

January 2012

# LESSONS FROM TRAGEDY:

A REVIEW OF CHILD FATALITIES IN NEW YORK CITY

*A Report by:*



Office of

**Bill de Blasio**

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

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## EXECUTIVE SUMMARY

The purpose of our child welfare system is to protect our most vulnerable children. Whenever a child in that system suffers further abuse or, even worse, dies despite the intervention of authorities, it is a call to action. The City must learn lessons and take every possible step to break the cycle of abuse, close gaps in support and prevent future tragedies.

The tragic death of Nixzmary Brown on January 11, 2006 gripped the entire city. As Chair of the City Council's General Welfare Committee at the time, Bill de Blasio led an oversight effort as part of a coordinated City response that prompted a major overhaul of our child welfare system. Exhaustive case reviews and the work of several task forces and working groups have since improved communication between City agencies.

As tragic as the loss of Nixzmary was, hundreds of other children have been lost in the years since, though their stories do not make the headlines or result in new laws and policies. On the sixth anniversary of Nixzmary's death, the Office of Public Advocate Bill de Blasio conducted a review of fatality reports issued by the New York State Office of Children and Family Services in order to improve prevention and learn lessons that can save the lives of vulnerable children.



"Mural for Nixzmary," Source: joujoubee's flickr stream (<http://www.flickr.com/photos/klr/>)

These reports are generated with the precise goal of identifying new risk factors and areas of focus to better protect children. Public Advocate de Blasio's review encompasses 75 child fatality reports released between January and December 2011. The review found:

- **Fatalities often occur following multiple reports of abuse or neglect.** Deaths occurred in families with, on average, more than five such reports; four families had over 15 accounts.
- **Many mothers of children who die have had a history of engagement with the child welfare system themselves as children.** 44% had contact as a child, and nine mothers had themselves spent time in the foster care system.
- **Despite sustained education efforts, unsafe sleeping arrangements continue to lead to premature deaths.** Practices such as co-sleeping with an adult were involved in 29% of fatalities for children under the age of one.
- **Lack of stable housing is common among these families.** 28% of child fatalities occurred in families with a history of homelessness or poor housing conditions, which place additional stress on families that often already face multiple challenges. The record number of families living in shelter, including nearly 17,000 children as of December 2011, must be addressed.

Public Advocate Bill de Blasio urges the Administration for Children's Service and other City agencies to take the following steps.

1. Implement a system at ACS that triggers comprehensive assessment of cases involving multiple reports of abuse or neglect by an internal review team. Submit a portion of these cases to a panel of outside experts for additional review, with the goal of developing recommendations for the rest of ACS's high-risk caseload.

2. Broaden outreach on safe infant sleeping arrangements by enlisting pediatricians, community health providers and other community leaders to convince parents to adopt sleeping practices that reduce the risk of injury and death.
3. ACS and the Department of Homeless Services should jointly review the demographic profiles of families in shelter to identify those facing multiple risks – in particular families with a history of multiple prior contacts with the child welfare system -- that would benefit from supportive housing.

Just as the facts surrounding the untimely death of Nixzmary Brown prompted a review of policy and practice, the Public Advocate presents this snapshot of recent fatality reports to prompt ongoing review and discussion regarding child welfare practice and policy in New York City.

## INTRODUCTION

Six years ago, the tragic death of Nixzmary Brown shook New York City and its child welfare system, generating major reforms at the New York City Administration for Children's Services ("ACS") and other agencies that work with ACS on child welfare matters. The tragic death led to significant reexamination of aspects of the City's systems and practices for preventing abuse and neglect and protecting our most vulnerable youth. Nixzmary's family was known to ACS prior to her death, leaving open questions regarding what additional steps could have been taken to protect her safety and well-being.

