NYC
Administration for
Children's Services

Accountability Review Panel

Report 2012, 2013 & 2014

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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. Each year, ACS investigates more than 55,000 reports of maltreatment for nearly 85,000 children. Child fatalities constitute a very small percent of all children alleged to be victims of child abuse and neglect. Approximately 100 of the 85,000 children (0.1%) investigated by ACS annually are the subject of a child fatality reported to the State Central Register (SCR), and roughly half of these children have no history of contact with ACS. Additionally, ACS investigations conclude that most 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. More than 99.95% of children known to ACS do not experience fatal maltreatment. 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 the years 2012 – 2014. The Accountability Review Panel (referred to hereon as "the Panel") reviews fatalities of children whose families were previously known to ACS within the past ten years. The Panel is a multi-disciplinary advisory body composed of experts from fields of medicine, psychiatry, psychology, social work and public administration. Panel members include representatives from ACS, other city agencies (e.g., Department of Education, Health and Hospitals Corporation, Police Department, Department of Health and Mental Hygiene), and external experts (e.g., child advocacy center medical directors, child mental health specialists, pediatricians, medical examiners). Two central purposes of the Panel's reviews are to identify systemic issues in ACS practice and policy and to provide expert opinions regarding individual child fatality cases.

This report outlines how ACS responds to child fatalities, provides national and local 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 2012, 2013, and 2014. Readers should not generalize findings in this report to the larger pool of child welfare cases handled by ACS. Panel cases are neither a random nor representative sample of families involved in the city's child welfare system. 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, as well as addressing individual and structural risk factors, for all families with whom ACS has contact.

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. In these cases, New York State law requires mandated reporters to communicate that suspicion to the appropriate medical examiner or coroner.

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 manner is certified as accident, homicide, natural, suicide, 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 fatality was due to a medical condition, such as a seizure disorder, for which medical treatment was withheld. In NYC, an increasing number of child fatalities related to unsafe sleep conditions have been classified as "undetermined" over the past 15 years. These deaths may be classified differently 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 evidence "worthy of belief" that abuse or neglect has taken place in relation to any of the allegations, then the case is "indicated." If there is no evidence of maltreatment, the report is deemed "unfounded." In addition to the DCP investigation, the New York City Police Department and District Attorney investigate child fatalities to determine the perpetrator(s)' criminal culpability and whether or not to initiate prosecution.

Upon learning of a suspected child maltreatment fatality from the SCR, DCP reports the case to ACS' Accountability Review Unit (ARU), which is part of the Division of Policy, Planning, and Measurement. An ARU worker then assesses the case to determine whether it falls within the Panel's purview. The Panel reviews the fatalities of children whose families are “known” to ACS. A family is considered “known” if it meets any of the following criteria: a) an adult in the family had been a subject of an allegation of child 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 family; or c) when the fatality occurred, a family member was receiving ACS services such as foster care or preventive services. If a family is known, that child’s death becomes a “Panel case” and receives a full Panel review. Panel cases from 2012 – 2014 are the subjects of this report.

For each Panel case, the ARU staff examine the family’s history with ACS as well as medical reports and records from service providers that had contact with the family. ARU examines the histories of all adults residing in the home of the child, such as parents, boyfriends, grandparents, aunts, and uncles.

The Panel convenes monthly to review fatality cases. The Panel reviews the facts of each case, questions ACS staff and representatives from other city agencies, makes observations, and offers recommendations. For each review, the Panel makes observations regarding case practice, features of the family in which the fatality occurred, and systemic issues that may warrant exploration. The Panel also suggests practice or policy changes. ARU presents the Panel’s observations and recommendations to a cross-divisional team within ACS, which determines the recommendations that will be forwarded to the relevant 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.

