ACCOUNTABILITY REVIEW PANEL REPORT 2017

NYC™
Administration for Children's Services

Accountability Review Panel Report 2017

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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 2017, ACS investigated almost 60,000 consolidated reports of child maltreatment, concerning more than 92,000 children. Each year, ACS investigates about 100 cases of child fatality reported to the Statewide Central Register (SCR), and roughly half of these children have no history of prior contact with ACS. Additionally, ACS investigations conclude that the large majority of child fatalities reported to the SCR are unrelated to abuse or neglect. The occurrence of a child fatality due to maltreatment is a rare event, comprising of about 0.1 percent of all cases investigated. Nonetheless, the death of a child with whom ACS has had contact requires special attention.

This report focuses on the work of New York City's Accountability Review Panel during calendar year 2017. The Accountability Review Panel (referred to hereafter as "the Panel") reviews fatalities of children whose families are "known to ACS", meaning they have been the subject of an investigation or have otherwise received services from ACS within the last 10 years, or who were receiving services or the subject of an investigation at the time of the fatality. These cases are referred to as Panel Cases. The Panel is a multi-disciplinary 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 + Hospitals, Police Department, Fire Department, Department of Homeless Services, Department of Health and Mental Hygiene), and external experts (including child advocacy center medical directors, child mental health specialists, pediatricians with specialized training and/or experience in evaluating child maltreatment, medical examiners). 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 2017. Due to the small number of fatalities when compared to the larger pool of child welfare cases handled by ACS, readers are cautioned not to generalize findings in this report. 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 analyses is to learn lessons that will help 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[1], 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 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.

This report looks at fatalities investigated by ACS where child abuse and/or neglect was suspected in the death. 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.

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

New York City's Review of Child Fatalities Alleging Maltreatment

The New York Statewide Central Register of Child Abuse and Maltreatment (SCR) receives all reports of suspected child 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 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, when a family is receiving prevention services, or while a child is placed in foster care must be reported to the New York State Office of Children and Family Services (OCFS), even if the circumstances of the fatality did not raise suspicion of maltreatment.

The New York City Office of the Chief Medical Examiner ("the ME") determines the cause and manner of a child's death. The cause of death is the injury, disease, or condition that resulted in the fatality, such as blunt trauma or drowning. 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 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 case as homicide in which a child died in a fire where s/he was left alone without adult supervision. 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 receives 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 determinations regarding the circumstances of the deaths. 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." 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. 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 did not contribute to the fatality.[2] In addition to the DCP investigation, the New York City Police Department and District Attorney investigate child fatalities to determine if there is criminal culpability and whether or not to initiate prosecution.

2 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."

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 it 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;

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 a family is known to ACS, that child's death becomes a "Panel case." Table 1, below, indicates that over half (58 percent) of the child fatalities reported to the SCR in 2017 alleging maltreatment in association with a child's death occurred in families known to ACS, and thus were subject to Panel review. This report focuses on those cases. Table 1 also provides an overview of all fatalities reported to the SCR and investigated by ACS in 2017 (see table 2 in the section that follows for Panel data alone). In 2017, the manner of death for fatalities which occurred in families known to ACS when compared to fatalities reported to the SCR in families that were not known to ACS prior to the fatality were generally similar.[3]

3 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.

Table 1: Manners of death for all 2017 child fatalities reported to SCR

	2017 Panel Cases		2017 non-Panel Cases*		Total 2017- all SCR reported child deaths	
Manner of Death	N	%	N	%	N	%
Accident	11	17%	9	20%	20	19%
Homicide	5	8%	5	11%	10	9%
Natural	27	43%	19	42%	46	43%
Suicide	2	3%	1	2%	3	3%
Undetermined	15	24%	11	24%	26	24%
Therapeutic Complications	0	0%	0	0%	0	0%
Pending/No Autopsy	3	5%	0	0%	3	3%
Total	63		45		108	

Percentages may not equal 100 due to rounding
*Average age of non-Panel 2017 fatalities was 32.5 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 child welfare histories of all adults related to or involved with the child, such as parents, boyfriends, grandparents, aunts, uncles, and others with known 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 suggestions for improvements. For each case reviewed, 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 ACS divisions for possible implementation.

