SYSTEMIC CHILD FATALITY REVIEW
2023 ANNUAL REPORT

Systemic Child Fatality Review - 2023 Annual Report

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Introduction

New York City's Administration for Children's Services (ACS) investigates alleged abuse and neglect of children residing in the City of New York. ACS also provides services and supports to prevent maltreatment and keep children safe at home, and provides care for children and youth where out of home care is necessary to ensure their safety. In 2023, ACS received 61,501 reports alleging child maltreatment, concerning 68,612 unique children. These reports were consolidated into a total of 52,870 child protective responses.

In 2023, ACS investigated 102 child fatalities reported to the Statewide Central Register (SCR) of Child Abuse and Maltreatment. Of the 102 child deaths, more than half (57) occurred in a family that had no previous contact with ACS or no contact within the last decade. This report focuses on child fatalities that happened in families with ACS involvement at the time of the fatality or within the previous 10 years. The report describes how ACS responds to child fatalities, summarizes demographic data, and provides systemic findings from cases reviewed. When considering the information in this report, it is important to remember the following context:

- Child fatality cases are a small fraction of cases known to ACS, comprising about 0.2 percent of all cases investigated by ACS annually. The loss of any child due to maltreatment is a tragedy. Moreover, a death where there is past or current ACS contact requires special attention and review. Those child fatalities are the focus of this report.
- The report does not discuss every child fatality in New York City that was reported to the SCR. As noted above, it does not review the deaths of the 57 children (in 55 families) which had no prior child welfare history in the past 10 years. Instead, this report reviews the 45 child fatalities from calendar year 2023 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 10 years in order to inform ACS's ongoing quality improvement efforts.
- The report is not a comprehensive analysis of ACS cases or its work with children and families, and readers are cautioned against generalizing findings. 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. The purpose of the case reviews and analyses is to gather insights from the lessons learned that can be incorporated into ACS' larger quality management and improvement processes to strengthen the child welfare system, reduce child deaths, particularly those due to maltreatment, and produce better outcomes for all children and families with whom ACS has contact.
- A fatality reported to the SCR does not necessarily mean that a child died from maltreatment. Of the 44 families known to ACS within the past decade, the fatality allegation was substantiated in 12 cases.
- Of the 45 child fatalities in 44 families known to ACS within the previous decade, eight were determined to be homicides.

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 as defined above 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 a safety science approach[2] to reviewing fatalities, based on innovations in aviation, health care and other industries to improve safety, and modeled after child fatality review systems developed in Tennessee, Arizona, Minnesota, Wisconsin and other jurisdictions around the country. The safety science approach encourages analyzing and applying data to drive learning and system improvements. ACS' Systemic Child Fatality Review (SCFR) process emphasizes a culture of system accountability and implements systemic methods of learning that identify and address underlying issues rather than installing quick fixes. The SCFR includes a review of fatality cases that examines the complex interplay of systemic factors, such as policies, workloads, availability of resources, supervision and training, among many other influences that may impact case practice and decision-making. The process produces data-driven learning and insights, and promotes a culture of openness and shared agency-wide accountability in order to strengthen investigative practice and the New York City child welfare system as a whole. Consistent with this approach, ACS seeks to learn and ultimately improve the system's ability to support quality case practice, secure safe outcomes for children and improve services to their families.

[1] 2018 N.Y.C. Local Law No. 19, N.Y.C. Admin. Code §§ 21-915 https://intro.nyc/local-laws/2018-19. This report on calendar year 2023 was due June 30, 2025.

[2] 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.

New York City's Review of Child Fatalities Alleging Maltreatment

The New York Statewide Central Register (SCR) of Child Abuse and Maltreatment 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 any suspicion of abuse or maltreatment, as well as from family, friends, neighbors and others with concerns. Among the reports the SCR receives are cases of child fatalities in which maltreatment may have been a factor, including reports when the parent does not have an explanation for the death and the cause of the fatality is not yet known. Additionally, any child 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 there is no suspicion of abuse and/or maltreatment surrounding the fatality.

The New York City Office of the Chief Medical Examiner ("the ME") determines the cause and manner of a child's death, and may also be a source of child fatality reports to the state, depending on its findings. The cause of death is the injury, disease, or condition that resulted in the fatality, such as blunt force 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 complication, or undetermined.[3] These classifications are administratively determined and may differ from other jurisdictions, therefore making 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, provides an overview of all fatalities reported to the SCR and investigated by ACS in 2023 where child maltreatment was alleged to have contributed to the death or the family was receiving services from ACS at the time of the fatality. In 2023, there were 57 child deaths in 55 families (there were two cases that each had two deceased children) where there had been no prior ACS involvement or contact with the agency within the last 10 years. The most common "manners" of death as certified by the ME for these 2023 fatalities with no ACS involvement were "undetermined" (n = 21, 37%), "natural" (n = 15, 26%) and "homicide" (n = 10, 18%). There were four cases with pending autopsies at the time of this report, and two in which no autopsies were performed. In addition, case reviews reveal that 40% (n = 22) of the mothers were Black/African-American/non-Hispanic, 25% (n = 14) were Hispanic and 24% (n = 13) were white. Where information was available on fathers/male involved with the family

[3] 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" usually when a medical device failure caused the death. Please see Appendix 1 for additional details.

(n = 53), 42% were Black/African-American/non-Hispanic, 28% (n = 15) were Hispanic and 21% (n = 11) were white[4].

Table 1 also shows that 44% of the child fatalities reported to the SCR in 2023 occurred in families that were "known"[5] to ACS within the past 10 years. Subsequent sections of this report focus only on those fatalities (see Table 2 for specific data on cases known to ACS).

Table 1. Manners of death for all 2023 child fatalities reported to SCR

	2023 Child Deaths in Families Known* to ACS within Last 10 Years		2023 Child Deaths with No ACS History in Last 10 Years		All 2023 Child Deaths Reported to the SCR	
Manner of Death	**N**	**%**	**N**	**%**	**N**	**%**
Accident	6	13	5	9	11	11
Homicide	8[+]	18	10	18	18	18
Natural	8	18	15	26	23	23
Suicide	1	2	0	0	1	1
Undetermined	17	38	21	37	38	37
Therapeutic Complications	0	0	0	0	0	0
Pending ME determination	3	7	4	7	7	7
Other[ψ]	2	4	2	4	4	4
Total	**45**	**100**	**57**	**100**	**102**	**100**

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.

[+]Includes homicides deaths where ACS has received the autopsy as well as homicides confirmed by OCME where the autopsy report has not been provided.

