SYSTEMIC CHILD FATALITY REVIEW 2020 ANNUAL REPORT

Systemic Child Fatality Review – 2020 Annual Report

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Introduction

The New York City's Administration for Children's Services (ACS) is charged with investigating alleged abuse and neglect among children residing in the city. ACS is also responsible for providing services and supports to New York City's most vulnerable children and families impacted by challenging issues such as poverty, substance use, mental health concerns and the COVID-19 pandemic. During 2020, ACS responded to more than 51,000 reports of child maltreatment, concerning more than 66,100 children. These reports were consolidated into 43,881 investigations or Collaborative Assessment, Response, Engagement and Support (CARES) cases.

In 2020, ACS investigated 86 child fatalities reported to the Statewide Central Register (SCR) with about 40% of these children having no history of prior contact with ACS. Following the investigations, the investigative teams concluded that the large majority of child fatalities reported to the SCR were unrelated to abuse or neglect. As noted in prior reports, the occurrence of a child fatality due to maltreatment is a rare event, comprising about 0.1 percent of all cases investigated. Nonetheless, the death of a child with whom ACS has had contact requires special attention.

This report focuses on child fatalities during calendar year 2020. It outlines how ACS responds to child fatalities, summarizes demographic data, and provides systemic findings from cases reviewed. Due to the small number of fatalities when compared to the larger pool of child welfare cases touched by ACS, readers are cautioned against generalizing findings in this report. 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. However, the purpose of the case reviews and analyses is to learn lessons that will help to strengthen the child welfare system for all families with whom ACS has contact.

This report is published pursuant to Local Law 19 of 2018[1], which requires ACS to issue a report on 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 applicable year;

b. The manner and/or cause of death in such fatalities;

c. The age, gender, race and ethnicity of children with fatalities for the previous year;

d. Any relevant trends and systemic recommendations, including opportunities for inter-agency collaboration; and

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

e. A summary of any case practice findings and agency policy changes made in response to child fatalities in the previous 12 months.

The New York State Office of Children and Family Services (OCFS) and the New York City Department of Health and Mental Hygiene (DOHMH) also produce annual reports on child fatalities using other criteria for inclusion.

In 2018, ACS adopted a safety science approach[2] to reviewing fatalities, based on innovations in aviation, health care and other industries to improve safety. ACS's Systemic Child Fatality Review (SCFR) process, modeled after systems developed in Tennessee, Arizona and other jurisdictions around the country, reviews fatality cases, thoroughly examining the complex interplay of systemic factors, such as policies, workloads, availability of resources, supervision and training, among many other issues that may impact case practice and decision-making. The safety science approach encourages analyzing and applying data to drive learning and insight. It promotes a culture of openness and shared agency-wide accountability, in order to strengthen investigative practice and the child welfare system as a whole. Using a safety science approach, ACS's objective is to carefully investigate child fatalities to learn and ultimately improve the system's ability to support quality case practice, safe outcomes for children and improve services to their families.

Consistent with the safety science approach, the SCFR process emphasizes a shift from a culture of blame to a culture of system accountability and implements systemic methods of learning from all investigations to identify and address underlying systemic issues rather than deploying quick fixes.

This report reviews 52 child fatalities from calendar year 2020 that occurred in families that were "known" to ACS because of active involvement in an ACS investigation or services at the time of the fatality, or because of such involvement in the preceding 10 years.

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[2] Technical assistance to implement the model in ACS was provided by Collaborative Safety LLC, and the Center for Innovation in Population Health at the University of Kentucky through The National Partnership for Child Safety, established in partnership with Casey Family Programs.

New York City's Review of Child Fatalities Alleging Maltreatment

The New York Statewide Central Register (SCR) receives all reports of suspected child abuse and maltreatment for anyone under 18 years old. Reports may come from professionals mandated by law to report (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 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, smoke inhalation, or bronchopneumonia. 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.[3] 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. Another source of variation in "manner of death" classifications, relates to sleep related injury deaths where the child's sleeping conditions or surface may have contributed to the fatality. These deaths are often classified as "undetermined" by the ME in New York City, though this classification varies for similar cases both within New York City and in other state and county systems.

Table 1, below, shows that about 60% of the child fatalities reported to the SCR in 2020 alleging maltreatment in association with a child's death occurred in families that were "known"[4] to ACS in the past 10 years. Subsequent sections of this report focus only on those fatalities. Table 1 also provides an overview of all fatalities reported to the SCR and investigated by ACS in 2020 (see Table 2 for data on cases "known" to ACS).