National child fatality rates occur disparately based on children’s age, gender, and racial identity[1]. Infants under one year of age are at greatest risk of death among all children. In 2014, the national fatality rate among infants was 5.8 deaths per 1,000 live births. After the first year of life, the fatality rate substantially decreases. In 2014, children between the ages of one and four years had an average rate of .24 deaths per 1,000, while those aged five to 14 had a much lower rate: .13 deaths per 1,000. Although still much lower than the infant death rate, the rate of death for youth aged 15 to 19 is higher than for other children over one year of age. In 2014, the death rate for

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[1] Child Trends. (2016). *Infant, child, and teen mortality: Indicators on children and youth.* Bethesda, MD: Child Trends.

teenagers aged 15 to 19 was .46 per 1,000. Across age groups, death rates for boys are higher than for girls, and the largest percentage difference is among youth aged 15 to 19, where boys were more than twice as likely to die as girls in 2014 (.63 versus .29 deaths per 1,000). Child fatality rates also differ based on racial and ethnic identities. Nationally, black children have the highest death rates, followed by white and Hispanic children. Asian/Pacific Islander children have the lowest death rates. In 2014, the infant fatality rates were 10.4 per 1,000 black infants, 5.0 per 1,000 white infants, 4.7 per 1,000 Hispanic infants, and 3.6 per 1,000 Asian/Pacific Islander infants.

In 2014, the infant mortality rate in New York City (4.2 per 1,000) was 27.6% lower than the national rate (5.8 per 1,000).[2] However, similar to national trends, racial disparities persist in New York City. In 2014, the city's infant mortality rate among non-Hispanic blacks was 2.9 times higher than among non-Hispanic whites (7.5 per 1,000 versus 2.6 per 1,000). Additionally infant mortality rates in New York City were 1.5 times higher in areas with very high concentrations of poverty compared to low poverty areas (4.7 per 1,000 versus 3.1 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 (5.0 per 1,000), followed by mothers aged 20 to 29 (4.1 per 1,000), aged 30 to 39 (3.8 per 1,000), and less than 20 years of age (3.7 per 1,000).

Inequitable child fatality rates based on poverty and racial identity extend beyond infancy in New York City. From 2009 – 2013 the rate of injury-related deaths among children aged 1 to 12 was 2.2 per 100,000 children living in low poverty areas compared with 4.1 per 100,000 children living in very high poverty areas. The injury death rate among children aged 1 to 12 during this same period was considerably higher for Non-Hispanic Black children (5.6 per 100,000) compared with Hispanic children (2.0 per 100,000), non-Hispanic white children (2.4 per 100,000) and Asian children (2.7 per 100,000).[3]

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[2] Li, W., Huynh, M., Lee, E., Lasner-Frater, L., Castro, A., Kelley, D., … Van Wye, G. (2016). *Summary of vital statistic, 2014.* New York, NY: New York City Department of Health and Mental Hygiene, Office of Vital Statistics.

[3] Conderino S., Spira-Cohen A., Caffarelli A., Norton J.M., Coyle C., & Stayton C. (2016). Understanding child injury deaths: 1999 – 2013. *Vital Signs Data Tables, 15*(2), 1 – 12.

Panel Data: 2012 – 2014

Overall Panel Cases

From 2012 – 2014, there were 152 child fatalities reviewed by New York City's Accountability Review Panel (see Table 1). The ME most frequently certified the child's manner of death as *undetermined* (*n* = 52, 34%), followed by *natural* (*n* = 40, 26%), *homicide* (*n* = 30, 20%), *accident* (*n* = 25, 17%), and *suicide* (*n* = 5, 3%).

Table 1. Manners of death for Panel-reviewed child fatalities from 2012 – 2014

	Year of Fatality Review							
	2012		2013		2014		**Total**	
Manner of Death	N	%	N	%	N	%	N	%
Accident	4	8%	12	27%	9	16%	25	17%
Homicide	15	30%	6	14%	9	16%	30	20%
Natural	15	30%	4	9%	21	36%	40	26%
Suicide	1	2%	2	5%	2	3%	5	3%
Undetermined	15	30%	20	45%	17	29%	52	34%
Total	50	100%	44	100%	58	100%	152	100%

Below are the aggregate data describing the case characteristics for all of the Panel cases reviewed during the three-year period of this report (*N* = 152). Following the overview of all Panel cases, the data are examined by subsection for four high-risk areas: unsafe sleep, homicide, medical needs, and homelessness. 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. Children at greatest risk of fatality are young. The average age of the Panel children was 2.9 years (*SD* = 4.2), and the median age was 7.8 months. Children's ages ranged from newborn to 17.7 years old. Eighty percent of the Panel children were aged 0 – 5, 15% were aged 6 – 12, and 5% were teenagers. More of the children were male (57%) than female (43%).