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 2017, the national fatality rate among infants was 5.8 deaths per 1,000 live births[4], not significantly different from the 2016 rate. Infants under one year of age continue to be at greatest risk of death among all children; that rate decreases substantially after the first year of life. In 2016, across age groups, except for ages one to four where the death rate for girls was slightly higher, death rates for boys were higher than for girls, with the largest percentage difference being among youth aged 15 to 19. Of note, in this age range, Black males were more than three times as likely to die as females, while American Indian/Alaska Native boys were twice as likely to die as their female counterpart.[5]

Child fatality rates also differ across racial and ethnic identities. Nationally, Black children have the highest death rates, followed by American Indian/Alaska Native, Native Hawaiian or other Pacific Islander, Hispanic and non-Hispanic white children. Asian children have the lowest death rates. In 2016, the infant fatality rates were 11.4 per 1,000 for Black infants, 9.4 per 1,000 per for American Indian/Alaska Native infants, 7.4 per 1,000 for Native Hawaiian/other Pacific Islander infants, 6.4 per 1000 for Puerto Rican infants, 5.0 per 1,000 for Hispanic infants, 4.9 per 1,000 non-Hispanic white infants, and 3.6 per 1,000 Asian.[6]

In 2017, the infant mortality rate in New York City was 4.6 per 1,000 live births, slightly higher than the 2016 rate of 4.1, the lowest in recorded history, and higher than the 2015 rate of 4.3. 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).[7]

The NYC Department of Health and Mental Hygiene, in a review of child injury deaths between 2010-2015, found that unintentional injuries (accidents) were the leading cause of death for NYC children between the ages of one and 12.[8]

4 Kochanek KD, Murphy SL, Xu JQ, Arias E. Mortality in the United States, 2017. NCHS Data Brief, no 328. Hyattsville, MD: National Center for Health Statistics. 2018

5 Xu JQ, Murphy SL, Kochanek KD, Bastian B, Arias E. Deaths: Final data for 2016. National Vital Statistics Reports; vol 67 no 5. Hyattsville, MD: National Center for Health Statistics. 2018.

6 Xu JQ, Murphy SL, Kochanek KD, Bastian B, Arias E. Deaths: Final data for 2016. National Vital Statistics Reports; vol 67 no 5. Hyattsville, MD: National Center for Health Statistics. 2018.

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

8 8 NYC Vital Signs: Understanding Child Injury Deaths: 2010-2015 Child Fatality Review Advisory Team Report. NYC Vital Signs Vol.17, No.4, May 2018. Please note that this report excluded infants under the age of one.

Panel Data: 2017

Overall Panel Cases

In 2017, there were 63 fatalities of children in families that have been the subject of an investigation or have otherwise received services from ACS within the last 10 years, or who were receiving services or the subject of an investigation at the time of the fatality. The most common manners of death as certified by the ME were *natural* (n = 27, 43%), followed by undetermined (n = 15, 24%), *accident* (n = 11, 17%), *homicide* (n = 5, 8%), and *suicide* (n = 2, 3%) (see Table 2). ME findings remain outstanding for three cases.[9] In 2017, deaths certified as natural represented a higher percentage of total Panel child fatalities when compared to prior years. For example, in 2015 natural deaths accounted for 14% of Panel fatalities, and in 2016 natural deaths accounted for 23%.

Table 2. Manners of death for Panel child fatalities from 2017

	Total 2017	
Manner of Death	N	%
Accident	11	17%
Homicide	5	8%
Natural	27	43%
Suicide	2	3%
Undetermined	15	24%
Therapeutic Complications	0	0%
Pending/No Autopsy	3	5%
Total	63	

*Percentages may not add up to 100 due to rounding

What follows is a review of case characteristics for all of the 2017 Panel fatalities (n = 63). Following the overview of all Panel cases, the data are examined by subsection for three key areas of concern: unsafe sleep fatalities (which are most often categorized as "undetermined" or "accidental" by the Office of the Chief Medical Examiner) , homicide, and natural deaths related to 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, children at greatest risk of fatality are young. The average age of the Panel children was 3.4 years, while the median age was 9.1 months. Children's ages ranged from newborn to just under 17.9 years old. Fifty-two percent of the fatalities were of infants under the age of one. Including infants, children under the age of five accounted for 75 percent of reviewed fatalities. Ten fatalities were of children between the ages of 5-12, and 10 percent were of children over the age of 12. A slightly larger proportion of the children were male (52%) than female (48%).