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[3] As noted, the manner of death is an administrative distinction made by the Office of the Chief Medical Examiner. In New York City, the Medical Examiner uses the undetermined category when the manner or cause of death cannot be established with a reasonable degree of medical certainty. Deaths are determined to be from therapeutic complications when a medical device failure caused the death. Please see Appendix 1 for additional details.

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

Table 1. Manners of death for all 2020 child fatalities reported to SCR

	2020 Child Deaths in Families Known* to ACS		2020 Child Deaths with No Prior ACS History		All 2020 Child Deaths Reported to the SCR	
Manner of Death	N	%	N	%	N	%
Accident	8	15	8	24	16	19
Homicide	5	10	6	18	11	13
Natural	15	29	10	29	25	29
Suicide	0	0	0	0	0	0
Undetermined	23	44	10	29	33	38
Therapeutic Complications	0	0	0	0	0	0
Pending ME determination	1	2	0	0	1	1
Total	52	100	34	100	86	100

* A family is considered "known" to ACS if an adult in the household has been the subject of an allegation of child abuse or maltreatment reported to the NY State Central Register within the last 10 years.

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.[5] Such cases 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.

[5] 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."

Case Review Criteria

The Child Fatality Review Team, consisting of specially trained Case Reviewers, screens each child fatality case reported to the SCR for ACS history to determine whether the family was "known" to ACS[6]. A family is considered "known" if it meets any of the following criteria:

a. Any adult in the household that has been reported to the SCR as the subject of an allegation of child abuse or maltreatment within 10 years preceding the fatality;
b. When the fatality occurred, ACS was investigating an allegation against an adult in the household; OR
c. When the fatality occurred, a household family member was receiving ACS services such as foster care or prevention services.

If the family is "known", the Case Reviewers assess the case to determine the appropriate review track. There are two possible tracks.

1. There is an open investigation or an open case with prevention and/or foster care services; or there was a prior ACS case within the past 3 years; or the Office of the ACS Commissioner requested a review.
2. A prior ACS case was closed more than 3 years ago but within 10 years.

Cases that fall within category one receive a summary and are eligible for the ACS Systemic Child Fatality Review Process, while cases in category two receive a case summary only.

[6] Although the family may have prior history, it does not mean that the deceased child(ren) was the maltreated child(ren) or alive during the prior ACS involvement.

ACS Systemic Child Fatality Review (SCFR) Process

Upon notification of a child fatality from the SCR, the Division of Child Protection (DCP) takes immediate action, in accordance with OCFS guidelines, to initiate the investigation and ensure the safety of any surviving sibling(s) and/or family members. During the investigation, as more information becomes available, DCP may take additional actions to assure child safety. The Child Fatality Review Team (CFRT), within the ACS Division of Policy, Planning & Measurement, also receives notification of each fatality. The CFRT assesses the fatality to determine whether it falls within the review criteria. If it does, the team implements the Systemic Child Fatality Review (SCFR) process.

Once a child fatality is determined to fall within the review purview, for each SCFR case, the Child Fatality Review Team examines the family's history with ACS as well as available autopsy reports and records from service providers that had contact with the family. Additionally, in order to understand family and child functioning prior to the fatality, the team examines the child welfare histories of all adults known to be related to or involved with the child, such as parents, significant others, grandparents, aunts/uncles, and others with known caregiving responsibilities.

The Child Fatality Review Team completes a case summary which includes a technical review of the case history from available databases. Upon summary completion, the case is presented to the ACS Interdivisional Team (IDT), consisting of cross divisional ACS staff, where key learning points or areas of study are discussed and the decision is made on whether a more comprehensive analysis of the case will surface internal and external systemic influences that impact child safety. When cases are selected for a full review, staff involved with the corresponding learning points are invited to participate in a "human factors debrief." In 2020, there were 40 cases eligible for the SCFR process.

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

Cases selected for a full review are mapped, a process whereby local multidisciplinary teams (Mapping Teams) made up of staff from the various ACS divisions, including those in direct service, discuss local, regional and regulatory conditions or processes that affect case practice and decision making. Information gathered from the case review, human factors debriefs and mapping sessions is analyzed to identify systemic influences and key findings which are used to produce recommendations that will lead to system improvements.