Half of the fatalities were indicated for abuse and neglect on at least one allegation (*n* = 77, 51%). The named perpetrators were most often the children's parents/caregivers, though about one-third were unrelated to the children. Most Panel children lived with their biological families at the time of death (91%), though 9% were living in out-of-home family-based settings (i.e., foster or kinship care) or institutional settings (i.e., hospital or nursing facility). Less than half (*n* = 70, 46%) of the fatalities occurred among families with open ACS cases at the time of death, and about half of the fatalities on the open cases were indicated for abuse and neglect on at least one allegation (*n* = 34, 49%).

Many Panel families faced environmental risk and hardship. Nearly one-third (30%) of the families had experienced homelessness in the past four years, and nearly two-thirds (65%) had a history of domestic violence. About half of the mothers (48%) had histories of ACS involvement as children, and 18% of the mothers had been placed in foster care as children. Twenty-four percent of the mothers had documented substance abuse issues when the fatality occurred, and 30% had documented mental health problems at the time of the child's death. Nearly one-third of the mothers gave birth for the first time as a minor under the age of 18. The mothers' average age was 29.0 years (*SD* = 8.8) at the time of death, and the median age for mothers was 27.5 years. On average, mothers had 3 children (*SD* = 2). An adult male was known to be involved with 80% (*n* = 121) of the families. Of the involved adult men, nearly three-quarters (*n* = 88, 73%) were fathers, followed by unrelated men (*n* = 24, 20%), and other adult relatives (*n* = 9, 7%). The average age of known adult men was 32.5 years (*SD* = 11.2).

Unsafe Sleep

Thirty-nine percent (*n* = 59) of all Panel fatalities from 2012 – 2014 had notations of unsafe sleep conditions (see Table 2). The percent of cases with sleep-related deaths was even higher when looking at a subset of cases by age. Of Panel fatalities *among infants under one year of age* (*n* = 82), there were 56 cases (68%) with a notation indicating unsafe sleep conditions.

Table 2. Panel-reviewed child fatalities from 2012 – 2014 with unsafe sleep conditions

Year of Fatality Review	Panel Fatalities (N)	Number of Panel Fatalities with Unsafe Sleep	Percent of Panel Fatalities with Unsafe Sleep
2012	50	19	38%
2013	44	21	48%
2014	58	19	33%
3-Year Total	152	59	39%

Unsafe sleep is not a manner or cause of death certified by the Medical Examiner. The ARU documents unsafe sleep conditions on Panel cases when cited by the Medical Examiner's report or documented in the progress notes during the investigation by ACS. Unsafe sleep conditions may include bed-sharing; infants sleeping with pillows, blankets, or other objects in the crib; defective furniture; or being found unresponsive in the crib. For the 59 sleep-related fatalities included in this report, the Medical Examiner certified two-thirds (66%) of the cases as having an *undetermined* manner of death, one-quarter (24%) of the cases as having an *accidental* manner of death, and one-tenth (10%) of the cases as having a *natural* 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 typical in cases where an unsafe sleep condition was present but the role of the hazard in the fatality is impossible to know, such as co-sleeping where the adult does not recall rolling over on the child. Among all child fatalities, most cases with an undetermined cause and manner of death are in infants.

Unsafe Sleep Case Characteristics. Similar to sleep-related deaths in New York City and nationally, risk of unintentional sleep deaths is highest among the youngest infants. Nearly half (*n* = 28, 47%) of the sleep related deaths from 2012 – 2014 involved infants younger than 3 months of age, and 83% (*n* = 49) of the sleep related deaths involved infants aged 6 months or younger. Slightly more than half (*n* = 32, 54%) of the children were male and nearly half (*n* = 27, 46%) were female, which was similar to the overall group of Panel cases.

Most (93%) of the sleep-related fatalities occurred in the infants' biological home. Roughly one-third (36%) of the families who experienced a sleep-related fatality had been homeless in the four years prior to the death, though only a few of the sleep-related fatalities (*n* = 4) occurred in a shelter setting. Twenty-five of the 59 fatalities (42%) had open ACS cases at the time of the death, and of the open cases, roughly half (56%) had prevention services in place. Sixteen of the infants' mothers (27%) were known to have substance abuse issues at the time of death, which is only slightly higher than the mothers of Panel cases not related to unsafe sleep (23%). Likewise, 17 of the infants' mothers (29%) were known to have mental health issues at the time of the death, which is slightly lower than the mothers of Panel cases not involving sleep-related deaths (31%).

