines the manner of death to be natural when disease or a medical condition is the sole cause of death.

**Table 5. Panel-reviewed child fatalities from 2015 and 2016 with certified natural deaths**

| Year of Fatality Review | Panel Fatalities (N) | Number of Natural Deaths | Percent of Panel Fatalities with Natural Deaths |
|---|---|---|---|
| 2015 | 43 | 6 | 14% |
| 2016 | 56 | 17 | 30% |
| 2 Year Total | 99 | 23 | 23% |

Though more than half of the cases (*n* = 12, 52 percent) involving natural deaths were open at the time of fatalities, child protective investigations concluded in the majority (n = 16, 70 percent) of natural fatalities that there were no indications that abuse or neglect contributed to the fatality. Though the ME may document children's medical conditions as contributory factors for manners of death other than natural, the majority of child fatalities due to medical conditions are classified as *natural* and are described below.

**Medical Conditions Case Characteristics.** Panel children who died of natural causes were slightly older than children who died of non natural causes. On average, children who experienced natural death were 4.6 years old, compared with all Panel children, who averaged 3.1 years of age. Almost two-thirds (*n* = 14, 61 percent) of the children were male, and 39 percent were female, which was similar to the overall group of Panel cases.

In terms of child level risk, ten of the 23 children who died of natural causes had no indication in the case record of chronic medical illness, developmental or mental health issues prior to the fatality. Of these, the most common cause of death was pneumonia. Of the remaining thirteen children who died of natural causes, slightly more than half (n = 12, 52 percent) of the children had a chronic medical condition. Six of the children had developmental or mental health issues in addition to their chronic medical conditions. The manner of death for fatalities classified as natural included two deaths related to leukemia, two asthma-related deaths, and two deaths related to seizure conditions. In four cases, the ME classified the cause of death as natural but the manner of death remained undetermined; three of the four involved infants less than six months old.

At the time of death, most children lived at home with their family (*n* = 19, 83%). Of the remaining four children, one was placed in a residential treatment center, while the other three were placed in family foster care, including one kinship foster home. Investigations in relation to the fatality reports of the four fatalities involving children placed in foster care were all unfounded.

[13] In addition, one case from 2015 was classified as a death from *therapeutic complications* related to treatment for a medical condition. The manner of death in this infant fatality was determined by the ME as "multiple complications including meningitis with cerebral abscess following placement of ventricular shunt for treatment of post-hemorrhagic hydrocephalus of prematurity."

Similar to other Panel cases, families in which a natural death occurred encountered environmental risks and stressors, which may have exacerbated the children's medical conditions. Like most families known to ACS, these families also faced economic hardship. It is well established that chronic and persistent poverty impacts children's health.[14] Children living in poverty have increased infant mortality, low birth weight, and heightened risk for health and developmental problems. They experience an increase in frequency and severity of chronic disease and often have poorer access to quality health care. Review of the case histories of family characteristics of families for this report found that families experienced many of these challenges, which heightened risk for each child.

### Panel Recommendations and ACS Initiatives.

The Panel recommended continued support of frontline staff to help recognize symptoms, assess safety and risk and connect families with chronic and serious medical conditions to appropriate services.

ACS has expanded the Medical Consultation Program (MCP) to provide additional supports to DCP staff during investigations. The MCP provides direct consultation for child protective specialists and other DCP staff on cases in which special medical needs and related issues are a factor in child safety assessments. At present, the program has 14 Pediatric Nurse Practitioners assigned to cover all of the DCP borough offices. The Pediatric Nurse Practitioners are available for formal consultations, brief consultations, case reviews, medical record reviews, trainings, assistance with meetings with healthcare providers, medication and medical equipment reviews. They also develop and provide instructional information and attend child safety conferences. Medical Consultants are also available to consult in any case that may warrant a referral to a skilled nursing facility.

The ACS Office of Child and Family Health (OCFH), the Office of the Agency Medical Director and the MCP are now redesigning the orientation training curriculum used to train DCP on the MCP and appropriate use of the resources in the program. The new training curriculum will detail:

- The types of cases and diagnoses that warrant reviews (e.g., syndromes, chronic medical conditions, etc.);
- Identification of special needs situations and red flags during home visits; and
- Case examples to illustrate the above.

Following curriculum development, ACS intends to develop a training webinar that will be available for ACS and Preventive agency staff year-round.

In addition to the Medical Consultation Program, ACS has partnered with a.i.r. NYC as a referral resource to support families where one or more child has an asthma diagnosis. In addition, a.i.r. NYC is working with the ACS Medical Director and the ACS Workforce Institute to create an asthma training curriculum for ACS, foster care and preventive staff. The program will instruct ACS and agency staff on the following skills for households in which asthma has been identified as a factor in the safety assessment:

- Directed interview to assess asthma and asthma treatment knowledge;
- Basic environmental assessment for risk factors; and
- Basic psychosocial assessment for related risk factors.

[14] Dreyer, B. P. (2013). To create a better world for children and families: the case for ending childhood poverty. Academic pediatrics, 13(2), 83-90

## Conclusion

Risk factors associated with child maltreatment include family, caregiver and household characteristics such as domestic violence, substance abuse, homelessness, behavioral health concerns, poverty and extreme poverty.[15] While research has found that these factors are associated with a greater likelihood of child abuse and neglect, these characteristics are so common that none are considered predictive of higher risk of child fatality caused by abuse or maltreatment. Fatalities in families known to ACS are a rare event, and are more likely to be the result of natural or sleep-related causes than abuse or neglect.

Continued and increased collaboration between New York City's child and family-serving agencies, including ACS and the departments of Homeless Services, Education, Health and Mental Hygiene, and others will support and sustain initiatives to stabilize and strengthen families and protect children from harm. As has been frequently recommended by the Panel, a comprehensive, systemic public health approach to identifying and addressing the needs and challenges of low-income families in New York will go a long way toward protecting children from abuse, maltreatment and the high-risk situations associated with child and youth fatalities.

[15] Stith, S.M., Liu, T., Davies, L.C., Boykin, E.L, Alder, M.C., Harris, J.M., … & Dees, J.E.M. E.G. (2009), *Risk Factors in Child Maltreatment: A meta-analytic review of the literature.* Aggression and violent behavior, 14(1), 13-29; and Lepore, J., *Baby Doe, A Political History of Tragedy*, the New Yorker, February 1, 2016 issue

## Appendix 1: Manner of Death determinations

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.