CHILD FATALITY REVIEW 2018 ANNUAL REPORT

NYC Children

Child Fatality Review - 2018 Annual Report

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INTRODUCTION

New York City's Administration for Children's Services (ACS) is required to respond to reported cases of alleged abuse and neglect of children residing in the city. In calendar year 2018, ACS investigated more than 58,000 consolidated reports of child maltreatment, concerning more than 80,000 children. Each year, among these investigations are about 100 child fatalities reported to the New York Statewide Central Register (SCR, also known as the "hotline") of Child Abuse and Maltreatment, which is maintained by the New York State Office of Children and Family Services (OCFS). On average, about half of these deceased children had no history of prior contact with ACS. Additionally, ACS investigations conclude that a large majority of child fatalities reported to the SCR are unrelated to abuse or neglect. Occurrences of child fatalities due to maltreatment continue to be rare events, comprising less than 0.1% of all cases investigated by ACS. The death of a child is a tragic loss for a family as well as the community, and the death of a child in a family with past ACS contact requires our special attention.

This report focuses on child fatalities that occurred during calendar year 2018. Specifically, child fatalities in families that are "known" to ACS—meaning that the families have been the subject of an investigation or otherwise received services from ACS within the last 10 years, were receiving services, or were the subject of an investigation at the time of the fatality. These types of cases are referred to as "Panel cases" and were subject to review by the Accountability Review Panel ("the Panel"), a multidisciplinary panel of experts from fields such as medicine, psychiatry, psychology, social work, and public administration. Panel members included community leaders and representatives from city agencies, including the Department of Education, Health + Hospitals, Police Department, Fire Department, Department of Homeless Services, and the Department of Health and Mental Hygiene, as well as outside experts (including child advocacy center medical directors, child mental health specialists, pediatricians with specialized training and/or experience in evaluating child maltreatment, and a medical examiner). In addition to the Panel members not affiliated with ACS, participants included ACS senior leadership, child protection staff from the five boroughs, clinical staff and, when applicable, representatives from contracted prevention services and foster care provider agencies. The Panel's main objectives were to identify systemic issues in ACS practice and policy, to foster intra-agency and inter-agency collaboration, and to improve information-sharing to better support and improve outcomes for high-risk families.

This report provides context for understanding Panel case fatalities; it thematically summarizes Panel case data; and it presents ACS' new and continuing initiatives aimed at preventing future child fatalities. Readers are cautioned not to generalize findings in this report, given that they are based on a relatively small number of fatalities, not the relatively large number of child welfare cases handled annually by ACS. 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.

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

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

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

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 influences impacting service delivery, 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.

New York City's Review of Child Fatalities Alleging Maltreatment

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

The New York City Office of the Chief Medical Examiner ("the ME") determines the cause and manner of a child's death. The cause of death is the injury, disease, or condition that resulted in the fatality, such as blunt trauma or acute and chronic bronchial asthma. The manner of death is determined by the findings of the ME's autopsy examination and the circumstances of the death. The ME certifies the "manner" as having been an accident, homicide, natural, suicide, therapeutic complications, or undetermined. These classifications are administratively determined and may differ from other jurisdictions, which can make comparisons across systems challenging. For example, the ME may classify a case 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, as discussed in further detail below, relates to deaths in which unsafe sleeping conditions 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.

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 may have taken place in relation to any of the allegations, the report is defined as "indicated." Alternatively, if there is no credible evidence of maltreatment, the report is classified as "unfounded." Some investigations result in an indication for some, but not all, of the allegations. Fatality investigations often include other allegations of maltreatment which may be "substantiated", but the child protective team may have "unsubstantiated" the fatality allegation after concluding that the parent or caretaker did not contribute to the fatality.[2] Such cases, then, may involve an allegation of educational neglect as "substantiated" for the deceased child and/or a sibling, but the fatality allegation may be "unsubstantiated." In addition to DCP investigations, the New York City Police Department and District Attorney also investigate child fatalities to determine if there might have been criminal culpability, to determine whether or not to pursue prosecution.