Panel Recommendations and ACS Initiatives. As in prior years, unsafe sleep practices continue to be identified as a factor in many Panel fatalities. The Panel suggests that ACS continue its multi-pronged approach to promote safe sleeping practices among families in New York City. Such an approach includes an externally focused public awareness campaign aimed at educating parents, family members, professionals, and the public about safe sleeping practices. Additionally, internally focused efforts include training CPS and provider staff to more consistently and thoroughly assess and educate families they encounter about safe sleeping practices.

In response to these Panel recommendations, ACS developed a team to oversee and champion its Safe Sleep Initiative. The team convened a safe sleep stakeholders' coalition with partner city and state agencies as well as public/private sector partners. Partners include representatives from DOHMH, OCFS, HHS, GYNHA, DHS, NYCHA, HRA, DOE, NYPD, the Breastfeeding Empowerment Zone, and the American Academy of Pediatrics. Together, the coalition has begun crafting a uniform safe sleeping message and strategy for dissemination across the city. Research utilizing focus groups of parents and caregivers in priority neighborhoods elicits information about barriers to safe sleep practices and ideas for effective messaging to inform the public awareness campaign.

In January 2016, ACS' Safe Sleep Initiative team began a targeted community engagement strategy and has thus far made outreach to more than 100 agencies and organizations citywide. In addition, the Safe Sleep Initiative team has provided education to parents and caregivers of the risks associated with unsafe sleep through presentations and tabling in over half of the zip codes identified with the highest rates of sleep-related infant injury deaths. ACS is also revising training curriculum for all child welfare staff.

In May 2017, ACS and the NYC Department of Health and Mental Hygiene (DOHMH) launched a new citywide public awareness initiative promoting life-saving safe sleep messages. The campaign, which directs parents and caregivers of children 0-12 months old to "Put Them To Bed As If Their Life Depends On It. Because It Does," is part of a comprehensive strategy to educate the public and professionals about the dangers of unsafe sleep practices and environments. Campaign ads are on display in bus shelters located in East and Central Harlem, throughout Brooklyn and the Bronx, and parts of Queens and Staten Island, where there are higher rates of infant fatalities due to sleep-related injury. Promotional posters have been distributed to barber shops, beauty and nail salons, Laundromats , and check cashing venues. Brochures are available in English, Spanish, Chinese, French and Haitian Creole. In addition, digital campaign materials are currently featured on social media via Facebook, Instagram and Twitter, and a new safe sleep video will soon be released.

The Safe Sleep team is also working with the ACS James Satterwhite Academy to finalize improvements to our safe sleep training curriculum for child welfare professionals. Our new safe sleep curriculum strengthens our training academy's existing safety and risk training around preventable sleep-related infant injury deaths and bed-sharing and co-sleeping; highlights the latest American Academy of Pediatrics recommendations and the reasons underlying them; reviews statistical data on unsafe sleep deaths, including the racial and geographic disparities; considers potential barriers such as how housing quality may impact parent and caregiver decisions about where and how to put their infants to sleep; and provides staff with Motivational Interviewing techniques to help them engage resistant clients around the issue of unsafe sleep.

Homicide

Twenty percent (*n* = 30) of the Panel cases from 2012 – 2014 were classified as homicides. Half of these homicides occurred in 2012 (see Table 3). The Medical Examiner classifies a death as homicide when the fatality results from an act of commission or omission (i.e., seriously negligent behavior) by the perpetrator. During this three-year period, the most common cause of death was blunt impact or blunt trauma injury (*n* = 12, 40%), followed by general or medical neglect (*n* = 6, 20%), and homicidal asphyxia (*n* = 4, 13%). No other cause of death accounted for more than 10% of the homicides.