Nixzmary Brown's death was a tragedy that could have been avoided. The substantial media attention the case received helped to prompt a thorough review of the circumstances and ultimately led to significant reforms at ACS. Every year, dozens of infants and children whose families had previously come in contact with the child welfare system die in New York City. Each of these deaths – which for the most part go unheralded – also represents a tragedy. As the City remembers Nixzmary on the sixth anniversary of her death, this policy brief focuses on other children whose families similarly were known to the child welfare system and whose deaths were reviewed by the New York State Office of Children and Family Services in reports issued between January and December 2011.

New York State's Office of Children and Family Services ("OCFS") investigates deaths and issues reports regarding fatalities in the following circumstances:

...the death of any child whose care and custody or custody and guardianship has been transferred to an authorized agency, any child for whom child protective services has an open case, any child for whom the local department of social services has an open preventive services case, and in the case of a report made to the central register involving the death of a child. A fatality review team may also investigate any unexplained or unexpected death of any child under the age of eighteen....<sup>1</sup>

The Office of Public Advocate Bill de Blasio reviewed and analyzed fatality reports issued by the OCFS during 2011 involving children whose families were known to the child welfare system prior to the fatality.<sup>2</sup>

This policy brief presents observations based on the review. It does not aim to provide a comprehensive analysis of issues raised by the reports, but to note a few common themes that emerge from the review: (1) a substantial percentage of the reports involved children from families that had numerous contacts with the child welfare system before the incident that led to the fatality; (2) many of the children came from families with a multi-generational history of engagement with the child welfare system; (3) a substantial number of children in the reports died from sleeping-related deaths; and (4) a significant number of reports involved children from families with unstable housing situations or with a history of housing instability within the past five years.

This policy brief offers demographic information regarding the children whose families were known to ACS or whose parents had been known to the child welfare system. While one cannot draw definitive conclusions regarding trends in abuse and neglect based on the small number of reports examined and the limited scope of the review, this brief seeks to draw lessons about how to protect thousands of vulnerable children across New York City. Just as the facts surrounding the untimely death of Nixzmary Brown prompted review of policy and practice, the snapshot offered by these reports should prompt ongoing review and discussion regarding child welfare practice and policy in New York City.

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<sup>1</sup> New York State Social Services Law § 422-A

<sup>2</sup> The analysis in this policy brief is based upon 75 reports issued by OCFS during 2011 that relate to fatalities of children whose families had contact with the New York City child welfare system prior to the fatality. The fatality reports do not provide any identifying information regarding children who were the subjects of the report or their families.

## BACKGROUND

Nixzmary Brown's death prompted a significant assessment of child welfare policies and practices. Case reviews, rigorous oversight, and a citywide interagency task force led to specific policy reforms based on the gaps that became evident in the case.

Shortly after Nixzmary Brown's death in January 2006, Mayor Bloomberg announced the creation of the Interagency Task Force on Child Welfare and Safety ("Task Force") to evaluate the coordination between ACS, the New York City Police Department ("NYPD") and the New York City Department of Education ("DOE"). In March 2006, the Task Force announced a series of reforms to address gaps in communication among City agencies revealed through Nixzmary Brown's case. The major reforms included:

### **Strengthening relationships between ACS and the NYPD, including:**

- A full-time NYPD supervisor was stationed at ACS to better facilitate communication between the NYPD and ACS.
- A senior level position within ACS designated for a former law enforcement officer to serve as ACS Senior Investigations Advisor
- Establishment of a central point of contact within the NYPD for ACS.
- New procedures to facilitate triggering an 'Instant Response Team' (IRT) or requesting police assistance.
- The creation of a radio sub-code with NYPD for assistance in child welfare calls.
- Formalized interagency meetings with the NYPD liaison to ACS and the ACS Senior Advisor for Investigations with other staff members included if necessary.