While conducting its investigations, DCP reports each fatality investigation it receives from the SCR to ACS' Child Fatality Review Team within the ACS Division of Policy, Planning and Measurement. The Child Fatality Review Team assesses each case to determine whether it meets the criteria for being classified as a Panel case. As noted above, these cases involve fatalities of children whose deaths

[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."

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 has been the subject of an allegation of child abuse or maltreatment to the SCR within 10 years preceding the fatality;

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

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

Table 1, below, shows how over one-half (55%) of the child fatalities reported to the SCR in 2018 alleging maltreatment in association with a child's death occurred in families that were "known" to ACS, and thus were classified as Panel cases. This report focuses only on those types of cases. Table 1 also provides an overview of all fatalities reported to the SCR and investigated by ACS in 2018 (see Table 2 in the section that follows for data on Panel cases only). In 2018, the manner of death for fatalities that occurred in families "known" to ACS were generally similar to fatalities reported to the SCR in families that were not "known" to ACS prior to the fatality.[3]

Table 1: Manners of death for all 2018 child fatalities reported to SCR

	2018 Panel Cases		2018 non-Panel Cases*		Total 2018 - all child deaths reported to the SCR	
Manner of Death	**N**	**%**	**N**	**%**	**N**	**%**
Accident	**8**	**14%**	**4**	**8%**	**12**	**11%**
Homicide	**10**	**17%**	**6**	**12%**	**16**	**15%**
Natural	**20**	**34%**	**18**	**37%**	**38**	**35%**
Suicide	**2**	**3%**	**1**	**2%**	**3**	**3%**
Undetermined	**19**	**32%**	**20**	**41%**	**39**	**36%**
Therapeutic Complications	**0**	**0%**	**0**	**0%**	**0**	**0%**
Total	**59**	100%	**49**	100%	**108**	100%

Percentages may not equal 100 due to rounding

*Average age of children in non-Panel 2018 fatalities was 19.0 months.

For each Panel case, the Child Fatality Review Team examines the family's history with ACS as well as autopsy reports and records from service providers that had had contact with the family. Additionally, in order to understand family and child functioning routines prior to the fatality, the team examines the child welfare histories of all adults related to or involved with the child, such as parents, boyfriends/girlfriends, grandparents, aunts/uncles, and others with known caregiving responsibilities.

[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.

In 2018, the multidisciplinary Panel convened monthly to review fatality cases. The Panel reviewed the facts of each case and engaged in dialogue with ACS staff and representatives from other city agencies regarding their interactions with the family. For each case it reviewed, the Panel made observations regarding case practice, characteristics of the family in which the fatality occurred, and systemic issues that might warrant further exploration. Issues regarding these cases were subsequently reviewed by the relevant ACS program divisions and considered for practice or policy changes.

Understanding the National and Local Context

In order to promote better understanding of ACS's work within a larger context, data below are presented as relates to child fatalities within the United States and New York City.

In 2018, the national infant mortality rate was 5.7 deaths per 1,000 children in the population[4] compared to the 2017 rate of 5.8. Infants under one year of age continue to be at greatest risk of death among all children, and life expectancy for children increases significantly after twelve months. Generally, in 2017, the last year for which more detailed statistics are available, male infants had a higher rate of death than females (6.3 compared to 5.2). When comparing the mortality rates for males and females within groups, the largest differences occurred among non-Hispanic Black/African-American infants (12.0 for males versus 9.9 for females) and Native American/Alaska Native (7.6 for males compared to 10.9 for females)[5].

As in past years, in 2017, infant mortality has continued to vary by race and ethnic identity nationally. Infants of non-Hispanic Black/African-American women had the highest mortality rate at 11.0 infant deaths per 1,000 births. Across the other racial/ethnic groups, the infant mortality rate was next highest for Native American/Alaska Native at 9.2 per 1,000 births, Native Hawaiian or other Pacific Islander (7.6) Hispanic children (5.1), non-Hispanic White children (4.7), and Asian children (3.8). Of note, Puerto Rican infants had a rate of 6.5 infant deaths per 1,000, the highest among Hispanics groups tracked. National data also showed that mortality rates were highest for infants of women under age 20 at 9.0 infant deaths per 1,000 births, followed by ages 20-24 (7.0), and ages 25-29 (5.5). Mortality rates for infants of women under the age of 20 were 89% higher than those for infants of women aged 30–34, the group with the lowest rates (4.8).[6]