Table 3. Panel-reviewed child fatalities from 2012 – 2014 with certified homicides

Year of Fatality Review	**Panel Fatalities (N)**	**Number of Homicides**	**Percent of Panel Fatalities with Homicides**
2012	50	15	30%
2013	44	6	14%
2014	58	9	16%
3-Year Total	152	30	20%

New York City's *Accountability Review Panel Report: 2009 & 2010* contains the results of a comprehensive outcome data and case file review conducted for the city's Panel homicide cases over a 10-year period (2001 – 2010). Many of the findings from this comprehensive report are consistent with the data from 2012 – 2014. Thus, the data presented below should be viewed in light of the conclusions drawn from the prior comprehensive review:

> The examination of Panel homicides reveals that while isolated cases are the tragic outcome of prolonged abuse and neglect by a caregiver with whom ACS had significant contact, most are less readily distinguishable from the other cases the Panel reviews. Perpetrators often are not the child's primary caregiver and few homicides result from a pattern of sustained abuse. … The families of Panel homicide cases often share several characteristics, such as extreme poverty, histories of violence and residential instability. These characteristics are shared by other Panel families and with families involved in the child welfare system generally.

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

Homicide Case Characteristics. On average, Panel homicide victims were slightly older than the overall group of Panel children (4.4 years versus 2.9 years). The median age of homicide victims was 3 years old. More than three-quarters (*n* = 23, 77%) of the victims were under 5 years old, 13% (*n* = 4) were aged 6 – 10, and 10% (*n* = 3) were over 12 years old. Slightly more than half of the children (53%) were male, and 47% were female, which was similar to the overall group of Panel cases. The majority of children (*n* = 27, 90%) were living with their biological parent(s) at the time of death, though two children lived in a foster home, while one child lived in a kinship home. Panel victims of homicide did not have significantly higher rates of chronic medical needs, mental health concerns, or developmental issues compared with non-homicide Panel children.

Half of the Panel homicides (*n* = 15) involved children whose families had closed ACS cases at the time of the fatality. The average length of time between the close of the case and the fatality was two years. Though the majority of the perpetrators were biological parent(s) (*n* = 17, 57%), a large proportion of the perpetrators were unrelated. These unrelated perpetrators were most often the boyfriends of the children's mothers.

Forty percent of the homicide victims' mothers were known to ACS as children, which is slightly lower than the percent of mothers known as children on non-homicide Panel cases. Thirty percent of the victims' families had histories of homelessness. Domestic violence was present in over half of the cases within four years of the homicide (*n* = 17, 57%), and a history of domestic violence at any point was present on two-thirds of the cases. Notably, these rates of homelessness and domestic violence do not significantly differ from the non-homicide Panel cases. Although not statistically significant, more mothers on homicide panel cases had mental health issues than mothers on non-homicide panel cases (40% versus 28%). Slightly more mothers of homicide victims had substance abuse issues (30%) compared with mothers of non-homicide Panel children (23%).

Panel Recommendations and ACS Initiatives. In order to strengthen safety practice, the Panel recommended a series of reforms aimed at addressing systemic and structural barriers. First, the Panel recommended the introduction of legislation to: (1) expand ACS caseworkers' access to court information pertaining to parents' and caregivers' active arrests and convictions, and (2) strengthen ACS' authority to supervise non-respondent parents to whom the subject child of a child protective proceeding has been released. The Panel further recommended the formation of a Children's Cabinet consisting of ACS, Department of Health and Mental Hygiene (DOHMH), Health and Hospitals Corporation (HHC), the New York Police Department (NYPD), Department of Education (DOE), New York City Housing Authority (NYCHA), Department of Homeless Services (DHS), Department of Probation (DOP), and Department of Youth and Community Development (DYCD) with the goal of establishing and/or bolstering interagency focus, communications, and contact regarding child safety and child well-being. Finally, the Panel recommended a public campaign to raise awareness among all New Yorkers that keeping children safe and healthy is a shared responsibility.

In 2014, ACS launched Operation S.A.F.E. (Sensitivity, Action, and Focus to Eliminate a life threatening danger to a child). Operation S.A.F.E. is a concerted effort to "red flag" and address high-risk child protective cases requiring immediate attention. Specifically, the purpose of Operation S.A.F.E. is to: (1) review and bolster ACS' approach to the highest risk child welfare cases; (2) improve collaboration with other city agencies to ensure child safety and well-being; (3) introduce and support state legislation to assist child protective practices; and (4) create a public awareness campaign around child safety and well-being. ACS hired an internal monitor to oversee the implementation of this plan. The monitor reports directly to the Commissioner and maintains an active role in the child fatality review process. The monitor tracks the implementation of the Panel's recommendations, coordinates the improvement of policies and practices across the child welfare system, and identifies ways to improve service delivery and overcome systemic barriers to child safety and well-being.