[ψ] The death did not fall under the jurisdiction of the Office of the Chief Medical Examiner (OCME) or no autopsy was performed. This includes children who were not autopsied for religious reasons or children where the hospital certified the manner of death.

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 death. When a DCP investigation finds "a fair preponderance of the evidence"[6] that abuse or

[4] See Appendix B, Table 9

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

[6] On January 1, 2022, New York State enacted legislation that changed the evidentiary standard for indicating child protective investigations from some credible evidence to a fair preponderance of the evidence. This means that CPS must weigh the information collected in its totality and determine whether the evidence collected that

neglect has taken place in relation to any of the allegations, the report is defined as "indicated." Alternatively, if the evidence collected does not meet the aforementioned standard, 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.[7] For example, such cases 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 some child fatalities to determine criminal culpability, and whether or not to pursue criminal prosecution.

Case Review Criteria – Cases with ACS History

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.[8] 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; OR
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
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.

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supports the allegation is stronger than the evidence gathered that does not. (From 21-OCFS -ADM 26, issued Nov. 4, 2021.)

[7] 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."

[8] 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 promote 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 ACS fatality review team, within the Division of Policy, Planning, and Measurement also receives notification of each fatality. The team 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.

The review includes an examination of the family's ACS history 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 living in the household, whether related or not, as well as others involved with the child, such as parents, significant others, grandparents, aunts/uncles, and others with known caregiving responsibilities.

The ACS fatality review team completes a case summary which includes a technical review of the case history from available databases. Upon summary completion, the case is discussed with an Interdivisional Team (IDT), consisting of cross-divisional ACS staff, to identify whether a more comprehensive analysis of the case would generate learning points or areas for study of internal and external systemic influences that impact child safety. When cases are selected for a comprehensive analysis, staff involved with the corresponding learning points/areas for study are invited to participate in a human factors debrief. In 2023, 32 of the 44 child fatality cases were eligible for the SCFR process.

Human factors debriefings are facilitated opportunities for staff to share, process and learn from their experiences working with the family, as well as explore critical decisions and interactions throughout ACS' involvement. Debriefings add to the technical review by uncovering and deepening the understanding of the elements involved in decision making. Debriefings are voluntary and typically include child protection specialists and their supervisors, but may consist of other staff, such as agency attorneys. During debriefings, all efforts are made to create a safe and supportive environment for staff to provide insight and identify opportunities for learning and improvement.

Cases selected for a full review are mapped, a process whereby borough-based multidisciplinary teams (Mapping Teams) of staff from child protection services as well as other ACS divisions, discuss local, regional and regulatory conditions or processes that may affect case practice and decision making. Information gathered from the completed case summary review, human factors debriefings, and mapping sessions is analyzed to identify systemic influences[9] and key findings which are used to produce recommendations that will lead to system improvements. In 2021, ACS added Systems Learning and Improvement Sessions (SLIS) to the SCFR process to further explore systemic themes as well as brainstorm possible recommendations for consideration and implementation by ACS leadership.

[9] See Appendix C for list and definitions of systemic influences

2023 Cases Reviewed

Manner of Death

In 2023, there were 45 fatalities of children in 44 families (there was one family with two deceased children) 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 for 2023 fatalities were "undetermined" (n = 17, 38%), followed by "homicide" (n = 8, 18%) and "natural" (n = 8, 18%) and "accident" (n = 6, 13%) (See Table 2).[10] At the writing of this report, there were three cases with pending ME determinations and two in which no autopsies were performed.

Table 2: Manners of Death for Systemic Child Fatality Cases in 2023

Manner of Death	Total 2023	
	N	%
Accident	6	13
Homicide	8	18
Natural	8	18
Suicide	1	2
Undetermined	17	38
Therapeutic Complications	0	0
Pending ME Determination	3	6
Other[ψ]	2	4
Total	**45**	**100**

Percentages may not equal 100 due to rounding

[ψ] The death did not fall under the jurisdiction of the Office of the Chief Medical Examiner (OCME) or no autopsy was performed. This includes children who were not autopsied for religious reasons or children where the hospital certified the manner of death.

Undetermined and Accidental: Sleep-Related Injuries

In 2023, 44 percent (n = 20) of the 45 child fatalities in families previously known to ACS included indicators of possible 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

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

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 note the presence of contributing unsafe sleep factors when determining the manner of death. 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 for an infant, such as an air mattress, couch, or car seat. Of the 20 child fatalities with unsafe sleep conditions noted, the ME certified seventy percent (n = 14) as having an undetermined manner of death. In addition, a review of case records and autopsy findings indicate that the most common unsafe sleep conditions were bed-sharing with an adult and/or a sibling, placed on stomach or on the side, and objects such as blankets and pillows on the sleeping surface. Of the 20 sleep related fatalities, all but five were of children less than six months old. More than half of the 20 children were female (n = 11, 55%) and 45% (n = 9) were male. Six of the sleep-related fatalities occurred in families with an open ACS investigation or case at the time of the death.

Homicides

In 2023, the Medical Examiner classified eight child deaths (18%) in families known to ACS as homicides. The ME classifies a death as homicide when the fatality results from an act of commission (such as physical assault) or omission (such as leaving toxic drugs or medication where it is accessible to a young child) by a perpetrator. The number of fatalities due to homicide varies from year to year (for a longitudinal view, see Table 7 in Appendix B). Children in this category varied in age from zero months to seventeen years old. Four of the deaths occurred in open cases. Among the eight fatalities, perpetrators included parents, relatives and unrelated individuals.

Natural Deaths

In 2023, 18 percent (n = 8) of child fatalities in families known to ACS were determined by the Medical Examiner to be natural (see Table 8 in Appendix B). The ME determines the manner of death to be natural when disease or a medical condition is the cause of death. Examples of common natural causes in child fatalities include acute and chronic bronchial asthma, pneumonia, and congenital conditions.

Of the eight natural deaths, half (4) had open cases with ACS at the time of death. None of the eight deaths was indicated for the fatality allegation or any other allegation (all reports were unfounded). Five of the children were female, and four of the eight children were noted to have had chronic medical conditions. Across all fatality types, the average age at death in 2023 was 3.2 years of age, while on average, children who experienced natural deaths were much younger, 1.2 years old. Natural causes of death in 2023 were linked to multiple reasons such as acute viral and bacterial infections, respiratory infections, including Respiratory Syncytial Virus (RSV), and acute bronchial asthma.

Case Demographics and Family Characteristics

The 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 including the race and/or ethnicity of the parents/caretakers; the number and ages of children in the family; and the gender of the children.