In calendar year 2017, the infant mortality rate in New York City was 4.3 per 1,000 live births[7], similar to the 2016 rate of 4.1 per live births. Racial disparities persist in New York City. In 2017, the city's infant mortality rate among non-Hispanic Black/African-American children was more than three times higher than among non-Hispanic Whites (7.8 versus 2.4). For other race/ethnic groups, the infant mortality rates varied: for Puerto Ricans it was 6.3 per 1,000 live births, for other Hispanics it was 4.3 per 1,000 live births, and for Asian and Pacific Islanders it was 3.4 per 1,000 live births. The infant mortality rate declined from 2008 to 2017 in all poverty groups; but in 2017, the rate in very high-poverty areas was still 1.4 times the infant mortality rate compared to low-poverty areas. The infant

[4] Xu JQ, Murphy SL, Kochanek KD, Arias E. Mortality in the United States, 2018. NCHS Data Brief, no 355. Hyattsville, MD: National Center for Health Statistics. 2020.

[5] Ely DM, Driscoll AK. Infant mortality in the United States, 2017: Data from the period linked birth/infant death file. National Vital Statistics Reports, vol 68 no 10. Hyattsville, MD: National Center for Health Statistics. 2019.

[6] Ely DM, Driscoll AK. Infant mortality in the United States, 2017: Data from the period linked birth/infant death file. National Vital Statistics Reports, vol 68 no 10. Hyattsville, MD: National Center for Health Statistics. 2019.

[7] Li W, Onyebeke C, Huynh M, Castro A, Falci L, Gurung S, Kennedy J, Maduro G, Sun Y, and Van Wye G. *Summary of Vital Statistics, 2017.* New York, NY: New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2019.

mortality rate in New York City was highest among infants born to the youngest mothers. Mothers less than 18 years of age had the highest rate (6.3), followed by mothers 18-19 years old (5.0), and mothers 20-29 years old (4.4). Mortality rates were lowest for mothers 30-39 years of age at 3.7 per 1,000 live births.[8]

[8] Li W, Onyebeke C, Huynh M, Castro A, Falci L, Gurung S, Kennedy J, Maduro G, Sun Y, and Van Wye G. *Summary of Vital Statistics, 2017.* New York, NY: New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2019.

PANEL DATA: 2018

Overall Panel Cases

In 2018, there were 59 fatalities of children in families that had been the subject of an investigation or otherwise received services from ACS within the last 10 years, or who were receiving services or were the subject of an investigation at the time of the fatality. The most common "manners" of death as certified by the ME were "natural" (n = 20, 34%), followed by "undetermined" (n = 19, 32%), "homicide" (n = 10, 17%), "accident" (n = 8, 14%), and "suicide" (n = 2, 3%). (See Table 2).[9] In 2017, natural deaths accounted for 44% of the Panel fatalities, 23% in 2016, 14% in 2015, and 36% in 2014, see Table 5. The ME certified natural death as the most common "manner" of death in the last five years, with the exception of 2016 (where undetermined was the most common manner of death)."

Table 2. Manners of death for Panel child fatalities from 2018

	Total 2018	
Manner of Death	**N**	**%**
Accident	**8**	**14%**
Homicide	**10**	**17%**
Natural	**20**	**34%**
Suicide	**2**	**3%**
Undetermined	**19**	**32%**
Therapeutic Complications	**0**	**0%**
Total	**59**	100%

*Percentages may not add up to 100 due to rounding

The following is a review of case characteristics for all of the 2018 Panel fatalities (n = 59). Later in this report, the data are examined by subsection so as to look at three key areas of concern: unsafe sleeping fatalities (which are most often categorized as "undetermined" or "accident" by the Office of the Chief Medical Examiner), homicides, and natural deaths related to medical issues.