2020 Cases Reviewed

Manner of Death

In 2020, there were 52 fatalities of children in 50 families (there were two families where two children died in each) 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 "undetermined" (n = 23, 44%), followed by "natural" (n = 15, 29%), "accident" (n = 8, 15%) and "homicide" (n = 5, 10%) (See Table 2)[7]. There was one case with a pending autopsy at the writing of this report.

Table 2: 2020 Manners of Death for Children in Families Known to ACS

	Total 2020	
Manner of Death	**N**	**%**
Accident	**8**	**15**
Homicide	**5**	**10**
Natural	**15**	**29**
Suicide	**0**	**0**
Undetermined	**23**	**44**
Therapeutic Complications	**0**	**0**
Pending ME Determination	**1**	**2**
Total	**52**	**100**

Case Demographics and Family Characteristics

The Child Fatality Review Team examined the child welfare case record of each family in which a fatality occurred and for each case collected information on family demographics, characteristics, and the presence of potential risk factors, including:

a. Race and/or ethnicity of the parents/caretakers;
b. Number of children in the family;

[7] Appendix A provides a description of what the Medical Examiner consider when making a manner of death determination.

c. Whether the mother was under eighteen when her first child was born, as well as the ages of the mother and father/male involved at the time of the fatality;
d. Whether the child had any documented developmental, medical or mental health conditions;
e. 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;
f. 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;
g. Identification in the case record of parent or caregiver mental health condition;
h. Identification in the case record of parent or caregiver substance use;
i. Identification in the case record of household domestic violence within the last four years;
j. Whether the family had an open case at the time of the fatality.

The following is a review of case characteristics for the 2020 fatalities (n = 52); Table 3 provides demographic information for the 50 cases (there were two cases where two children died in each).

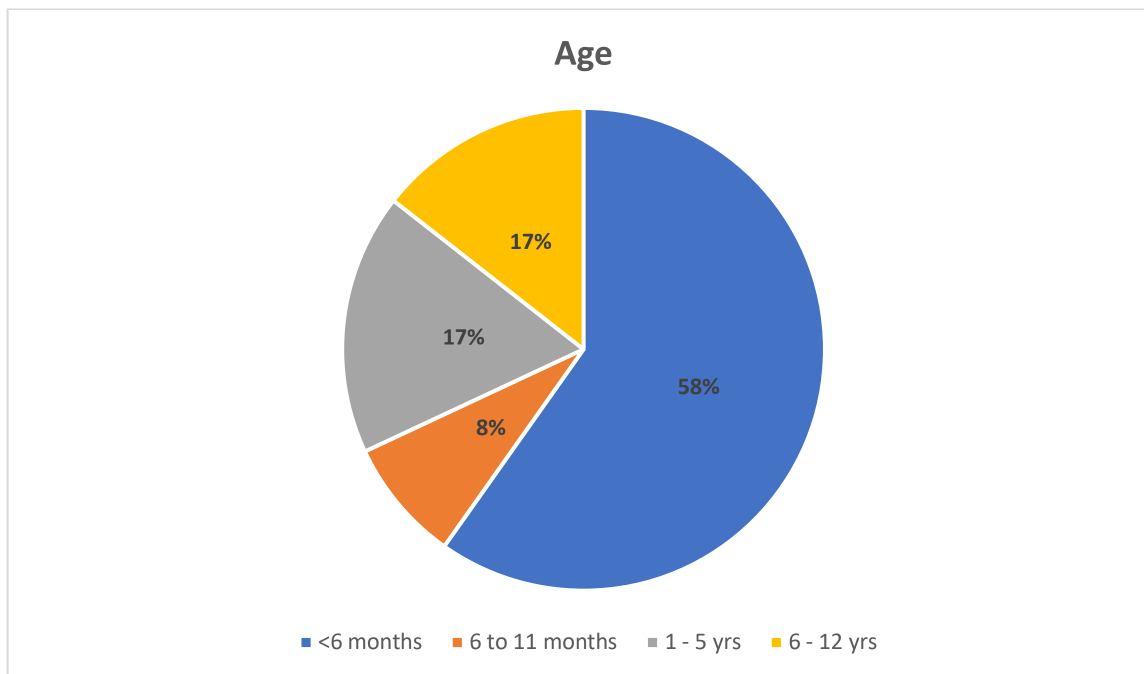
Table 3: Demographics

Demographics	n	%
Race (of mother, n = 50)		
Asian	0	0
Black	30	60
Hispanic	17	34
Pacific Islander	0	0
Native American	0	0
Multiracial	2	4
White Non-Hispanic	0	0
Not Available	0	0
Other	1	2
Unknown	0	0
Gender (of child n = 52)		
Female	20	38
Male	32	62
Age (of child n = 52)		
<6 months	30	58
6 to 11 months	4	8
1 to 5 yrs	9	17
6 to 12 yrs	9	17
≥13 yrs	0	0