The review team also gathers information on the presence of potential risk factors, such as:

a. Whether the child had any documented developmental, medical or mental health conditions;
b. 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;
c. Extent of history with ACS, including the parents' history with child welfare as a child and the number of previous investigations of the family;
d. 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;
e. Identification in the case record of parent or caregiver mental health condition;
f. Identification in the case record of parent or caregiver substance use;
g. Identification in the case record of household domestic violence within the last four years;
h. Whether the family had an open case at the time of the fatality.

The following is a review of case characteristics for the 2023 fatalities (n = 44); Table 3 provides demographic information for the 44 cases (there was one case with two deceased children).

Table 3: Demographics

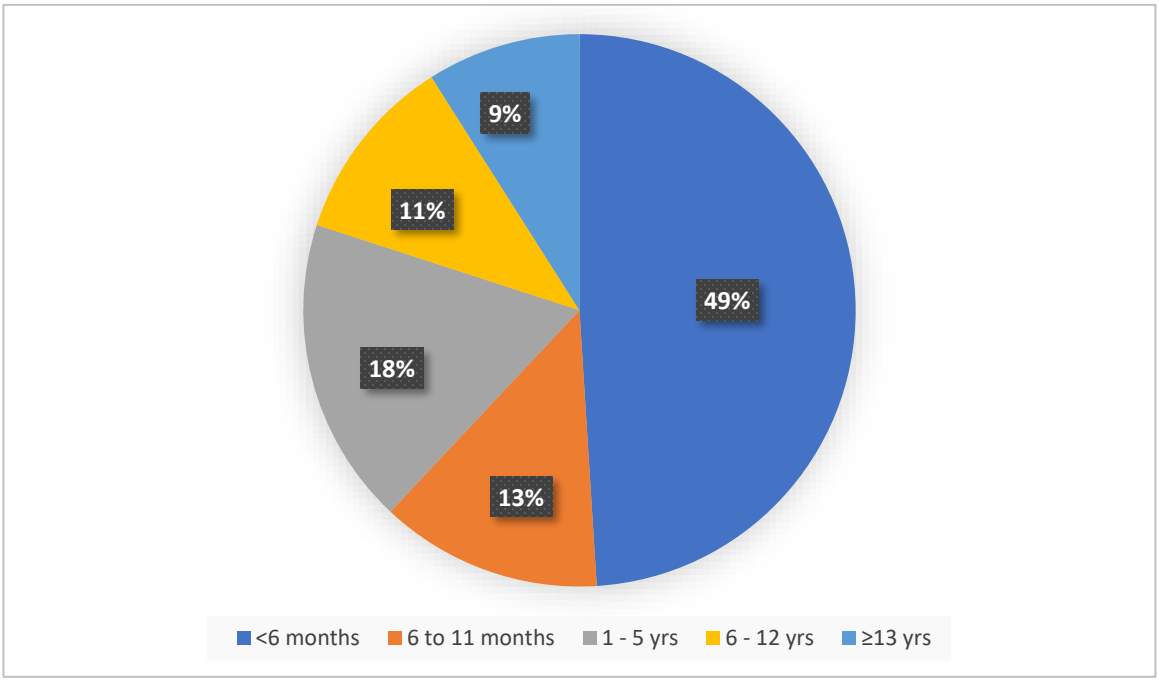
Demographics		
	n	%
Race (of mother, n = 44)		
Asian	3	7
Black	19	43
Hispanic	14	32
Pacific Islander	0	0
American Indian/Alaska Native	1	2
Biracial/Multiracial	2	5
White Non-Hispanic	5	11
Not Available	0	0
Other	0	0
Unknown	0	0
Gender (of child, n = 45)		
Female	23	51
Male	22	49

Age (of child, n = 45)		
<6 months	22	49
6 to 11 months	6	13
1 to 5 yrs	8	18
6 to 12 yrs	5	11
≥13 yrs	4	9

Percentages may not equal 100 due to rounding

Mothers were most likely to be Black/African-American/non-Hispanic (43%) or Hispanic (32%). When available, data was also collected on the fathers or males involved with the family. Of the 42 fathers/involved males, 52% (n = 22) were identified as Black/African American/non-Hispanic, while 33% (n = 14) were Hispanic. Three fathers/involved males were Asian and three were White. No race or ethnicity data was available for the father in two cases.[11] (In Fiscal Year 2024, 44% of adults in ACS child protection cases were Hispanic; 36% were Black non-Hispanic; 8% were White non-Hispanic; 5% were Asian; and 3% were of multiple races.)

Figure 1. Child's Age at Time of Fatality



Percentages may not equal 100 due to rounding

As in previous years, children at greatest risk of fatality were of the youngest ages. In 2023, the average age of the children was 3.2 years. Also in 2023, the median age at death was 6.6 months, significantly lower than the 1.7 years recorded in 2022. Children's ages ranged from zero months to 17 and a half years of age. Almost three quarters (62%, n = 28) of the fatalities were of infants under the age of one,

[11] Data on race and ethnicity of mothers, fathers and males involved with the family is based on information available in CONNECTIONS.

and of these, seventy-nine percent (n = 22) were less than six months of age. Children under the age of six, including infants, made up 80% (n = 36) of the 2023 fatalities. Of the 45 child fatalities in 2023, females accounted for 51% while males were 49%. For children less than one year of age, 15 (54%) were female and 13 (46%) were male.

A little more than a third of the cases (n =16, 36%) were open with ACS at the time of the fatality; this includes open investigations and families receiving foster care and/or prevention services.

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 regarding the deceased child(ren) and/or surviving siblings. Of the 44 cases, exactly half (n = 22, 50%) were unfounded, i.e., no allegation was substantiated (see Table 5 in Appendix B). Of the 22 cases where one or more allegation was substantiated, the fatality allegation was substantiated for 12 of the 22 indicated cases. While a fatality allegation may be substantiated, this does not mean the Medical Examiner deemed the death a homicide or that the parent/caretaker intentionally harmed the child. A close reading of the case circumstances is necessary to fully understand the substantiation decision made by the child protection team. For example, fatality allegations may be substantiated in some cases where the Medical Examiner ruled the manner of death as an Accident or Undetermined, yet child protection services concluded that the adult caregiver's actions or inactions placed the child at risk of death.

Many of the families known to ACS prior to the fatality faced multiple challenges, such as recent or ongoing homelessness (30 percent of families in cases reviewed), and a recent history of reported domestic violence within the last four years, which was noted in 39 percent of the cases reviewed. Thirty-nine percent (n = 17) of the mothers had histories of ACS involvement as children and of those, forty-seven percent (n = 8) had a history of foster care placement as children. For the males involved with these families (where information was available, n = 42), five had histories of ACS involvement as children, and one had a history of foster care placement. There were seven families residing in a shelter at the time of the fatality; four of the seven had an active ACS case or involvement at the time of the fatality.