Overall Panel Case Characteristics. As in previous years, and consistent with national and citywide statistics, children at greatest risk of fatality are of the youngest ages. In Panel cases, the average age of children was 3.1 years, slightly lower than 2017 (3.4 years), while the median age was 6.6 months (also younger than the 2017 median age of 9.1 months). Children's ages ranged from newborn to just under 17.9 years. Sixty-six percent of the fatalities were of infants under the age of one. Children under the age of five, including infants, accounted for 78% of 2018 Panel fatalities. Seven fatalities were of children aged 5-12, while 10% (n = 6) were of children over the age of 12. Of these six children over 12

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

years of age, four of the deaths were of children between the ages of 15 and 17.9 years old. A significantly larger proportion of the children were male (59%) compared to female (41%).

Families in which a Panel fatality occurred were disproportionately non-Hispanic/Black/African-American (60%) and Hispanic/Latino/non-Black (32%). Four of the fatalities occurred in White families. In one of those cases, the family was identified as Black and Hispanic. (No other race or ethnicity was identified.)[10] Data was also collected on the male members of the families or involved with the family. Fifty-three percent of the males identified as non-Hispanic/Black/African American while 30% were Hispanic/Latino/non-Black. Males were listed as White in four cases and "unknown" in three cases. No information was available on the males in three cases.

A fatality investigation concludes with the child protective investigative team making a decision on 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. Slightly more than two-thirds of the Panel cases reviewed for this annual report showed that the SCR reports were indicated for at least one allegation (n = 38, 67%), with 44% indicated for the fatality itself. Forty-six percent of the fatalities occurred among families with open ACS cases at the time of death, while 33% of the deaths occurred in families where the case was closed within the three years prior to the fatality.

As with other families who interact with ACS in any capacity, families in which a fatality has occurred tend to be disproportionately families of color. Many families face multiple challenges, including recent or ongoing homelessness, (as is experienced by 23 percent of Panel case families), and a recent history of domestic violence (within the last four years), which was noted in 44 percent of the cases reviewed. Forty-nine percent of the mothers have had histories of ACS involvement as children; of those, 43% had a history of foster care placement as children. For the males involved with these families (where information was available) 21% had histories of ACS involvement as children, but only two showed a history of foster care placement.

Twelve of the Panel cases reviewed involved families residing in a shelter at the time of the fatality (two of the deaths occurred elsewhere). Seven had an active ACS case at the time of the fatality. In the 12 cases where the family resided in a shelter facility, the ME ruled that six deaths were natural, five were "undetermined," and another one was an accident.

The Child Fatality Review Team examined the child welfare case record of each family in which a fatality occurred, and tracked 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;

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

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;

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

Reviews of the case records indicated that the average age of mothers was 30.7 years at the time of the child's death; and the median age of these mothers was 30.1 years, both slightly above the 2017 ages for these data points. On average, as in 2017, mothers had three or more children. An adult male was involved with the family in 95% of the cases reviewed. Of the identified males, 85% (n = 50) were fathers or step-fathers of the deceased child. Fifty-four percent of the mothers had current or prior substance abuse issues noted, and 44% had current or ongoing mental health concerns (diagnosed or undiagnosed) noted in the case record. Where the adult male was known to be a part of the household and/or in a caregiving role, 40% had current or prior substance use noted, and current or past mental health concerns were noted on eight of these cases.

Unsafe Sleep

Thirty-six percent (n = 21) of the 2018 Panel fatalities, either from the ME autopsy findings or from a review of the ACS investigation of the fatality, included notations of sleep-related injuries or unsafe sleep conditions (see Table 3). Usually, the ME designates and records the manner of death for these cases as "undetermined" or "accident." Of the 21 sleep related fatalities, all but three were of children under six months of age.

Table 3. Panel-reviewed child fatalities from 2018 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
2018	59	21	36%

While unsafe sleep is not a manner or cause of death certified by the ME, the ME may make note of the presence of contributing unsafe sleep factors when determining the manner of death. The above table represents Panel cases categorized as sleep-related fatalities because they include notations of unsafe sleep conditions either cited by the ME's report, or as documented in the progress notes during an ACS investigation. Unsafe sleep conditions can include factors such as bed-sharing with an adult or sibling; infants sleeping with pillows, blankets, or other objects in the crib, (which can create a risk of entanglement and/or asphyxia); and defective or unsuitable sleeping furniture, such as an air mattress, couch, or car seat. Of the 21 cases, the ME certified two-thirds (67%) as having an undetermined manner of death, and about 20% (n = 4) as having an accidental manner of death. Of these four cases,

positional asphyxia was noted as the cause of death in three cases, while in the fourth case, compression of the neck and chest during bed-sharing with an adult was the cause of death. In fact, a review of case records and autopsy findings show that an overwhelming number of the 21 children in this category died while bed-sharing, or sleeping on another surface, with one or more adults and/or another child (n = 16, 76 %).