In 2014, ACS sought state legislation to expand the agency's access to court databases and information about active arrests, not just convictions. The legislation did not pass. In 2015, the legislature passed a bill (introduced in 2014) to allow ACS to supervise parents who are not the subject of a child welfare investigation but are caring for a child who is under ACS supervision. The bill became law on December 21, 2015.

The New York City Children's Cabinet has been meeting since April 30th, 2014, and is led by Deputy Mayor for Strategic Policy Richard Buery. The cabinet is comprised of the heads of 27 city agencies and mayoral offices. More broadly, ACS is closely involved in a number of new collaborative initiatives with the Department of Homeless Services (DHS, which is now part of the Department of Social Services) the Department of Health and Mental Hygiene (DOHMH), and the Department of Education (DOE), among others. These efforts include data sharing agreements, joint planning of interventions, and implementation of new policy initiatives that support shared responses on cases that involve families and children with very high service needs.

In October 2014, ACS launched a multifaceted citywide advertising campaign that concentrated on the importance of New Yorkers voicing their concerns about child maltreatment, while also emphasizing that neighbors, family members, elected officials, faith leaders, community-based organizations, and others must all support parents to raise healthy children. The campaign offered tips describing how all New Yorkers can make a difference in the life of a child, and offered guidance for parents on how to find resources and support when they feel overwhelmed. All of the advertisements, in both English and Spanish, appeared in locations throughout the city, including numerous subway lines, Laundromats, and check cashing locations as well as in the mass media.

Recently, ACS has taken several steps to heighten oversight of young children who are most at risk of severe physical harm. In late 2016, the ACS Instant Response Team (IRT) Program was moved under the supervision of the Senior Advisor for Investigations within the Commissioner's Office at ACS, in order to strengthen oversight, leverage law enforcement expertise and more tightly integrate the IRT work with the Investigative Consultant program. The Senior Advisor implemented a new quality assurance process to ensure that IRT Coordinators screen cases appropriately and identify cases that require NYPD involvement. The reform also established a new process for immediate notification of all incoming IRT cases to the multi-disciplinary team leaders at the borough Child Advocacy Centers (CAC). This allows the multi-disciplinary team (which includes Safe Horizon, NYPD, the diostrict attorney's office, ACS and medical staff) the time necessary to coordinate and plan their response.

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 is serious injury or sexual abuse. The HOP process establishes close collaboration within the investigative team, including the Investigative Consultant and supervisors, and lays out supervisory and managerial markers to guide the investigative team's efforts throughout the case. The process mandates a close working relationship between the Child Protection Manager and Supervisor and the IC Supervisor on these cases. To support this initiative, ACS is expanding the Investigative Consultation Program, adding 18 Investigative Consultants to Emergency Children's Services (ECS) operations to strengthen investigations on evenings and weekends, and an additional 12 Investigative Consultants to provide guidance on complex domestic violence cases to our Preventive services provider agencies. ACS has also placed full time Child Protective Managers and Family Court Legal Services (FCLS) Attorneys on-site at the CACs to oversee assessments of children and consideration of possible legal action in the child welfare context.

In 2017, FCLS also expanded its counseling role, providing legal consults when the Division of Child Protection (DCP) is not seeking to file an Article X abuse/neglect petition on matters involving allegations of serious physical abuse and/or sexual abuse, and on cases involving frequently encountered families.

Medical Conditions

From 2012 – 2014, one-quarter (*n* = 40, 26%) of the child fatalities were determined by the ME to be *natural* (see Table 4). The Medical Examiner 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 4. Panel-reviewed child fatalities from 2012 – 2014 with certified natural deaths

Year of Fatality Review	Panel Fatalities (N)	Number of Natural Deaths	Percent of Panel Fatalities with Natural Deaths
2012	50	15	30%
2013	44	4	9%
2014	58	21	36%
3-Year Total	152	40	26%

Though more than half of the cases (*n* = 21, 53%) involving natural fatalities were open at the time of death, the large majority (n = 32, 80%) of natural fatalities were not indicated for abuse or neglect. When parents and caregivers followed medical direction in caring for their sick child, they were not indicated for maltreatment related to the circumstances of their child's natural death. Though the ME may document children's medical conditions as contributory factors for manners of death other than natural, the majority of child fatalities due to medical conditions are classified as *natural* and are described below.