The review of the case records indicated that the average age of mothers in cases reviewed in 2023 was 30.1 at the time of the child's death, more than two years older when compared to the average age of 27.6 years recorded in 2022. The median age of the 2023 mothers was 30 years. Nine of the mothers of children who died in 2023 were under the age of 18 at the birth of their first child. Consistent with previous years, the mothers had, on average, three children. A review of the case records for the 44 families where a child died shows that 43 percent (n = 19) of the mothers had documented current or prior substance use. In addition, 45 percent (n = 20) also had current or ongoing mental health concerns (diagnosed or undiagnosed and apparent in child protection services assessments), which was sometimes co-occurring with past or current substance use.

Data was collected and available on the father/male involved with the family at the time of the fatality in all but two cases. Of the 42 males identified, three-quarters (n = 33) 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 33 percent (n = 14) of the cases, current or prior substance use was recorded. Current or past mental health concerns specific to the father/involved male were noted in four cases.

Typically, about half of ACS child protection investigations involve safety concerns related to mental health, substance abuse, and/or domestic violence.

ACS Initiatives and Recommendations to Improve Child Safety and Reduce Child Fatalities

Reducing Child Protection Workload

ACS' top priority in any child protection case is to determine whether or not a child is in immediate danger of serious harm—and when a child is assessed to be unsafe, ACS is to immediately intervene to protect the child.

This requires child protection teams to respond quickly to reports of possible maltreatment; to visit with and interview family members named in reports; to speak with others who know the family such as school staff, medical providers, and friends and relatives; and to constantly assess for child safety.

ACS seeks to maintain manageable workloads for child protection staff so that their work is completed both timely and well. Factors that impact workload include the number of new case assignments each team receives; the nature and complexity of the cases they are assigned; hiring and attrition rates of staff; and the many practice requirements mandated by city and state policy and regulation.

ACS has substantially reduced caseloads for child protective staff in recent years. As of April 2025, the average caseload for ACS Child Protective Specialists (CPS) was just 7.7—down from 10.6 in April 2023, and nearly 50 percent below than the most recent high of 14.4 in April 2018. The national standard for child protection investigations is 12 cases.

ACS achieved its caseload reduction through a number of strategies, including hiring and training new child protection staff at a pace that ran well ahead of attrition. In 2023, ACS onboarded and fully trained 480 new CPS. In 2024, 491 new CPS completed training and joined teams working in communities across the city. This means a total of 971 new CPS joined investigative teams over the last two years**.**

Following the recommendations of a 2019 study of ACS child protection workload by Chapin Hall, supervisors and managers seek to carefully distribute the most complex cases so that no one investigator is overloaded with the most demanding cases.

In addition, ACS is eliminating duplicative and outdated policies and guidance, and has simplified some case documentation requirements, including for transfers of court ordered supervision cases from child protection investigative teams to family service units, so that child protection staff can spend more time focused on all-important assessment of child safety and support for families, and less time on administrative tasks.

The agency is working closely with partners including the state's Office of Children and Family Services and fellow city agencies to reduce the number of unnecessary reports made by mandated reporters to the Statewide Central Register for Child Abuse and Maltreatment (SCR). ACS has conducted more than 300 training sessions to educate mandated reporters about when a call to the SCR is necessary because they have reasonable cause to suspect, based on rational observations, professional training,

and experience, that the parent or other person legally responsible for a child has abused or maltreated the child.[12] The trainings help professionals understand that a call to the SCR is not necessary when a child is not in danger, but a family is in need of assistance to address critical needs. The trainings provide guidance about alternative routes to accessing supports and services, including the ACS Support Line (212-676-7667), which connects families with formal prevention services and other resources responsive to their needs. The Support Line receives hundreds of inquiries per month.

Enhanced Oversight of High-Risk Cases

The Accelerated Safety Analysis Protocol (ASAP) and the Heightened Oversight Process (HOP) are core components of ACS' approach to strengthening protection for children at the greatest risk of physical abuse. These initiatives provide additional levels of consultation, oversight and supervisory support in everyday child protective investigative practice.

The Quality Assurance team within the Division of Child Protection (DCP QA) reviews hundreds of the city's highest risk cases each month, and identifies potential risks or signs of abuse/neglect early, allowing for interventions to protect the child(ren) and for increased support, resources and stability for families in need. These reviews also allow staff to receive real-time coaching and support and also identify training/development needs for staff citywide. DCP QA is also incorporating coaching guidance for the staff in Emergency Children's Services (ECS), which are the CPS teams who provide child protective response on evenings, weekends and holidays. DCP QA provides guidance to the ECS leadership team, which is then used in supervision to enhance case practice, individualized feedback on specific cases, helping workers refine their approaches and improve outcomes for children and families.

ACS' Heightened Oversight Process (HOP) remains a key mechanism for promoting child safety during high-risk cases involving young children. Implemented 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 housed with the ACS Office of Investigations. The HOP 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 been 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.

[12] Appropriate reports to the SCR must include a related concern or suspicion of a safety risk to the child, wherein the reporter has "reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent or other person legally responsible comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child" (NYS SSL § 413(1)). ACS is obligated to open a case, either by initiating an investigation or Family Assessment Response (FAR), whenever the SCR accepts a report and transmits it to ACS. In all child protective cases, including those with substance misuse allegations, CPS are responsible for assessing child safety and a family's service needs on a case-by-case basis, looking at actual or potential harm to a child and the parent's capacity to care for the child

ACS is expanding the role of the Investigative Consultants to provide additional support to child protection teams, including making community visits and participating in interviews with family members. In addition, the Investigative Consultants continue to support prevention services provider agencies, teaming up with the Office of Prevention Technical Assistance (OPTA) within ACS' Division of Prevention Services to provide guidance on complex domestic violence cases. In addition to the cross training mentioned later in this report, the Office of Investigations is working with the NYPD to improve response times to child protection staff who are in need of police assistance. Child protections teams can now make requests for police assistance directly to staff members of the Office of Investigations. The NYPD has provided a hotline number for the Office of Investigations to call to request an expedited police response when needed. The collaboration with the NYPD is vital, as there has been an increase in the number of reports made to the SCR by the NYPD in recent years.