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. 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.

Unsafe Sleep Fatalities: Case Characteristics

Similar to sleep-related deaths in New York City and nationally, risk of unintentional sleep deaths is greatest among the youngest infants. Eighty-six percent (n = 18) of the sleep-related deaths occurred in infants under six months of age. More than half (n = 13, 62%) of the children were male and 38% (n = 8) were female, which varied from the overall group of Panel cases where more males died (n = 35, 59%). In past years, with the exception of 2017, males have outnumbered females in this category.

Of the sleep-related fatalities, five of the 21 (24%) occurred in families that had an open ACS case at the time of the death. Fourteen of the other children died while living in their parents' home, although the fatality may have actually occurred elsewhere. Seven children died in a shelter setting.

Homicide

In 2018, the Medical Examiner classified 10 Panel cases (17%) as homicides. The ME 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 of the past 10 years.

Table 4 Panel reviewed child fatalities from 2008 and 2018 with certified homicides

Manner of Death	2008	2009	2010	2011	2012	2013	2014	2015	2016	*2017	2018
Homicide	16	6	10	11	15	6	9	10	11	6	10
Total Panel Fatalities Per Year	49	39	46	43	50	44	58	43	56	63	59
Percent of Panel Fatalities with Homicides	33%	15%	22%	26%	30%	14%	16%	23%	20%	10%	17%

*updated to reflect autopsies from 2017 previously unavailable

Characteristics and case circumstances in the families in which a homicide occurred were largely indistinguishable from those characteristics of families in which other types of fatalities occurred and were also indistinguishable from the larger population of families who have had contact with ACS. A longitudinal review of the data (Table 4) illustrate that the number of homicides fluctuate from year to year.

Research suggests that to prevent child homicide, jurisdictions should consider strengthening violence prevention, expanding the array and availability of prevention services, and striving for continuous quality improvement across the child protective system.

Homicide Fatalities: Case Characteristics

Seven of the 10 homicide fatalities were of children less than three years of age. The homicides reflected a variety of causes of death as noted by the Medical Examiner. Blunt-force trauma was the most prevalent factor (three cases). In one case, the ME cited Fatal Child Abuse Syndrome as the cause of death. The oldest child among the Panel cases, a 17-year-old male, was strangled by an unknown assailant. The children who died from homicides were overwhelmingly male (seven).

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. The mother (in four cases) or father (in three cases) was the alleged perpetrator in seven of the 10 fatalities. In five cases, the mother had current or past substance use and current or past mental health issues. Overall, the mother had past or current substance use in six cases. In five cases, the father had current or past substance use.

Medical Conditions/Natural Deaths

In 2018, thirty-four percent (n = 20) of the child fatalities were determined by the Medical Examiner to be natural (see Table 4). The ME determines the manner of death to be natural when disease or a medical condition is the sole cause of death. Examples of common natural causes in child fatalities include acute and chronic bronchial asthma, pneumonia, and congenital conditions.

Table 5. Panel reviewed child fatalities for 2018 with certified natural deaths

Manner of Death	2008	2009	2010	2011	2012	2013	2014	2015	2016	*2017	2018
Natural	11	8	13	11	15	4	21	7	17	28	20
Total Panel Fatalities Per Year	49	39	46	43	50	44	58	43	56	63	59
Percent of Panel Fatalities with Natural Deaths	22%	21%	28%	26%	30%	9%	36%	16%	30%	44%	34%