Percentages may not equal 100 due to rounding

Mothers were disproportionately Black/African-American/non-Hispanic (60%) and Hispanic (34%). When available, data was also collected on the fathers or males involved with the family. Of the 47 males where information was available, seventy-two percent (n = 34) were identified as Black/African American/non-Hispanic while 26% (n = 12) were Hispanic. One male was identified as biracial and no race/ethnicity data was available on males in three cases.[8] (See Table 8 in Appendix B for parents' race/ethnicity in 2020 child fatalities in families known to ACS, as well as fatalities reported to the SCR for which there was no prior ACS involvement.)

Figure 1. Age of Child at Time of Fatality



Children at greatest risk of fatality were of the youngest ages, consistent with prior years. However, in 2020, the average and median ages of children were lower than the preceding three years. In 2020 cases, the average age of children was 2.3 years, almost a year younger than the 3.2 average in 2019, the 3.1 average in 2018 and the 2017 average of 3.4 years. The median age was 3.9 months, significantly lower than the 2019 median age of 6.8 months, the 2018 median age of 6.6 months and the 2017 median age of 9.1 months. Children's ages ranged from newborn to just under 13 years. Fifty-eight percent (n = 34) of the fatalities were of infants under the age of one, and of these, 88 percent (n = 30) were less than six months of age. Children under the age of six, including infants, accounted for 83% of 2020 fatalities. A significantly larger proportion of the children were male (62%) than female (38%). Male deaths accounted for 59% (n = 20) of the 34 children who were less than one year of age.

[8] All race and ethnicity data is based on information available in CONNECTIONS.

A fatality investigation concludes with the child protective investigative team making a determination regarding the fatality allegation made in the SCR report, as well as any additional allegations included in the report, such as inadequate guardianship or lack of supervision. A little more than half of the cases were indicated for at least one allegation (n = 27, 54%), with 22 percent of the cases indicated for the fatality itself. Forty-four percent (n = 23) of the fatalities occurred among families with open ACS cases at the time of death, and 44 percent of the deaths occurred in families that had a case closed either in or between 2017 and 2020.

Many of the families known to ACS face multiple challenges, such as recent or ongoing homelessness (36 percent of families in cases reviewed), and a recent history of domestic violence (within the last four years), which was noted in 46 percent of the cases reviewed. Sixty-two percent (n = 31) of the mothers had histories of ACS involvement as children and of those, a little more than half (52%, n = 16) had a history of foster care placement as children. For the males involved with these families (where information was available, n = 47), 30 percent (n= 14) had histories of ACS involvement as children, and six had a history of foster care placement. Seven cases reviewed involved families residing in a shelter at the time of the fatality; five of the seven had an active ACS case at the time of the fatality.

Reviews of the case records indicated that the average age of mothers was 27.7 years of age at the time of the child's death, three years younger than the 31.3 years recorded for mothers in 2019. Two of the mothers of children who died in 2020 were 17 years old or younger. The median age of these mothers was 26.5 years, below the 32.0 and 30.7 rates for 2019 and 2018, respectively, for this data point. On average, the mothers had three or more children, similar to previous years. Sixty percent (n = 30) of the mothers had current or prior substance use issues, and 44 percent had current or ongoing mental health concerns (diagnosed or undiagnosed) noted in the case record. An adult male was involved with the family in 94 percent of the cases reviewed. Of the identified males, 84 percent (n = 42) were fathers of the deceased child. Where information was available on the male known to be a part of the household and/or in a caregiving role, in 40 percent of the cases, current or prior substance use was recorded. Current or past mental health concerns were noted on five of the cases.