Family Service Units (FSU) in DCP. are involved when a New York State Family Court judge orders supervision for a family because of concerns about elevated risk and possible safety. FSU Teams are in each borough and assess for families' engagement in their service plans and whether behavioral changes mitigate the safety concerns that led to the Family Court's involvement. Over the last two years, DCP has worked to reduce FSU caseloads to allow workers additional time to focus on case practice, the family's needs, partnering with preventive services and conducting joint visits with provider agencies. As a result, service planning with families has been enhanced and families are working toward achieving their goals.

ACS has a comprehensive quality management system; ChildStat is one of many processes within that system. Created in 2006 and modeled after NYPD's CompStat program, ChildStat combines discussion of aggregate data findings and case-level decision making to inform and drive system-level changes to improve outcomes for children and families. In these weekly meetings, the focus is on child safety, with a structured discussion that offers opportunities to assess policies and practices and identify strengths and areas for learning and improving. At ChildStat, the ACS Commissioner and executive leadership lead the conversation with leadership from the DCP borough offices. Lessons learned from ChildStat form the basis for recommendations that support zone, borough, and system-wide performance and improvements.

ACS Safe Sleep Strategy

Between 40 to 50 babies in New York City die from sleep-related injury each year.[13] The U.S. Centers for Disease Control and Prevention (CDC) estimates that there are about 3,500 sleep related deaths reported nationally; this rate has been increasing since 2020.[14] An earlier CDC analysis[15] also shows that the high-risk practice of placing babies on their side or stomach to sleep was more common among mothers who were Black/Non-Hispanic, younger than 25, or had 12 or fewer years of education. In addition, the American Academy of Pediatrics published a 2022 report which noted that

[13] Sudden Infant Death Syndrome - NYC Health
[14] Trends in SUID Rates by Cause of Death, 1990—2022 | SUID and SIDS | CDC
[15] Vital Signs: Trends and Disparities in Infant Safe Sleep Practices — United States, 2009–2015 | MMWR

sleep related fatalities have notable and persistent racial, ethnic and socioeconomic disparities,[16] which aligns with New York City findings.[17]

In 2015, the Mayor established the NYC Infant Safe Sleep Initiative to prevent sleep-related infant injury deaths and address long-standing disparities to promote and protect the health and well-being of the youngest and most vulnerable New Yorkers. The initiative focuses on community engagement, public awareness campaigns, free training and resources, collaborations and stakeholder partnerships to increase infant survival in NYC. Since 2017, the initiative has convened an annual summit of professionals and advocates to inform and unite a community of action focused on preventing the tragic loss of children to sleep-related infant injury deaths.

The ACS Office of Child Safety and Injury Prevention (OCSIP) within the Division of Child and Family Well-Being leads the agency's work to promote infant safe sleep practices. In addition to housing the NYC Infant Safe Sleep Initiative, OCSIP's efforts include public education, training, and resource distribution to support parents and child-serving professionals to understand the risks of and prevent injuries and fatalities that affect children under age six, specifically, Shaken Baby Syndrome and unintentional child poisoning caused by exposure to toxins, medication or cannabis-infused edibles. OCSIP offers free resources, supplies, trainings and public campaigns to heighten awareness about how to keep children safe.

Infant Safe Sleep Initiative Activities

During 2024, OCSIP continued its work to address infant safe sleep practices. Most notably, OCSIP:

- Distributed more than 17,000 Safe Sleep Toolkits to discharging maternity patients at all 11 NYC Health + Hospitals medical centers.
- Sustained a hybrid training model—providing both free in-person and virtual trainings for parents, caregivers and child-serving professionals. The caregiver training highlights potential barriers to adopting safe sleep practices such as housing quality concerns (i.e. lack of heat, vermin), discusses caregiver stress and fatigue, and provides tips, strategies and practical solutions on how to manage inconsolable crying and feelings of being overwhelmed. The child-serving professionals training provides tips on leading a strengths-based conversation with caregivers that build trust, address resistance and help families understand the life-saving importance of adopting safe sleep practices.
- Provided virtual and in-person infant safe sleep training to more than 4,400 parents and caregivers and over 1,000 child-serving professionals, including the Department of Homeless Services staff. In addition, more than 870 child welfare professionals completed the Safe Sleep eLearn Course, "Communicating Infant Safe Sleep Practices," designed to dispel common myths and misconceptions about infant sleep, identify the behaviors that may contribute to sleep-related injury deaths, establish and practice Safe Sleep habits, and guide child-serving

[16] Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment | Pediatrics | American Academy of Pediatrics
[17] infant-sleep-2025

professionals on how to lead a strengths-based conversation with parents and caregivers around implementing infant safe sleep practices.

- Distributed free resources, including the safe sleep brochure, video, "Breath of Life: The How and Why of Infant Safe Sleep," wearable blankets (sleep sacks), and portable cribs to support NYC parents and caregivers in safeguarding infants while they sleep.
- Conducted crib demonstrations at in-person community events and shelters, modeling a safe sleeping environment for parents and caregivers and simulating the suffocation risks associated with stomach/side sleeping and the use of excess bedding like blankets, quilts, and comforters.
- In October 2024, during Infant Safe Sleep Awareness Month, ACS 1) released an Op-Ed with guidance for parents and caregivers, 2) held Safe Sleep Information and Resource Fairs to distribute free information and resources across NYC, and 3) partnered with the ACS Division of Family Permanency Services' Older Youth Services to deliver annual Safe Sleep Symposium for expectant and parenting foster youth.
- Issued a Press Release during the winter months—between December and February—to remind parents caregivers to use a sleep sack in place of a blanket to keep infants warm during the cold winter months.
- Partnered with several NYC government agencies, including the NYC Department of Health and Mental Hygiene, NYC Department for Homeless Services, NYC Housing Authority, NYC Health and Hospitals, NYC Department for the Aging, NYC Fire Department, NYC Police Department and NYC Department of Transportation, and other community stakeholders to deliver infant safe sleep training and distribute educational materials and resources to the parents and caregivers they serve.

Intensive In-Home Family Support

The Family Preservation Program (FPP) is an intensive, immediately available home-based program designed to support families to offset safety and risk while a full assessment is being completed. As of July 2024, DCP's FPP units are now operating in every borough. Each FPP unit is staffed with 5 Preservationists, a supervisor, and a manager. Preservationists help families access emergency housing resources, accompany them to appointments, advocate for the family in several areas, such as school meetings, landlord or other housing issues, housing, benefits applications, etc., help organize, budget, and/or improve skills to maintain their home, and connect them to other services. The referral process has been streamlined to minimize wait times. Families receive a 24-hour response and joint home visit arranged with the referring child protection team. Families are referred to FPP after their encounter with DCP child protection's Investigative, Family Service Units (for families with Court Ordered Supervision) and/or CARES[18] teams. Any family who requests FPP can receive the service, which supports families for up to 5 weeks.