*updated to reflect autopsies from 2017 previously unavailable

Of the 20 natural deaths, 12 had open cases with ACS at the time of death; half of these cases (n = 6) were indicated for abuse or neglect; and in these six cases, the fatality allegation was substantiated on three cases, while the other three cases were indicated for other types of allegations. 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 and Natural Fatalities: 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 deaths were 3.6 years old, compared with all Panel case children, who averaged 3.1 years of age. However, the majority of children (n =12) were less than one year old. Half of the children were male, which was significantly different to the overall group of Panel cases where male deaths outnumbered those of females by about 19 percent. Of the 20 children who died of natural causes, a review of the autopsies showed that the most frequently occurring causes were congenital conditions (five cases), and pneumonia or viral infections (four cases). Of note, two children died from acute or chronic bronchial asthma and two children died from diabetic ketoacidosis. Two cases had death certificates with no cause of death noted and in the other two, the Medical Examiner ruled the cause of death as undetermined. Of the 20 fatalities in this category, about two-thirds of the children (n = 13, 65%), had chronic medical issues. At the time of death, the children lived with their families of origin in all but one case; in that case, the child lived in a non-kinship foster home. Fifty percent (n = 10) of the mothers had current or past substance use while 40 percent (n = 8), had current or past mental health concerns.

Similar to other Panel cases, families experiencing natural fatalities encountered environmental risks and other stressors that may exacerbate children's medical conditions. A history of domestic violence was present in almost two-thirds (n = 12, 60%) of natural death Panel cases. For natural deaths in 2018, almost one-third of the 20 Panel fatalities occurred in families that had experienced homelessness within four years of the fatality (n = 7, 30%). Like most families "known" to ACS, families with children who died of natural causes also faced economic hardship. Research has consistently shown that chronic and persistent poverty impacts children's health.[11] Furthermore, children living in poverty have higher rates of infant mortality, lower average birth weight, and a heightened risk for health and developmental problems. These children experience an increase in frequency and severity of chronic disease and may not have access to appropriate health care. These risk factors heighten the challenges faced by families and are all too prevalent in families "known" to ACS.

As noted in prior reports, the Academic Pediatric Association (APA) has stated that 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.

[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.

ACS INITIATIVES

Safe Sleep

Unsafe sleep practices are a recurring factor in many Panel fatalities, and children less than six months of age prove to be the most vulnerable. The ACS NYC Infant Safe Sleep Initiative team continues to collaborate with and provide training curriculum to DHS provider agency staff who work in shelters, to date more than 850 DHS staff have participated. The training utilizes an interactive workshop and includes current Safe Sleep recommendations from the American Academy of Pediatrics (AAP). The training recognizes and explores values and barriers that may impact a family's success in adopting safe sleep practices and explores strategies for helping families better understand the importance of practicing Safe Sleep behaviors.

The Infant Safe Sleep Initiative team also continues to provide cribs and "Pack 'n Plays" (portable cribs) to families with whom ACS has had contact when there is not a safe sleep environment for their infant. They also provide safe sleep information, coaching and training to parents and caregivers in communities with high rates of sleep-related infant injury deaths; provide training to child protection specialists and provider agency staff; and conduct safety assessments of the Children's Center nursery. ACS' Infant Safe Sleep Initiative team also continues to partner with NYC Health + Hospitals (H+H) on the Safe Sleep Toolkit Distribution Program, providing the toolkits to H+H facilities.

The Safe Sleep Initiative team is also finalizing a Safe Sleep E-learn course for child welfare professionals in collaboration with the ACS Workforce Institute. This will include a 30-minute module entitled "Communicating Infant Safe Sleep Practices" and another entitled "Effective Infant Safe Sleep Conversations," both intended to guide child welfare professionals in their assessments and messaging in all matters regarding safe sleep practices for infants. Another module, a 15-minute version entitled "Infant Safe Sleep Practices", will provide a general overview of safe sleep guidelines, highlighting potential barriers and solutions.

Enhanced Oversight of Highest-Risk Cases

To strengthen protection of children who are at the greatest risk of physical abuse, ACS has integrated additional levels of consultation, oversight and supervisory support into everyday child protective investigative practice.