### **Strengthening relationships between ACS and DOE, including:**

- Improved response mechanisms for dealing with excessive absenteeism – particularly through DOE's Form 407 Tracking System.<sup>3</sup>
- Monitoring the response time for DOE staff to investigate reasons for excessive absences for students in Pre-K through Grade 8.
- Provide school administrators the authority to promptly file a report of educational neglect if the parent/caregiver refuses to work with the school staff.
- Stronger review and oversight mechanisms for dealing with truancy data.
- Development of an alert in the school data system to notify school staff of the names of students who have 407's in grades Pre-K – 8 that have been open for more than 10 days, including a 407 history for the current school year for each child listed.
- Requiring bi-weekly monitoring of Form 407s generated by schools for grades Pre-K - 8 that have been open for more than 10 days.
- Establishment of education liaisons with DOE in all ACS field offices & establishment points of contact for ACS at each school
- To improve communication with school staff, DOE committed to providing ACS with a list of designated reporters for each school for ACS staff to use as the primary point of contact at the school.

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<sup>3</sup> Form 407s are DOE's mechanism for tracking student attendance and triggering investigation of unexcused absences.

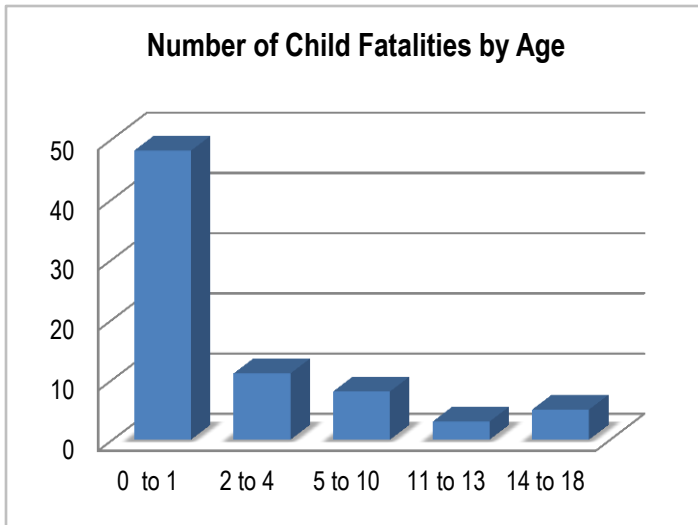
**Improvements within ACS, including:**

- Provide ACS Specialists with more guidance, particularly on the definition of educational neglect
- Enhancement of ACS' case practice guide and training materials to more clearly define an educational neglect case

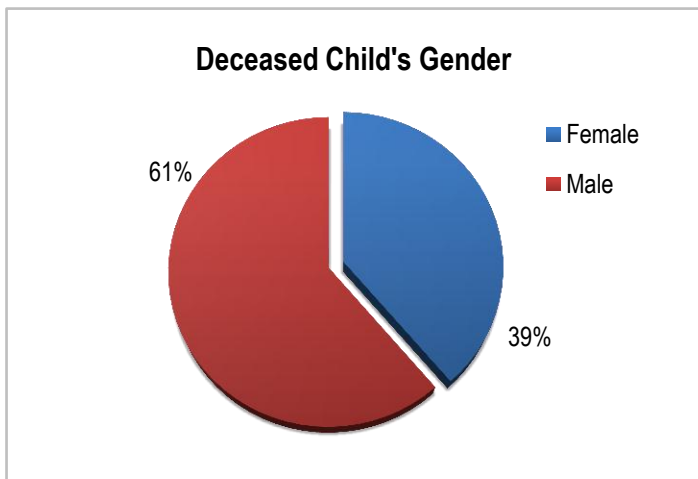
The tragic death of Nixzmary Brown in January 2006 led to many positive changes within ACS. Nonetheless, in the years since Nixzmary's death, many more children whose families were known to ACS have died prematurely. While their deaths have not, by and large, grabbed headlines or led to task forces or large scale reforms, they should play a role in strengthening City policy and practice designed to preserve the health and safety of vulnerable children. The 75 child fatality reports analyzed by the Office of the Public Advocate share themes that are worthy of discussion amongst ACS and child welfare advocates; the balance of this policy brief presents a basic picture of the lives lost and identifies a few of those themes.