Families in which a Panel fatality occurred were disproportionately Black/African American/Non-Hispanic (51 percent) and Hispanic/Latino/Non-Black (37 percent). Three of the fatalities occurred in White families.

9 Appendix 1 provides descriptions of what the Medical Examiner considers when making a manner of death determination.
10 This data was based on the race and ethnicity information available in CONNECTIONS.

The remaining five fatalities occurred in families of Asian, other, or multiple race/ethnicity.[10] Data was also collected on the male involved with the family. Forty-one percent identified as Black/African American/Non-Hispanic while 33 percent were Hispanic/Latino/Non-Black. Of the remaining categories, the male was listed as other in six cases and White on five cases.

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. Sixty percent of the Panel investigations reviewed in this report resulted in an indication for at least one allegation (n=38), and one-third were indicated for the fatality itself. Ninety-seven percent of the Panel children lived with their biological families at the time of death. Two fatalities occurred in out-of-home family-based settings, one in a kinship foster home and one in a non-kinship foster home. Fifty-nine percent (n=37) of the fatalities occurred among families with open ACS cases at the time of death.

Panel families share similar characteristics to other families with whom ACS has contact. As with other 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 27 percent of Panel families, and a recent history of domestic violence (within the last four years), which was noted in 51 percent of the reviewed cases. Forty-three percent of the mothers had histories of ACS involvement as children; of those, 56 percent had a history of foster care placement as children. Incidentally, for the male involved with the family, where information was available, 14 percent had histories of ACS involvement as children, and only one showed a history of foster care placement. No information was available on seven cases.

Five of the cases reviewed by the Panel involved families residing in a shelter at the time of the fatality; of these, three had an active ACS case at the time of the fatality. In the five cases where the child died in a shelter facility, the Medical Examiner certified the deaths as natural (n=3) and undetermined (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 within four years prior to the fatality, 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.

10 This data was based on the race and ethnicity information available in CONNECTIONS.

Reviews of the case records indicated that 49 percent of the mothers had current or prior substance abuse issues noted, and 46 percent had current or ongoing (diagnosed or undiagnosed) mental health concerns noted in the case record. The mothers' average age was 30.3 years at the time of the death, and the median age for mothers was 30 years. On average, mothers had three or more children. An adult male was involved with the family in 89 percent (n=56) of the cases reviewed. Where the adult man was known to be a part of the household and/or in a caregiving role, 41 percent had current or prior substance use noted, and current or past mental health concerns were noted on six of the cases. Of the identified males, 77 percent (n=43) were fathers or step-fathers of the deceased child.

Safe Sleep

Thirty-eight percent (n=24) of the 2017 Panel fatalities had notations of sleep related injuries contributing to the death, also referred to as unsafe sleep conditions (see Table 3). The percent of cases with sleep-related deaths was significantly higher when looking at a subset of children by age. Usually, the ME records the manner of death for these cases as "Undetermined" or "Accidental". Of the 24 sleep related fatalities, all but two were under six months of age.

Table 3. Panel-reviewed child fatalities from 2017 with Sleep-Related Deaths

Year of Fatality Review	Total Number of Panel Fatalities (Children)	Number of Panel Fatalities with Unsafe Sleep Injuries	Percent of Panel Fatalities with Unsafe Sleep Injuries
2017	63	24	38%

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 because they include notations of unsafe sleep conditions either cited by the Medical Examiner's report or documented in the progress notes during an ACS investigation. 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 or car seat. In over half of the 24 sleep related fatalities included in this report (n=13), 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 almost half (46 percent) of the cases as having an undetermined manner of death, and more than a third (38 percent) of the cases as having an accidental manner of death.

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 where an infant was found prone in a crib or bassinet in which soft bedding was present. Cases deemed undetermined by the ME are most common in infants.