[18] CARES (Collaborative Assessment, Response, Engagement and Support) formerly known as Family Assessment Response (FAR) is an alternative child protective response to some low- and moderate-risk reports of child maltreatment. Consistent with all child protective concerns reported to the SCR alleging abuse/neglect, the primary focus is the safety of the child.

Child and Home Safety Activities

ACS's Division of Child Protection (DCP) continues to partner with the Fire Department of New York (FDNY), coordinating directly with its Fire Safety Education Unit to offer and co-deliver the FDNY & ACS Fire Safety Training where topics addressed by the FDNY Fire Safety Educator include:

- Smoke Alarms and Carbon Monoxide Detectors installation, including how and where devices should be positioned and placed.
- Smoke Alarms and Carbon Monoxide Detectors maintenance, including testing frequency and suggested time to change batteries.
- Smoke Alarms and Carbon Monoxide Detectors sound patterns, raising awareness about when the device "chirps" and its meaning.

Also, during the training, the DCP facilitator provides agency-specific context to child protection teams on the importance of checking that smoke/carbon monoxide detectors are operable and that findings are documented in the case records in CONNECTIONS. Additionally, child protection teams are advised to immediately follow up and provide detectors on the same day when smoke/carbon monoxide detectors are not observed/operable. If necessary and depending on the hour, a request is made to DCP's Emergency Children Services (which operates nights, weekends and holidays) to deliver the device to the family. ACS' child protection teams can also request installation of the detectors through the American Red Cross (excluding those living in the New York City Housing Authority developments, which equips each apartment with smoke/carbon monoxide detectors).

Services for Children and Families with Complex Medical and Developmental Needs

ACS remains committed to securing high-quality health care for all children with whom the agency and its contracted providers have contact. The ACS Office of Child and Family Health (OCFH) manages health care issues throughout ACS, providing expert technical assistance to child welfare, juvenile justice, and child care programs, in addition to developing and implementing strategies to enhance the understanding of medical issues throughout ACS systems in order to improve case practice and outcomes. OCFH continues to lead the agency's efforts to provide access to quality health services as well as educate agency staff and foster care and prevention service providers on assessing whether the medical needs of the children and adolescents we serve are being met.

Beginning in 2019, OCFH partnered with NYC Health + Hospitals medical consultants to support DCP offices across the five boroughs on cases in which a child is identified as having a 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 consultation is prioritized so that children with the most complex and acute medical needs receive immediate intervention. Additionally, OCFH medical staff have re-opened nurseries to provide on-site medical support at ACS DCP Borough offices in Queens, the Bronx and Brooklyn.

In 2023, OCFH expanded the Psychiatry and Behavioral Health Unit (PBHU) tby hiring of two part-time psychologists. Additionally, PBHU developed a mental health resource guide for ACS/foster care agencies.

OCFH has expanded the ACS Developmental Disabilities Unit (DDU), hiring additional staff to serve as liaisons to the DCP borough offices to ensure that children, youths, parents, caregivers and/or other adults involved in the child welfare system who are suspected of or diagnosed with an intellectual or developmental disability receive the necessary attention and service. The liaisons provide case consultation, technical support, resources, and guidance to child protection teams. Liaisons also participate in multi-disciplinary team meetings, child safety conferences and other types of family conferences when appropriate given case circumstances. In addition, the liaisons facilitate regular DDU trainings for child protection staff.

Responding to Families with Mental Health Needs

ACS continues to collaborate with the State Office of Mental Health (OMH) to ensure that youth have access to needed services. This includes coordinating trainings to ACS and contracted agency staff from OMH and the NYC Department of Health and Mental Hygiene (DOHMH) representatives on Children's Single Point of Access (CSPOA), a centralized referral system for children and youth with serious emotional disturbance who need intensive mental health services to remain safely at home.

The ACS Clinical Consultation Program supports case work decision making through consultants with specialized knowledge and skills in areas that often come to the attention of the child welfare system such as intimate partner violence, mental health, and substance misuse. ACS released an RFP seeking a refined approach to the ways that these contracted nonprofits support the child protective team in assessing the safety of and identifying options for the families that come in contact with child welfare. New contracts for an updated "Clinical Support Program" will be awarded and begin in January 2026.

The ACS Office of Training and Workforce Development (OTWD) continues to train child welfare staff on how to work with families impacted by mental illness, and navigating the mental health system. To address maternal mental health, ACS has partnered with a comprehensive treatment center for new and expecting parents that offers support groups, therapy, medication management, and other services. The partnership is aiding ACS to develop in-depth training materials for staff on perinatal mood and anxiety disorders (PMADs) that affect parents during pregnancy and the postpartum period. ACS believes that in order for children to thrive and have their needs met, both parents must be healthy physically and mentally; therefore supporting the mental health and well-being of fathers is also important as fathers can play a critical role in recognizing PMADs symptoms in their pregnant or postpartum partner that might interfere with their ability to care for the child and the family. In late winter 2024, ACS recorded the third video in the perinatal mood anxiety disorders series which centered on the voice of fathers with mental health needs and experience providing support to partners with PMADs.

Engaging with Fathers

Working with fathers is often a challenge for child protective staff, including those who do not reside with their children. ACS is seeking to expand resources for fathers and other male caregivers, and to strengthen coaching, training and other supports for CPS and others in the child welfare system responsible for interviewing fathers during investigations, organizing family team conferences and planning services and referrals. In collaboration with Casey Family Programs, ACS is developing an Office

of Fatherhood Engagement. The ACS Fatherhood Working Group, which includes ACS staff, outside agency staff, and community nonprofits, is driving the planning process. The goal is to stand up the Office of Fatherhood Engagement and create policy and practice recommendations that will increase engagement with fathers.

The Multidisciplinary Review Panel

In 2025, ACS launched the Multidisciplinary Review Panel (MRP), which brings experts external to ACS into the child fatality review process to help identify systemic solutions that will enhance ACS' ability to protect children and deliver high-quality services. The panel includes a group of esteemed child welfare stakeholders, including those in the fields of child abuse pediatrics, mental health, the office of the district attorney, law enforcement, accident prevention, parent advocacy, community-based services and more. Through a state-approved process, the panel will have access to confidential case information which can help panelists gain insight into child welfare practices and enhance cross systems learning and improvements.