Medical Conditions Case Characteristics. Panel children who died of natural causes were slightly older than children who died of non-natural causes. On average, children who experienced natural death were 3.7 years old (*SD* = 4.0), compared with all Panel children, who averaged 2.9 years of age (*SD* = 4.2). Slightly more than half (*n* = 22, 55%) of the children were male, and nearly half (*n* = 18, 45%) were female, which was similar to the overall group of Panel cases. In terms of child-level risk, one in four children who died of natural causes also experienced developmental delays. At the time of death, children most frequently lived at home with their biological family (*n* = 33, 83%), though some children lived in out-of-home family settings (*n* = 5, 12%) or residential settings, such as a hospital or skilled nursing facility (*n* = 2, 5%). There were not significant differences between natural death and non-natural death Panel cases in terms of the presence of parental substance abuse or mental health concerns.

Similar to other Panel cases, families experiencing natural fatalities encountered environmental risks and stressors, which may have exacerbated the children's medical conditions. A history of domestic violence was present in half of the natural fatality Panel cases, and one-quarter of the families had current or past spells of homelessness. Like most families known to ACS, these families also faced economic hardship. It is well established that chronic and persistent poverty impacts children's health.[4] Children living in poverty have increased infant mortality, low birth weight, and heightened risk for health and developmental problems. They experience an increase in frequency and severity of chronic disease and often have poorer access to quality health care. 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 special 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. In terms of assessment, the Panel recommended a standardized form to better assess and more consistently gather pertinent information about a child with special medical needs. Regarding information sharing, the Panel recommended additional support for Child Protective Specialists in cases where critical information is needed from medical personnel, including hospital staff and pediatricians, in order to accurately assess safety. The Panel further recommended that ACS routinely inform physicians about a family's known history of medical neglect. Finally, the Panel recommended that ACS expand its capacity to provide specialized services, particularly preventive, for families with medically fragile children.

In March 2012, DCP instituted its Special Medical Needs Policy to promote the assessment and gathering of information to inform decision making and services to this population. In response to the Panel recommendations, ACS strategically evaluated the use of its Special Medical and Developmental Programs to identify both the need for additional service capacity as well as the underutilization of some specialized services.

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[4] 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.

Following this evaluation, ACS increased the total special medical preventive family support slots in the city by 50 over a three-year period, to a total of 520.

In order to improve access and reevaluate eligibility criteria and service standards for the Special Medical Preventive Services Program, ACS convened a Special Medical Needs (SMN) working group. Chaired by ACS' medical director, the working group consists of ACS staff from Preventive Services; Policy, Planning, and Measurement; and the Department of Child Protection. Additionally, program directors from each of the Special Medical Preventive provider agencies and hospital medical providers have participated. Using data from a targeted Special Medical Needs case file review, Action Research Partners (ARP) compiled data profiles for groups of special medical needs children to help ACS better understand risk and protective factors associated with well-being outcomes for this vulnerable population.

ACS also uses the medical and mental health consultants in our Clinical Consultation Program to support Child Protective workers in their assessment of children with special medical needs/medically fragile. In 2017, ACS made these consultants available to provider agencies as well, to support their assessments and service planning.

Homelessness

From 2012 – 2014, nearly one-in-three (30%) Panel families experienced homelessness within four years prior to their child's fatality. Additionally, nearly one-in-10 (8%) of the families reviewed by the Panel were residing in a shelter at the time of the child fatality (see Table 5).

Table 5. Panel-reviewed child fatalities from 2012 – 2014 among families with histories of homelessness

Year of Fatality Review	Panel Fatalities (N)	Number of Families with History of Homelessness	Percent of Families with History of Homelessness
2012	50	16	32%
2013	44	13	30%
2014	58	16	28%
3-Year Total	152	45	30%

Families experiencing homelessness are at increased risk for poor wellbeing outcomes. Health risks associated with homelessness are well known and include increased rates of poor overall health, disease, behavioral health disorders, and limited access to healthcare.[5] One study found that children in New York City experiencing homelessness had a significantly higher rate of mortality (41.3 per 100,000) than children from the city's general population (22.5 per 100,000).[6] The study concluded that the increased mortality rate of New York City's homeless children may reflect the impact of poverty and poor-quality, unstable housing. The data below pertain to the child fatalities among families with histories of homelessness reviewed by the Panel from 2012 – 2014.