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, 92 percent (n = 22) of the sleep-related deaths involved infants under six months. More than half (n = 14, 58 percent) of the children were female and 42 percent (n = 10) were male, which varied from the overall group of Panel cases, where more males died (n = 33, 52 percent), and past years where males outnumbered females in this category.

Of the sleep-related fatalities, one child died in a non-kinship foster care home while another died in a family shelter. 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 as noted above,

only one such fatality occurred in a shelter setting. Ten of the 24 sleep related fatalities (42%) occurred in families that had an open ACS case at the time of the death.

Panel Recommendations and ACS Initiatives

As in prior years, unsafe sleep practices continue to be identified as a factor in many Panel fatalities and the data suggests that children less than six months of age are particularly vulnerable. The Panel suggested that ACS continues its multi-pronged approach to promote safe sleeping practices among families in New York City. This includes educating parents, family members, professionals, health providers, and the public about safe sleeping practices. Training CPS and provider staff to more consistently and thoroughly assess and educate families they encounter about safe sleeping practices, was also suggested.

ACS continues to provide cribs and Pack 'n Plays to families with whom ACS has contact when there is a lack of a safe sleep environment for their infant. ACS, as part of its regular casework practice, also provides safe sleep information and coaching to families during home visits.

In July 2016, Governor Andrew M. Cuomo signed legislation that requires all New York State hospitals and birth centers to provide new parents information about safe sleep. In support of this statewide effort to keep babies safe, ACS and NYC Health + Hospitals partnered together to introduce a Safe Sleep Tool Kit Distribution Program to put resources, educational materials, and supplies directly into the hands of maternity patients at the point of hospital discharge to make it much easier for parents, families and caregivers to follow recommended safe sleep guidelines and eliminate the risk factors associated with sleep-related infant injuries. Approximately 15 percent of NYC's 120,000 annual births occur in NYC Health + Hospital facilities.

Initially piloted at four hospitals, by February 2019 the Safe Sleep Toolkit Distribution Program was in place at all 11 Health + Hospital facilities (Jacobi, Lincoln and North Central Bronx Hospitals in the Bronx; Woodhull, Kings County and Coney Island Hospitals in Brooklyn; Harlem, Bellevue and Metropolitan Hospitals in Manhattan; and Elmhurst and Queens Hospitals in Queens).

The items in the new Safe Sleep Tool Kit respond to common barriers to practicing safe sleep identified in focus groups identified. For instance, parents disclosed that they were more likely to practice safe sleep if they knew the why behind safe sleep recommendations, so the Tool Kit includes a Safe Sleep Brochure and DVD "Breath of Life: The How and Why of Safe Sleep," which explain the rationales behind the recommendations and offer solutions to everyday challenges many parents face when trying to maintain a safe sleep environment for their infants. Many parents disclosed that they often shared a bed with their babies as a protective measure—to keep their babies warm during winter months when there was poor heating or to protect their babies from vermin. As a result, the Tool Kit includes a wearable blanket, known as a sleep sack, that can be used in place of a loose blanket which can cover a baby's face and interfere with breathing. To address concerns regarding household pests, the Tool Kit includes protective crib netting, which provides babies with natural protection against mosquitoes and other insects. The Tool Kit also includes an infant onesie with a printed message reminding parents to practice safe sleep.

Two other new initiatives are focused on reducing unsafe sleep deaths:
Department of Homeless Services (DHS) Trainings. The ACS Safe Sleep team expanded its training curriculum and, in January 2019, began training DHS provider agency staff who work in shelters. The Safe Sleep Provider Training includes an interactive workshop and PowerPoint presentation that highlights the most up-to-date Safe Sleep recommendations from the American Academy of Pediatrics (AAP); shares

the latest citywide data on sleep-related infant injury deaths; and explores values and barriers families may face, including historical family practices, cultural beliefs and housing quality concerns (i.e. lack of heat and pest infestations) that may interfere with a family's ability to adopt safe sleep practices. In addition, through role-play exercises, the training explores strategies and conversations for building trust and addressing resistance, to help families understand the existing recommendations and why it is important to adopt Safe Sleep habits.

Free Sleep Sack Distribution. In 2019, ACS announced that anyone may come to one of the Division of Child Protection (DCP) offices and get a free, wearable sleep sack for their baby. This initiative recognizes that some unsafe sleep practices, like bed sharing and putting blankets in cribs, are common especially in cold weather. ACS has distributed more than 860 free wearable blankets to families, many of which were not involved with ACS.