## DEMOGRAPHIC PROFILE

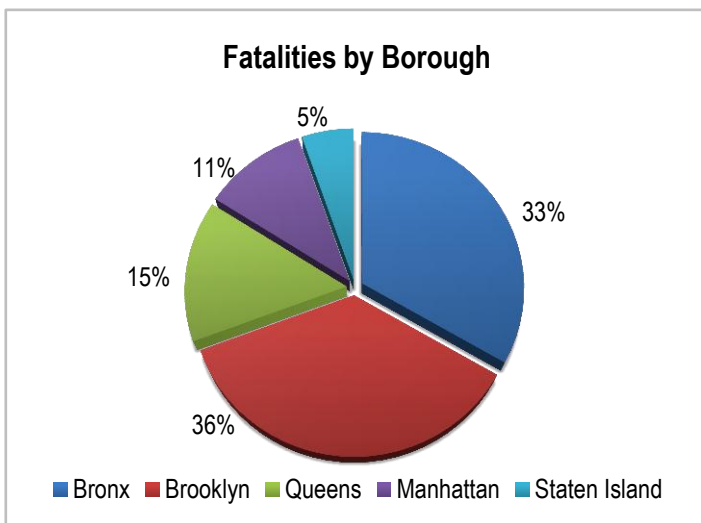
The graphs below illustrate basic demographic information derived from the child fatality reports reviewed.



48 of the 75 fatalities reviewed involved children who were under the age of two. Eleven involved children between the ages of two and four. Eight involved children between five and ten years old. Eight involved children who were eleven years old or older.

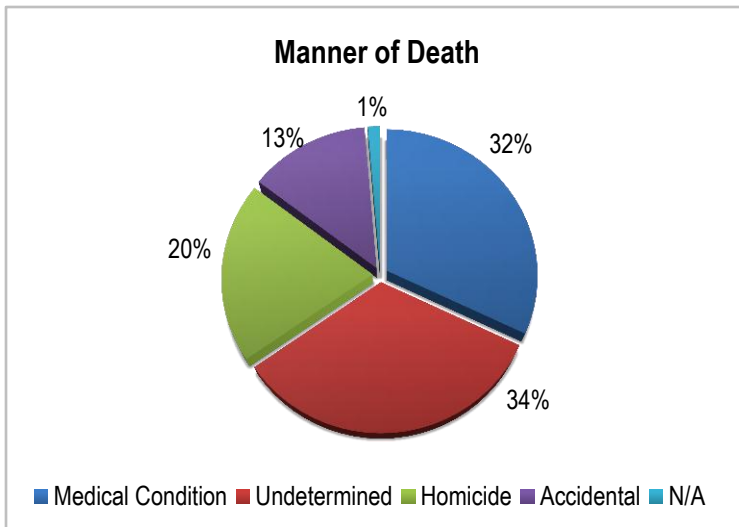
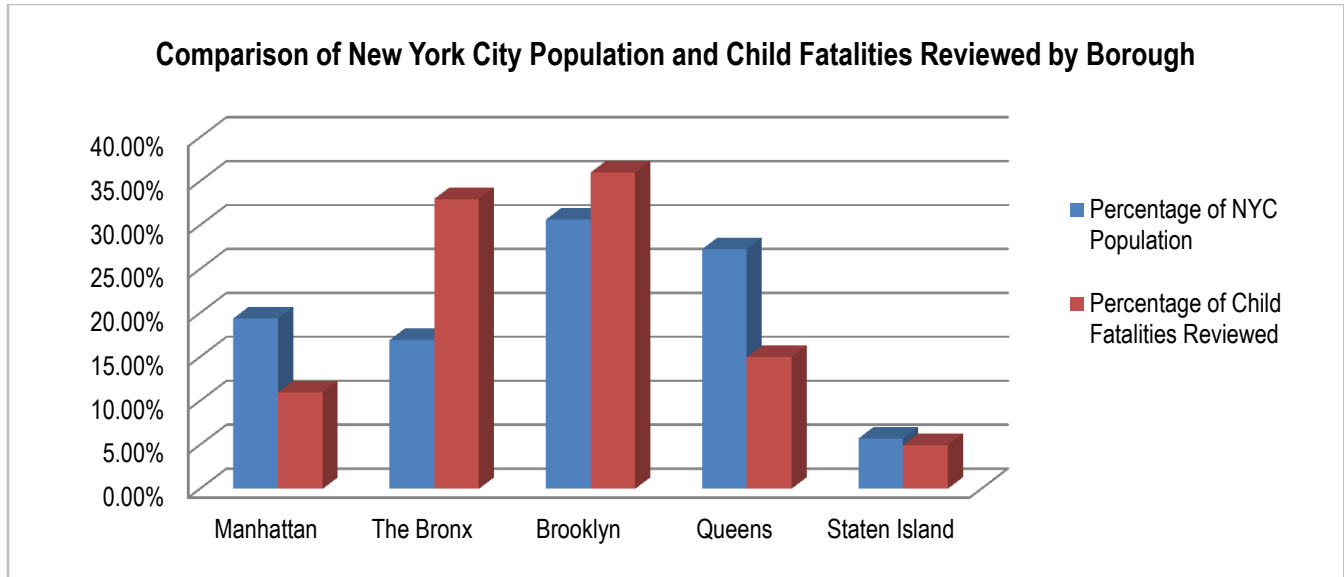