The multi-disciplinary fatality review team meets at least three times yearly to discuss trends and patterns (systemic influences) that impact child welfare staff's effectiveness in their roles, including the intersection of child welfare and other public/private agencies that interact with families or that provide services to families experiencing circumstances similar to those in which a child fatality has occurred. There will be standing members as well as the opportunity to invite others as needed, based on the topic being discussed. The team reviews case studies as well as aggregate trend data related to critical issues identified in the systemic child fatality review process, these include sleep-related injuries, mental illness, homelessness, substance and alcohol misuse, intimate partner violence, investigative practices and staffing challenges. Systemic elements explored may include: ACS' operations, policies, practices, training and fiscal resources; coordination/collaboration with entities external to ACS, such as law enforcement, courts, health care, mental health care and social services, and related cross-system challenges; and government and regulatory bodies, including City, State, and Federal oversight and accreditation bodies, including law, regulations, policies and other mandates that impact decision making and service delivery. Ultimately, the multi-disciplinary review team will produce recommendations for possible implementation by ACS and other public and/or private organizations that will improve systems responses and prevent injuries and/or similar fatalities in the future.

System Recommendations

The safety science approach to reviewing child fatalities encourages proactively exploring systemic influences that impact decision making in the moment, with the goal of reducing the likelihood of future deaths due to maltreatment. The 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 ACS 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 with child protection teams and other relevant stakeholders, and using a Systems Analysis Scoring Tool to score systemic influences.[19]

In addition to the many specific initiatives detailed in the previous pages, the ACS Systemic Child Fatality Review process identified recurrent systemic themes noted in past reports and which are endemic to child welfare work. For 2023, the most prevalent were Managing Workloads (discussed above) and the many associated tasks; Teamwork/Coordinating Activities within the agency and across other systems, and Family Conflicts.

Teamwork/Coordination

Child welfare practitioners collaborate and partner with many individuals, service providers, and other systems every day to keep children safe. Families known to ACS come into contact with many individuals and other systems over the course of a child's life, including health care, schools, youth services, housing services, and many others. A large portion of child welfare work depends on contacting and fostering relationships with professionals and family members who have valuable knowledge to inform thorough assessments of child safety, as well as to provide assistance to make sure families are well-supported and decisions are informed by the most relevant information. During reviews conducted in 2023, child protective teams conveyed difficulty connecting with collaterals to conduct comprehensive assessments of children and their caretakers/families.

- ACS's Division of Child Protection is engaged in an agency-wide initiative to support staff in effectively identifying and contacting collateral resources who can provide insight during investigations into child safety, child development and family functioning.
- As outlined above, ACS is expanding the role of the Investigative Consultants to provide additional support to child protection teams, including making community visits and participating in interviews with family members.
- In addition, ACS is reprocuring its Clinical Consultation Contracts. This program supports casework decision making through consultants with specialized knowledge and skills in areas that often bring families to our attention: intimate partner violence, mental health, and substance misuse. ACS released an RFP seeking a refined approach to the ways that contracted nonprofits support the child protective team in assessing the safety of and options for the families we serve. New contracts for an updated "Clinical Support Program" will be recommended for award over the summer and will begin in January 2026.
- In 2022, building on the quality management process of ChildStat, ACS instituted "Systemwide ChildStat" to promote shared responsibility and accountability across all ACS divisions in their support of DCP's efforts to protect children from harm. These sessions emphasize that protecting children and strengthening families is everyone's responsibility, not only child protection, and provide an opportunity for ACS divisions to share the work they are doing to address systemic issues and support child protective teams. Outcomes have included new

[19] Systemic influences have specific definitions developed from relevant Safety Science literature (see Appendix C) .

strategies for recruiting child protection staff; strengthening technology and administrative supports; improved transportation response time; facility upgrades, and staff safety initiatives.

Family Conflict

Family Conflict, and in particular Intimate Partner Violence, impacted many of the children in families that experienced a child fatality, as it does children generally involved with the child welfare system. The data indicates that recent or current Intimate Partner Violence was present in 39% of the 2023 child fatalities. Domestic Violence Incident Reports (DIRs) revealed a history of violence with previous partners and in current relationships for both the person causing harm and for survivors. In many cases, children were impacted by witnessing a great deal of violence and familial discord.

- ACS employs many avenues to address family conflict and IPV. Borough office staff have access to designated staff at the NYPD and to Clinical Consultants who provide critical support during child protective investigations and family service cases. The NYPD has increased the number of liaisons who serve as points of contact for the ACS Office of Investigations staff. In addition to a liaison in the Chief of Departments, and the Domestic Violence Unit, ACS Investigations staff also now has a liaison in each of the eight NYPD Patrol Boroughs who can assist with investigative concerns.
- Clinical Consultants provide expertise in several areas including Intimate Partner Violence. The program has been in place for many years and ACS has recently reassessed the program and will be enhancing the services offered to better support child protective teams and provider agency teams. (As noted above, new contracts for an updated "Clinical Support Program" will begin in January 2026.)
- In 2023, ACS' Division of Prevention Services expanded A Safe Way Forward, which is now available in Brooklyn, the Bronx and Staten Island. This innovative program serves the entire family, including intimate partner violence survivors, the persons causing harm and children, providing trauma-informed case planning and research-informed therapeutic services.
- ACS continues to partner with the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV) to collaborate on best practices to support families experiencing intimate partner violence, including exploring effective training models for child protection staff. The two agencies continue to meet quarterly to bolster relationships among service providers, including NYC's Family Justice Centers (providing gender-based violence survivors with legal, economic and other supports) and to continue training child protective staff who work with families experiencing violence.
- The ACS Office of Training and Workforce Development (OTWD) continues to offer training on identifying and addressing intimate partner violence, building skills and knowledge to assess and engage the survivor, the person causing harm and their children, as well as safety planning.

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: 2023 Data Tables

Table 4. Manner of Death for Child Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2014 - 2023)

Manner of Death	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Accident	9	6	8	11	8	9	8	11	9	6
Homicide	9	10	11	6	10	10	5	10	9[+]	8
Natural	21	7	16	28	20	14	16	12	9	8
Suicide	2	2	0	2	2	3	0	0	0	1
Therapeutic Complications	0	1	1	0	0	0	0	0	0	0
Undetermined	17	16	19	16	19	19	23	19	11	17
Body not Located	0	1	1	0	0	0	0	0	0	0
Pending	0	0	0	0	0	1*	0	1*	0	3*
Other[Ψ]	0	0	0	0	0	1	0	0	1	2
Total	58	43	56	63	59	57	52	53	39	45

[+]Includes homicide deaths where ACS has received the autopsy as well as homicides confirmed by OCME where the autopsy report has not been provided.