For example, the Accelerated Safety Analysis Protocol (ASAP) is a quality assurance initiative that includes reviews of investigative practice in child protection cases that involve children at elevated risk of serious harm. Reviewers are experienced child protective staff. Each month, on hundreds of active cases with children flagged as high risk, the review team checks to see if all relevant safety assessments, contacts with collaterals, requests for appropriate consultations, and implementation of safety interventions have been completed, to alleviate risk and promote optimal safety for children.

When the review team identifies safety concerns or opportunities to improve case practice, it meets with the investigative unit and provides coaching on case practice to quickly identify and implement appropriate safety interventions, and to support the unit in identifying steps or tasks to address safety concerns. Through the coaching process, the review team not only addresses individual cases, it also promotes professional development and skills for collaboration that can be applied to the investigative unit's entire caseload and future casework.

Similarly, on many cases that involve allegations of severe harm to a child three years old or younger, ACS deploys its Heightened Oversight Process (HOP). The HOP team consists of ACS Investigative Consultant Supervisors—former NYPD detective supervisors currently employed by ACS—and DCP Child Protection Managers. They collaborate to identify an appropriate investigative strategy at the beginning of the investigation, and also conduct a 25-day follow-up conference to assess if additional investigative steps are still needed. ACS Investigative Consultants also support prevention services provider agencies by teaming up with the Office of Prevention Technical Assistance (OPTA) to provide guidance on complex domestic violence cases.

Overall, ACS has designed and implemented a comprehensive quality management system that includes frequent ChildStat meetings with the ACS Commissioner and executive leadership along with DCP managers and directors from the borough offices. Every ChildStat meeting includes a review of DCP Zone-level performance metrics, presentations of each Zone's annual quality improvement plan, and a case practice assessment of a randomly selected active investigation. Each DCP Zone presents at ChildStat three times during a 15-month cycle. Lessons learned from ChildStat spur recommendations for zone, borough, and system-wide improvements.

ACS' quality assurance processes produce important insights and lessons learned that help shape ACS training, coaching and supervision and informs improvements in management, technology, policies and standards. These processes together hold the entire agency accountable for the quality of services and the safety of children. ACS' Quality Improvement strives to promote an agency-wide culture of learning, focused on progress, and mandates and facilitates continuous quality improvement across ACS.

Consultation and Services for Families with Complex Medical Needs

ACS recognizes the importance of quality health care for all children with whom the agency and its contracted providers have contact. To this end, ACS has increased efforts to provide access to health services and educate staff on assessing whether children and adolescents medical needs are being met.

The ACS Office of Child and Family Health has embarked on comprehensive efforts to address issues of diabetes, asthma and other complex medical issues. The NYC Health + Hospitals (H+H), in collaboration with ACS, did a soft launch of the Foster Family Health Centers Project in April 2020. This initiative provides an integrated system of health care for children and youth in receipt of prevention and foster care services. H+H will provide a network of clinics and health centers that offer trauma informed primary care and the child or youth will also be able to access the H+H's subspecialty network. These clinics are designed around the unique needs of children and youth in care, including frequency of visits, flexibility in scheduling and close communication with social service systems.

To address asthma, the ACS Workforce Institute has developed a training module with a.i.r. nyc[12] to educate ACS and provider agency staff about the risks of asthma and effective care and treatment. The

[12] According to the a.i.r. nyc website, Asthma, Intervention and Relief (a.i.r. nyc), was created to help asthmatic kids stay healthy, in school, and out of the hospital. The mission is to improve the quality of life of asthmatic children and adults, helping families break the revolving cycle of poverty that is worsened by chronic disease.

ACS Workforce Institute, in partnership with the ACS Office of Child and Family Health, is also exploring an asthma peer-mentor project with H+H as a collaborating/clinical partner. The peer-mentoring project will engage youth with severe asthma who require enhanced support managing the disease.