46 of the fatality reports (61%) involved male children, while 29 (39%) involved females.



Twenty-seven (36%) of the child fatalities reviewed were in Brooklyn; 25 (33%) of the fatalities were in the Bronx; 11 (15%) of the fatalities were in Queens; 8 (11%) were in Manhattan; and 4 (5%) were in Staten Island.

The graph below compares the percentage of fatalities by borough with the percentage of New York City population by borough.



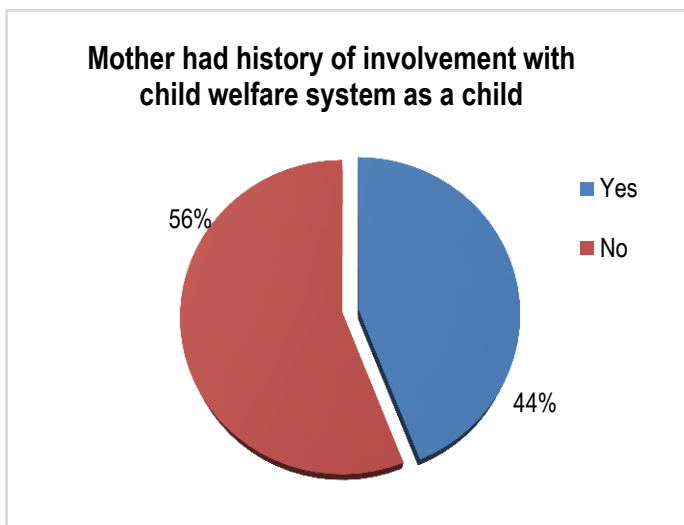
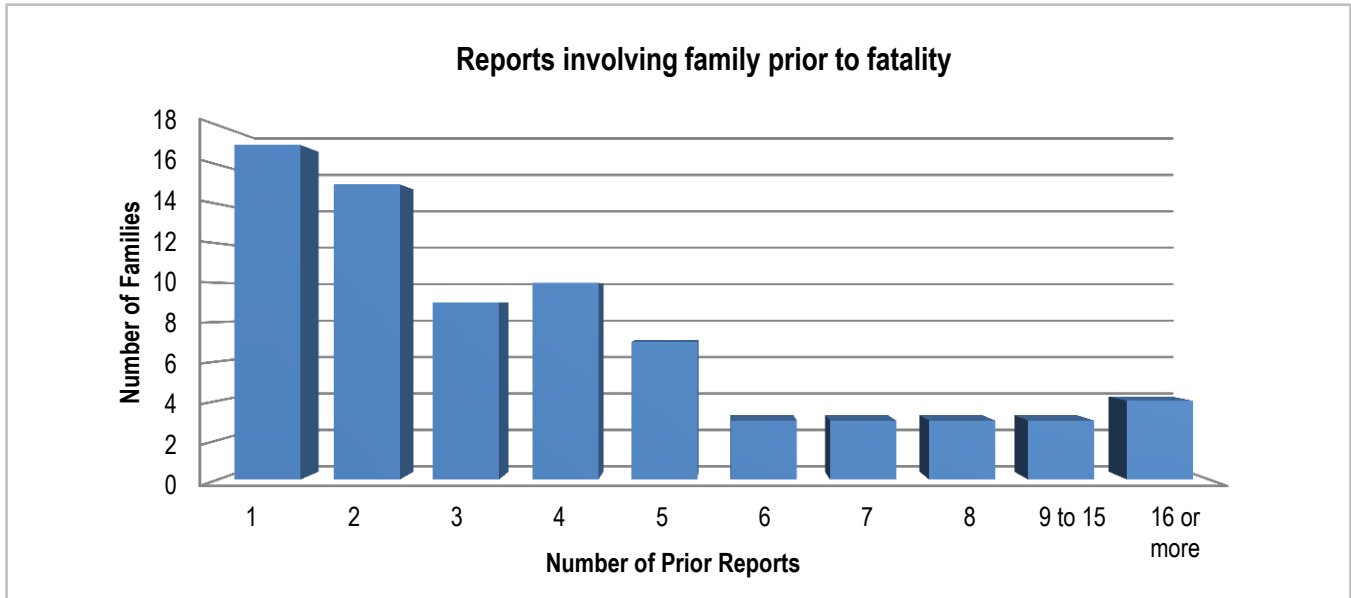