Additional Case Characteristics and Related ACS Initiatives

Sleep-Related Injury Deaths

In 2020, there were 28 fatalities in families known to ACS that included notations of sleep-related injuries or unsafe sleep conditions, either from the Medical Examiner (ME) autopsy findings or from a review of the ACS investigation of the fatality. 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. In 22 of these cases,

the ME included language consistent with sleep-related death on the autopsy (see Table 5 in Appendix B). For the other six deaths, the fatality investigation uncovered sleeping hazards that may have contributed to the child's demise; the ME classified these deaths as "natural".

The ME often designates and records the manner of death for sleep-related injury deaths as "undetermined" or "accident." In New York City, the ME 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 when an infant is found unresponsive after bed-sharing with an adult or alone in a crib or bassinet in which blankets or pillows are present. For the 22 cases noted on Table 5, "boppy"-type pillows were noted in six of the cases. Other unsafe sleep conditions included bed-sharing with adults, soft bedding in the crib or bassinet, sleeping on an adult bed surrounded by pillows, and positional asphyxia. Of the 22 cases with unsafe sleep conditions noted, the ME certified more than 80 percent of them (n = 18, 82%) as having an undetermined manner of death. Of the 22 sleep-related fatalities noted on Table 5, all but two were over six months of age. More than half (n = 13, 59%) of the children were male and 41% (n = 9) were female.

ACS Safe Sleep Strategy

Between 40 and 50 babies in New York City die from a preventable, sleep-related injury each year. The Centers for Disease Control and Prevention (CDC) estimates that nationally about 3,400 babies in the US are lost to sleep-related deaths each year. The CDC's analysis also shows that placing babies on their side or stomach to sleep was more common among mothers who were Black/non-Hispanic, younger than 25, or had 12 or fewer years of education.[9]

In 2015, A Mayoral Initiative established the NYC Infant Safe Sleep Initiative to prevent sleep-related infant injury deaths and address long-standing disparities to promote and protect the health and well-being of the youngest and most vulnerable New Yorkers. Data at the time revealed that Black families were twice as likely to have their baby die before their first birthday than white families, and infants living in the Bronx and Brooklyn die at higher rates than other boroughs in the first year of life. The initiative focused on primary prevention, collaborations and stakeholder partnerships to increase infant survival in Black families.

In August 2021, ACS established the Office of Child Safety and Injury Prevention (OCSIP) within the Division of Child and Family Well-Being. The office supports efforts to reduce or eliminate preventable child injuries and fatalities. The NYC Infant Safe Sleep Initiative, housed in the OCSIP, serves all of NYC with a priority focus on communities with high rates of sleep-related infant injury deaths.

[9] *CDC/NCHS, National Vital Statistics System, Mortality Files online publication,* Data and Statistics for SIDS and SUID | CDC

The Safe Sleep Initiative continued its outreach and education efforts throughout 2020, 2021 and 2022, despite the many challenges and limitations associated with the COVID-19 pandemic. During this period, the Safe Sleep team:

- Continued to distribute Safe Sleep Toolkits to discharging maternity patients at all 11 NYC H+H medical centers.
- Strengthened the Safe Sleep training curriculum to further highlight parental stress, fatigue and sleepiness as potential barriers to safeguarding infants during sleep.
- Adopted a hybrid training model—providing both in-person and virtual trainings for parents, caregivers and child-serving professionals.
- Established a monthly virtual training calendar with training offerings in both English and Spanish.
- Distributed free resources, including the safe sleep brochure, video, "Breath of Life: The How and Why of Infant Safe Sleep," wearable blankets (sleep sacks), and portable cribs to support NYC parents and caregivers in safeguarding infants while they sleep.
- Conducted crib demonstrations at in-person community events and in trainings of parents and caregivers to model a safe sleeping environment and simulate the suffocation risks associated with stomach/side sleeping and use of excess bedding like blankets, quilts, and comforters.
- Partnered with several NYC government agencies, including the NYC Department of Health and Mental Hygiene, NYC Department for Homeless Services, NYC Housing Authority, NYC Health and Hospitals, NYC Department for the Aging, NYC Fire Department, NYC Police Department and NYC Department of Transportation, and other stakeholders, including the Bronx District Attorney's Office, Queens Borough Community Affairs Unit, and the Kings Borough Community Fatherhood Academy, to deliver safe sleep training, educational materials and resources to the parents and caregivers they serve.
- Partnered with ACS Division of Family Permanency Services' Older Youth Services to co-design a peer-to-peer training module for credible messengering of infant safe sleep among parenting youth.