Homicide

At the writing of this report, the Medical Examiner had classified five Panel cases (8 percent) as homicides. 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. The number of fatalities due to homicide varies from year to year. Table 4 provides a longitudinal view over the past 10 years.

Table 4 Panel reviewed child fatalities from 2007 and 2017 with certified homicides

Manner of Death	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	*2017
Homicide	9	16	6	10	11	15	6	9	10	11	5
Total Panel Fatalities Per Year	41	49	39	46	43	50	44	58	43	56	63
Percent of Panel Fatalities with Homicides	22%	33%	15%	22%	26%	30%	14%	16%	23%	20%	8%

*3 autopsies are still 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.

Homicide Case Characteristics

Four of the five homicide fatalities were of children less than seven years of age. Two of these deaths were due to acute intoxication after the child ingested the mother's medication. In two others, the cause of death was blunt impact. The fifth fatality was of a 17-year-old who was shot by an unrelated assailant. Three of the children were male and one was female.

At the time of the fatality, each of these children was living in the home of their parent(s), although the fatality may have occurred elsewhere. In three of the cases, either one or both parents had current or past substance use issues.

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. The Division of Policy, Planning and Measurement (DPPM) uses a predictive risk model ("Severe Harm") to identify any investigative case in our system in which a child may be at elevated risk of physical injury or sexual abuse. These cases are reviewed by the ACS Division of Child Protection Quality Assurance (DCP QA) team between the 8th and the 20th day of an investigation, to make certain that all fundamentals of strong investigative practice have been followed, and that the children are safe. On these case reviews--and on any other review by the DCP QA team—any gap in the investigation is immediately addressed.

Also in 2017, ACS implemented a Heightened Oversight Process (HOP) for cases where the subject child in an investigation is three years old or younger and the allegation includes a fatality, a serious injury, or sexual abuse. In 2018, ACS modified the criteria to include any allegation involving children 3 years of age or younger where the parent or caregiver named in the SCR has had one or more children removed and placed in ACS foster care prior to the current investigation, and the child(ren) and parent have not reunified. The HOP review process combines the expertise of ACS Investigative Consultants—former detectives currently employed by ACS—with the Child Protection Managers in real time, early in the investigation. The close collaboration lays out investigative, supervisory and managerial markers to guide the investigative team's efforts throughout the case.

To strengthen practice throughout the child welfare continuum, ACS also made Investigative Consultants available to provide guidance on complex domestic violence cases to our prevention services provider agencies.

In addition, the ACS divisions of Child Protection and Policy, Planning & Measurement are working together to strengthen investigative practice in the borough office zones through a systematic continuous quality improvement cycle that highlights performance on key metrics, leverages collaborative problem solving with investigative units, and develops plans for improvement. Each zone shares its progress on the plans through frequent ChildStat meetings with the ACS Commissioner and leadership.

Medical Conditions/Natural Deaths

In 2017, 43 percent (n=27) of the child fatalities were determined by the Medical Examiner to be natural (see Table 4), the highest percentage and number when compared with the previous 10 years. The ME determines the manner of death to be natural when disease or a medical condition is the sole cause of death. Examples of common causes for natural child fatalities include acute and chronic bronchial asthma, pneumonia, and complications of premature birth.

Table 5. Panel reviewed child fatalities for 2017 with certified natural deaths

Manner of Death	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	*2017
Natural	14	11	8	13	11	15	4	21	7	17	27
Total Panel Fatalities Per Year	41	49	39	46	43	50	44	58	43	56	63
Percent of Panel Fatalities with Natural Deaths	34%	22%	21%	28%	26%	30%	9%	36%	16%	30%	43%

* 3 autopsies are still pending

Of the 27 natural deaths, 16 were open with ACS at the time of fatalities; however, of these 16 cases, the majority (n=12, 75 percent) were not indicated for abuse or neglect. 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.