In 25 (34%) of cases, the manner of death was undetermined; in 24 (32%) of the cases, the manner of death was a medical condition; in 15 (20%) cases, the manner of death was determined to be homicide; and in 10 (13%) cases, the manner of death was accidental.



## OBSERVATIONS

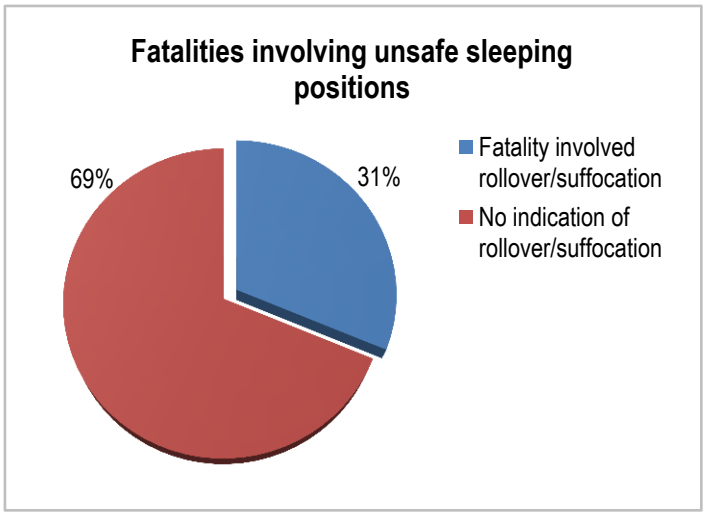
### Prior engagement with the child welfare system

The reports reviewed reveal patterns of engagement with the child welfare system among families involved in fatalities. Fifty-six percent (42 of 75) of the reports involved families that had a record of three or more contacts with the child welfare system prior to the fatality.