The Child Protective Services (CPS) Practice Core for onboarding new child protective staff is rich in information about addressing the medical needs of children. Addressing medical care, or the lack thereof, and medical neglect allegations are a large part of the assessment of families and children and an integral part of the investigative process when assessing for abuse and/or maltreatment. Initial assessments of families and children include identifying the complete medical condition of children in the home and assuring that medical care for children, and the resources and insurance for its provision, is appropriately provided, as well as whether the child's condition warrants special attention or there are developmental concerns. Additional topics in the CPS Practice Core include dental needs, issues contributing to failure to thrive, sleep apnea, as well as significant disabilities such as autism, Down Syndrome, hearing or visual impairment, cerebral palsy, and other vulnerabilities. This training also provides examples of safety planning with a parent when asthma or diabetes is present. ACS also offers a course in Medical Issues, facilitated by a physician, where these health conditions and how to assess safety plans and respond, when needed, are discussed. Consultation with the ACS Office of Child and Family Health is also encouraged throughout the life of the case.

Safety Science

In 2016, to combat child fatalities, the U.S. Commission to Eliminate Child Abuse and Neglect Fatalities recommended using a public health approach to engage a broad spectrum of community agencies and systems to identify and implement strategies to prevent harm to children.[13] The Commission recognized Safety Science as a promising approach for eliminating child deaths due to abuse and neglect and recommended that the federal government fund pilot projects to test the effectiveness of the application of Safety Science to improve child protection services practice. Safety Science draws from the same knowledge base and critical incident protocols that safety-critical industries such as aviation, healthcare and nuclear power use to improve systems and develop a culture of safety. Safety Science, in these industries, looks beyond human error to examine the full range of system forces at work when critical incidents occur.

In 2018, ACS adopted and began piloting the Systemic Child Fatality Review process, modeled on initiatives in Tennessee, Arizona, Minnesota, Wisconsin and other jurisdictions. Utilizing a Safety Science approach to review fatality cases, the process goes beyond the surface level understanding of why a fatality has occurred and carefully examines the complex interplay of systemic factors, such as agency policies, workloads, availability of resources, and effectiveness of training, among many other issues that may play a role in a case. Safety Science seeks to produce applied, data-driven learning and insight, and promotes a culture of openness and shared agency-wide accountability, in order to strengthen investigative practice and the child welfare system as a whole. ACS continues to

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

build and implement a Safety Science approach to reviewing child fatalities to strengthen the work of the Accountability Panel Review model.

ChildStat

2018 was the first full year of the newly restructured ACS ChildStat, which prioritizes ACS child protective investigative performance across borough offices and zones, as well as agency-wide accountability for providing strong support to our direct-service child protection teams. ChildStat brings together child protection managers and ACS leadership to analyze data, assess the quality of casework, identify actionable lessons to promote system learning, and elevate challenges met by our child protection teams so they are fully understood and addressed by senior leadership. Each ACS zone participates in ChildStat three times during a 15-month cycle. In each meeting, both the zone and ACS leadership assess and discuss the zone's progress in areas they've identified as needing attention, and review whether practices previously identified as strengths for the zone have been sustained.

Since its creation in 2006, ChildStat has been a cornerstone of the ACS quality assurance and improvement system for child protection. The revamped ChildStat model features an in-depth review of zone-level data on key indicators, with comparative data on the same indicators presented at the borough and city level, as well as a comprehensive case review and discussion of case practice. The combined review of aggregate data findings and case-level decision-making informs and drives system-level changes that aim to reduce child maltreatment and improve outcomes for children and families.

CONCLUSION

A review of the literature indicates there are a variety of caregiver characteristics and environmental factors that may place children at greater risk of maltreatment; these factors include family history of domestic violence, caregiver substance or alcohol misuse, caregiver mental illness, social isolation, large family size, as well as poverty and extreme poverty.[14-15] According to the U.S. Commission to Eliminate Child Abuse and Neglect Fatalities, nothing is definitive when it comes to preventing child fatalities from abuse or neglect. This means no single factor can be attributed to child maltreatment fatalities and therefore, no single action will, in and of itself, prevent future fatalities.

Combating child fatalities due to abuse and maltreatment, therefore, requires an "all in" approach. Government, public and private agencies, and communities must partner to keep children safe from harm. Often, vulnerable children are also impacted by persistent racial/ethnic and neighborhood disparities. This underscores the importance of cross-system collaboration to produce a comprehensive response that will keep New York City's children safe, and lead to better outcomes for those at greater risk of injury or death from abuse and maltreatment.

[14] 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.

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

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.