Homelessness Case Characteristics. On average, Panel children who experienced homelessness were younger (M = 1.9 years, SD = 3.2) than Panel children who were never homeless (M = 3.4 years, SD = 4.5). Slightly more than half (n = 25, 56%) of the homeless children were male, and nearly half (n = 20, 44%) were female, which was

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[5] Zlotnick , C., & Zerger, S. (2009). Survey findings on characteristics and health status of clients treated by the federally funded (US) health care for the homeless programs. *Health & Social Care in the Community, 17*(1), 18 – 26.

[6] Kerker, B. D., Bainbridge, J., Kennedy, J., Bennani, Y., Agerton, T., ... & Thorpe, L. E. (2011). A population-based assessment of the health of homeless families in New York City, 2001-2003. *American Journal of Public Health*, *101*(3), 546-553.

similar to the overall group of Panel cases. About one-third of the Panel children who had been homeless also had medical needs, and almost one-tenth (9%) had developmental issues. The manners of death for homeless children occurred at similar rates to the overall group of Panel children. Less than half (*n* = 20, 44%) of the families with histories of homelessness had an active case at the time of the fatality, and less than half of the active cases (*n* = 8, 40%) had fatalities that were indicated for abuse or neglect. More than half (56%) of the mothers who had been homeless had histories of ACS involvement as children. Roughly one-third of the mothers had substance use issues (36%), mental health challenges (31%), or were under 18 years old when they first gave birth (31%). About two-thirds (69%) of families who had been homeless also had histories of domestic violence. These rates are not significantly different from Panel families without histories of homelessness.

Panel Recommendations and ACS Initiatives. The Panel recommended that ACS strengthen practice to more effectively assess for safety and provide more intensive services for high-risk families experiencing homelessness. This may be particularly relevant for families residing in "cluster-site" or scattered-site housing. Targeted efforts should focus on better identifying, assessing, and monitoring homeless families who are at high risk for safety threats or have a history of repeated ACS involvement due to chronic neglect. When high-risk families are identified, a protocol is needed to ensure that these families receive a higher-level review informed by all providers and team members across systems. Service coordination and information sharing is needed between ACS and all service providers.

In order to enhance coordination between New York City's Department of Homeless Services (DHS) and ACS, the two agencies convened a workgroup that included ACS and DHS providers, and pursued a joint-response initiative in 2014 that brought together case management support for families served by both the child welfare and homeless services systems. Over the following two years, the agencies developed several joint initiatives and policy changes regarding communication and information sharing. In March 2017, DHS and ACS signed a memorandum of understanding (MOU) that allows DHS and ACS provider staff to have case conferences on shared families, strengthening child safety and facilitating discharges from shelter and continuity of support services. The MOU also allows DHS (including shelter providers) to obtain more information about a family's child welfare history as they enter the shelter system. The two agencies also developed a joint policy to support the implementation of the MOU.

Conclusion

There is a well-developed literature that documents a host of caregiver characteristics and environmental factors that put children at risk for caregiver maltreatment generally, including: caregiver mental illness, caregiver substance abuse, a parent or parents of young age, family history of domestic violence, low educational level among parents, social isolation, large family size, and perhaps most frequently, poverty and extreme poverty.[7 - 8] 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 maltreatment fatalities. Data from a limited number of states indicate that the distribution of caregiver risk factors (i.e., substance abuse and domestic violence) among fatality cases is similar to those among victims of maltreatment generally.[9]

In its recently published Final Report, the U.S. Commission to Eliminate Child Abuse and Neglect Fatalities concluded that a public health approach is needed that engages a broad spectrum of community agencies and systems to identify and implement strategies to prevent harm for children.[10] 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 and provide opportunities to steer children, youth, and families away from the pathways that lead to fatalities.

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[7] 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.

[8] 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.

[9] U.S. DHHS, Child Welfare Information Gateway. *Child Maltreatment* 2010.

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