Many of the reports indicate multigenerational engagement with the child welfare system. Forty-four percent (33 of 75) of mothers in the reports reviewed had a history of engagement with the child welfare system as a child. Nine of the mothers had themselves spent time in the foster care system. Overall, many of the reports reviewed involved families where one or both parents had a record of involvement with ACS as a child. In a significant number of these cases, the children who were the subjects of the fatality reports were being raised in the context of inter-generational, extended families with substantial history of engagement with the child welfare system. The OCFS reports reviewed

provide some information regarding the history of the extended family's engagement with the child welfare system, but the information available is often insufficient to determine whether ACS and other agencies involved with the families provided services that took into account the complexity of the problems faced by the family.

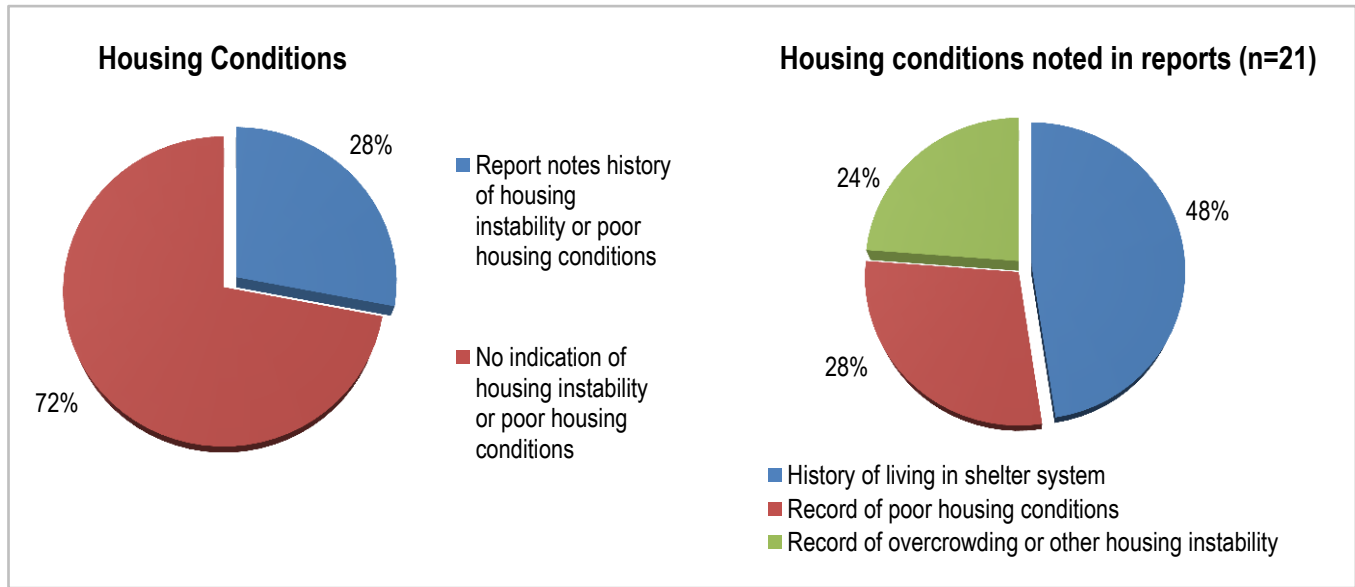


### Sleep-related deaths

Sixty-four percent (48 of 75) of the reports reviewed concerned the death of a child under the age of one. Thirty-one percent (15 of 48) of these deaths involved hazardous sleeping conditions or positions, including co-sleeping with an adult or another child and the presence of pillows, soft bedding, or stuffed animals in the sleeping area.

### Housing Conditions

The fatality reports describe current housing conditions; some provide information regarding recent housing history. The reports do not present information regarding housing history and conditions in a consistent fashion – some provide substantial detail and others provide little information. Based on the information available in the reports, 28% of families faced current or past housing instability – including poor or overcrowded living conditions or residence in the shelter system. Nearly half of these families had a history of living in the shelter system.