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 3.9 years old, compared with all Panel children, who averaged 3.4 years of age. Almost three-quarters (n=20, 74%) of the children were male, and 26 percent were female, which was vastly different to the overall group of Panel cases. In terms of child-level risk, of the 27 children who died of natural causes, upon review of the autopsies and the most frequently occurring causes, nine children died from acute illnesses, with the most common ailment being pneumonia or the influenza virus; one child in this category died from a ruptured appendix. Five children died due to issues of prematurity, five died of various syndromes or cerebral dysgenesis, and four died from asthma-related complications. The other four cases covered a range of issues including cardiac arrhythmia, Sudden Infant Death Syndrome (SIDS) and narrowing of the aorta. Of the 27 fatalities where the death was determined to be natural by the ME, almost half (n=13, 48 percent) had chronic medical issues. At the time of death, the children lived at home with their biological family in all but one case, in that case the child died in a kinship foster home. Forty-one percent (n=11) of the mothers had current or past substance use while a third (n=9, 33%), had current or past mental health concerns.

Similar to other Panel cases, families experiencing natural fatalities encountered environmental risks and stressors, which may exacerbate children's medical conditions. A history of domestic violence was present in a little more than a third (37%) of natural death Panel cases. When looking at the total 2017 Panel fatalities, slightly more than one-quarter of the 63 fatalities occurred in families that had experienced homelessness within four years of the fatality (n=17, 27%). Like most families known to ACS, these families also faced economic hardship. Research shows that chronic and persistent poverty impacts children's

health.[11] Children living in poverty have higher rates of infant mortality, lower average birth weight, and a 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. These heightened risks describe the challenges faced by the families from this Panel review.

According to the Academic Pediatric Association (APA), a public health approach aimed at simultaneously lifting families out of poverty and alleviating the effects of poverty is needed to improve health outcomes and decrease mortality rates for poor children.

Panel Recommendations and ACS Initiatives. To better address children's medical needs, the Panel recommended that ACS bolster its assessment of children with special medical needs; improve information sharing between systems, professionals, and with families; and increase specialized services for families with medically fragile children as part of continued efforts to support frontline staff in recognizing symptoms, assessing safety and risk and connecting families with chronic and serious medical conditions to appropriate services.

ACS has expanded its Medical Consultation Program to provide additional supports to child protection teams during investigations. The program provides direct consultation for child protective specialists and other staff on cases in which special medical needs and related issues are a factor in child safety assessments. Medical Consultants are also available to consult on any case that may warrant a referral to a skilled nursing facility. In 2017, ACS made these consultants available to contracted provider agencies as well in both foster care and prevention services, to support their assessments and service planning.

Conclusion

A well-developed body of literature documents a variety of caregiver characteristics and environmental factors that may put children at greater risk of maltreatment, including caregiver mental illness, caregiver substance abuse, family history of domestic violence, social isolation, large family size, and—perhaps most frequently—poverty and extreme poverty.[12-13] A less-developed subset of the research literature indicates that many of these factors are also associated with abuse or neglect fatalities, but studies have not isolated any definitive profile of perpetrators of such fatalities.[14]

To combat child fatalities, the U.S. Commission to Eliminate Child Abuse and Neglect Fatalities recommended that authorities use a public health approach to engage a broad spectrum of community agencies and systems to identify and implement strategies to prevent harm for children.[15] No single trigger causes child maltreatment fatalities, and no single suggestion will prevent future fatalities.

The Panel's recommendations are intended to strengthen New York City's efforts to keep children safe from abuse and neglect. The Panel recognizes that 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

11 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

12 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.

13 Coulton, C. J., Crampton, D. S., Irwin, M., Spilsbury, J. C., & Korbin, J. E. (2007). Howneighborhoods influence child maltreatment: A review of the literature and alternative pathways. *Child abuse & neglect*, *31*(11), 1117-1142.

14 U.S. DHHS, Child Welfare Information Gateway. Child Maltreatment 2010.

15 U.S. Commission to Eliminate Child Abuse and Neglect Fatalities. Within our reach: A national strategy to eliminate child abuse and neglect fatalities, 2016.

strengthen families and protect children from harm. The Panel encourages New York City to pursue a comprehensive, systemic public health approach to identifying and addressing the needs and challenges of low-income families in New York in order to better protect children from abuse, neglect and the high-risk situations associated with child, youth and adolescent fatalities.

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.