*In one 2019 case, one 2021 case, and three cases in 2023, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

[Ψ]The death did not fall under the jurisdiction of the Office of the Chief Medical Examiner (OCME) or no autopsy was performed. This includes children who were not autopsied for religious reasons or children where the hospital certified the cause of death.

Table 5. Investigation Decision on Fatality Allegations in Families Known to ACS in Previous Decade with Fatality Reported to SCR (2014 - 2023)

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Fatality Allegation Substantiated	27	13	21	23	25	21	11	17	12	12
Other Allegation Substantiated (excluding fatality)	13	13	13	15	13	21	15	10	9	10
Unfounded Investigation	18	17	19	25	19	14	24	26	13	22
Total Investigations*	58	43	53	63	57	56	50	53	34	44

*Some investigations involved families with more than one child fatality

Table 6. Sleep-Related Child Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2015 - 2023)

Year of Child Fatality	Number of ACS Known Sleep Related Fatalities	Total Number of ACS Known Fatalities	Percent of ACS Known Fatalities that had Unsafe Sleep Injuries
2015	21	43	49%
2016	21	56	38%
2017	24	63	38%
2018	21	59	36%
2019*	20	57	35%
2020	22	52	42%
2021*	20	53	38%
2022	15	39	38%
2023*	20	45	44%

*For one case in 2019 and 2021 and three cases in 2023, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 7. Homicides in Families Known to ACS in Previous Decade and Reported to SCR (2014 - 2023)[+]

Manner of Death	2014	2015	2016	2017	2018	2019*	2020	2021*	2022	2023*
Homicide	9	10	11	6	10	9	5	10	9[+]	8
Total Fatalities	58	43	56	63	59	57	52	53	39	45
Percent of Fatalities Deemed Homicides	**16%**	**23%**	**20%**	**10%**	**17%**	**16%**	**10%**	**19%**	**23%**	**18%**

[+]Includes homicides deaths where ACS has received the autopsy as well as homicides confirmed by OCME where the autopsy report has not been provided.

*****For one case in 2019 and 2021 and three cases in 2023, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 8. Fatalities reported to SCR and Certified as Natural Deaths in Families Known to ACS in Previous Decade (2014 - 2023)

Manner of Death	2014	2015	2016	2017	2018	2019*	2020	2021*	2022*	2023*
Natural	21	7	16	28	19	14	16	12	8	8
Total Fatalities	58	43	56	63	59	57	52	53	39	45
Percent of Fatalities Deemed Natural Deaths	36%	16%	29%	44%	32%	25%	31%	23%	21%	18%

*****For one case in 2019 and 2021 and three cases in 2023, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 9. Race and Ethnicity Demographics of Parents in 2023 Child Fatalities Reported to SCR[ǂ]

Race/Ethnicity	Families Known to ACS Within Previous Decade*		Families With no Prior ACS Involvement*	
	Mother	Father	Mother	Father
American Indian/ Alaska Native	1	0	0	0
Asian	3	3	5	5
Black/African American	19	22	22	22
Biracial/Multiracial	2	0	0	0
Hispanic	14	14	14	15
Pacific Islander	0	0	0	0
White Non-Hispanic	5	3	13	11
Other	0	0	0	0
N/A[†]	0	2	0	2
Unknown	0	0	1	0
Total	**44**	**44**	**55**	**55**

[ǂ]2023 New York City child fatalities reported to the SCR alleging maltreatment associated with the fatality.
*There were multiple fatalities in one or more cases.
[†]N/A = no information is available about the male in the family

Appendix C: Systemic Influences Definitions

Systemic influences are identified within and across cases. The frequency of the systemic influences informs opportunities for learning and improvement.

Cognition: A faulty understanding of a situation due to cognitive fixation or intrinsic biases (e.g., confirmation bias, focusing effect, tunneling, transference).

Knowledge Gap: An absence of requisite experience and/or knowledge and/or difficulties applying knowledge and integrating it into practice (e.g., absence of knowledge regarding policy or practice).

Documentation: Absent, incomplete or inconsistent documentation. (Documentation was completed according to policy timeframes, clearly recorded with relevant and necessary details of case activities.)

Stress/Fatigue: Professional or personal stress or tension. Fatigue as a result of casework and/or other life circumstances. (e.g. staff express or exhibit difficulty managing the strains of casework, staff morale, vicarious trauma, and/or other life circumstances.)

Demand-Resource Mismatch: A lack of internal resources or programs (e.g. lack of preventive and community-based service slots, inadequate staffing-including consultants) to meet the needs of staff to carry out their work.

Equipment/Tools/Technology: An absence or deficiency in the equipment, tools and/or technology utilized to carry out safe work practices.

Training: The absence or ineffectiveness of formal instruction.

Policies/Prescribed Practice: When practice prescribed by policy or practice standards is absent, conflicting, vague or does not adequately support work.

Service Availability: The absence, ineffectiveness of or difficulty accessing a particular external service or support.

Teamwork/Coordinating Activities: Ineffective collaboration between two or more internal and/or external entities (e.g., CPS and Law Enforcement, CPS and Preventive Services, Foster Care, Mental Health/Medical Providers and other entities).

Medical and Mental Health Collaboration: Difficulties in communicating with medical/mental health providers, obtaining or understanding medical records and/or integrating medical information into assessment(s).

Production/Efficiency Pressure: Demands to increase production and/or efficiency (workload, economics-including cuts to workforce).

Supervisory Support: Difficulties in carrying out supervisory functions. Supervision is often unavailable, provides ineffective support, communication, does not foster teamwork or create a safe environment for staff.

Supervisory Knowledge Transfer: Supervision provided guidance/directives that were inconsistent with policy, procedure and/or best casework practice.

Procedural Drift: A gradual departure away from written procedure due to system constraints and influences, and the workforce/local team has experienced success.

Family Conflict: This item refers to fighting and arguing between family members. Domestic violence refers to physical fighting which might lead to injury as well as verbal, or emotional abuse.

Caregiver Development: This item refers to developmental disabilities including autism and intellectual disabilities of the caregiver.

Caregiver Medical Challenges: This item refers to physical/medical disabilities and/or diagnosis of the caregiver.

Caregiver Mental Health: This item refers to the evidence of or confirmed diagnosis of mental illness.

Caregiver Substance Use: This item includes problems with alcohol, illegal drugs and/or prescription drugs.

Child/Adolescent Medical Health: This item is used to describe the child/youth's current medical/physical health.

Child/Adolescent Development/Intellectual: This item describes the child/adolescent's physical and intellectual development as compared to standard developmental milestones. Rate this item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.

Child/Adolescent Mental Health: Refers to the child/adolescent's mental health. A formal mental health diagnosis is not required to score this item.