## **FURTHER OBSERVATIONS & SUGGESTIONS FOR PRACTICE:**

Review of OCFS child fatality reports delivered to the Public Advocate's Office in 2011 presents only a snapshot of the reports reviewed. The following recommended steps are based on the limited observations set forth above:

### **1. Families with history of involvement with child welfare system, including families with multigenerational record of involvement with child welfare system**

The substantial number of cases in which families had multiple contacts with the child welfare system prior to the fatality raise numerous questions regarding the comprehensiveness of services provided to vulnerable families, methods used to ensure that investigations of families that are already known to the system through multiple prior reports take into account the findings of earlier reports. Service assessments for families that have multiple prior contacts with the child welfare system – including cases involving families where one or both parents have a substantial history of involvement with the child welfare system -- should include detailed analysis of the impact of services that have been provided to the family, which should indicate where problems have persisted notwithstanding prior assistance. ACS's current strategic plan, released in December 2011, acknowledges that the high number of investigations of allegations of abuse and neglect that involve three or more prior SCR reports requires serious attention.<sup>4</sup> In addition to pursuing the strategies set forth in its 2012-2013 strategic plan, ACS should consider implementing a system that triggers comprehensive assessment of cases involving multiple reports of abuse or neglect by an internal review team and developing a panel of outside experts to review a portion of these cases.

### **2. Fatalities related to sleeping position**

Of the 48 fatality reports reviewed involving children under age one, 15 noted sleeping conditions that could be hazardous, including co-sleeping and placement of pillows, blankets and other items in a baby's sleeping area. While ACS and other state and local agencies have taken numerous steps in recent years to address these hazards,<sup>5</sup> there is still work to be done. ACS should expand its outreach and enlist pediatricians, community health providers and other community leaders to amplify efforts to inform parents of safe sleeping practices.

### **3. Unstable Housing/Homelessness**

The reports reviewed reveal that a significant number of families involved in fatalities had a record of inadequate housing or homelessness, which places additional stress on families that often already face multiple challenges. As

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<sup>4</sup> See *Achieving Excellence in Child Welfare, Juvenile Justice, and Early Care and Education: The Administration for Children's Services 2011-2013 Strategic Plan*, December 2011, 2-3.

<sup>5</sup> In March 2008, the city joined the statewide 'Babies Sleep Safest Alone' campaign and created a 'Babies Sleep Safest Alone' brochure. This 2 page brochure can be accessed in .pdf format through the city's website. Also, the city provides a more general brochure on safe practices for a new baby which was most recently updated in November 2011. (brochure comes in English, Spanish, & Chinese). This is an excerpt from a December 10, 2008 press release from the NYC Health Department on a goal for the city to help get donated cribs to 250 families in NYC by the holiday season: The Health Department started working with the National Cribs for Kids program in 2007. Since then, the agency has provided cribs and safe-sleep education through its Newborn Home Visiting Program, which serves new parents with one visit from a health educator. Of the nearly 8,000 families this program visited in 2007, roughly one in six lacked a crib. The Health Department also distributes cribs and educates parents through the Nurse-Family Partnership, an intensive home visiting program for first-time mothers that begins during a woman's pregnancy and continues until her child is two years old.

of December 9, 2011, over 9,900 families -- including 16,726 children -- were living in the New York City shelter system.<sup>6</sup> The absence of a clear, citywide plan for addressing family homelessness during the past year has left many vulnerable families that could benefit from stable, permanent housing living in shelter for longer periods of time. ACS and DHS should work together to review the demographic profiles of families in shelter to identify families facing multiple risks -- in particular families with a history of multiple prior contacts with the child welfare system -- that would benefit from supportive housing.

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<sup>6</sup> <http://www.nyc.gov/html/dhs/downloads/pdf/dailyreport.pdf>