In 2021, the Safe Sleep team provided training to 4,881 parents and caregivers (virtually and in-person) and virtually to 2,455 child-serving professionals. In addition, more than 3,900 child welfare professionals completed the eLearn course, "Communicating Infant Safe Sleep Practices."

Homicides

In 2020, the Medical Examiner classified 5 fatalities (10%) in cases known to ACS as homicides. The ME classifies a death as homicide when the fatality results from an act of commission or omission by the perpetrator. The number of fatalities due to homicide varies from year to year (for a longitudinal view, see Table 6 in Appendix B). 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. All of the children in this category were less than 24 months old. Of note, two fatalities involved children who died of starvation and malnourishment.

ACS Enhanced Oversight of High-Risk Cases

ACS remains committed to strengthening its efforts to protect children who are at the greatest risk of physical abuse, including the use of the Accelerated Safety Analysis Protocol (ASAP) and the Heightened Oversight Process (HOP), initiatives that enhance everyday child protective investigative practices by leveraging additional levels of consultation, oversight and supervisory support.

The Accelerated Safety Analysis Protocol (ASAP) is a proactive process for evaluating safety practice in the early stages of select investigations, including those in which a child may be at high risk of physical harm. It is one component of a comprehensive quality management program at ACS that includes frequent oversight of outcomes and process data as well as qualitative case reviews. Through ASAP, a quality assurance review team identifies possible safety concerns in potentially high-risk investigations, examines documentation on the case, and, when necessary, meets with the investigative team to provide coaching around appropriate safety practices and interventions.

ACS implemented the Heightened Oversight Process (HOP) in 2017 and strengthened it in 2019. The HOP combines the expertise of the Child Protection Manager and the Investigative Consultant Supervisor on the most high-risk cases involving young children. It provides a structure for collaboration and consultation among child protection investigative teams and the Investigative Consultants, an ACS team of former NYPD detectives. The HOP is initiated when an SCR report contains allegations that include a fatality, a serious injury, or sexual abuse of children three years old or younger, as well as any reports that include children three years of age or younger where the parent/caregiver named in the report has had one or more children residing elsewhere, or removed and placed in ACS foster care prior to the current investigation, and the child(ren) and parent have not reunified. The HOP team identifies an investigative strategy at the beginning of the investigation and requires the Child Protection Manager and IC Supervisor to jointly review the case 25 days later to ensure all investigative steps have been completed and assess if any additional actions are needed.

In addition, ACS quality management includes collaborative efforts to improve child safety, identify key insights and opportunities for learning and improvement, and inform agency initiatives. Among these is ChildStat, in which the ACS Commissioner meets with his executive leadership and DCP borough leadership and managers to discuss performance metrics and case practice. Lessons learned from ChildStat spur recommendations for zone, borough, and system-wide improvements. ACS's continuous quality improvement processes help leadership identify

staff development needs and flag challenges to be addressed in management, technology, policies and standards. ACS uses these quality management and continuous quality improvement processes to promote an agency-wide culture of learning and accountability.

Natural Deaths

In 2020, 29 percent (n = 15) of the child fatalities were determined by the Medical Examiner to be natural (see Table #7 in Appendix B). 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.

Of the 15 natural deaths, four had open cases with ACS at the time of death. Only one of the 15 cases was indicated for the fatality allegation at the conclusion of the investigation; five others were indicated for other allegations. Slightly more than 50 percent of the children were male (n= 8), and less than half of the 15 (n = 7) had chronic medical conditions and/or developmental issues. Across all fatality types, the average age of death in 2020 was 2.3 years of age; however, children who experienced natural deaths were older, averaging 4.3 years old, and almost half of them (n = 7, 47%) were less than six months old.

Services for Children and Families with Complex Medical Needs

The ACS Office of Child and Family Health (OCFH) leads the agency's efforts to provide access to quality health services as well as educate staff and foster care and prevention service providers on assessing whether children and adolescents' medical needs are being met.

Since 2019, OCFH and the Health + Hospitals medical consultants stationed in DCP offices across the five boroughs have utilized a Complex Needs Protocol on cases in which a child is identified as having a diagnosis or suspicion of a significant cognitive delay, neurological disorder, developmental disability, neurosensory limitation, significant neuromotor limitation, or organ system failure. In these cases, the medical consultant is required to schedule a consultation within 1-2 business days, thereby prioritizing children with the most complex and acute medical needs for immediate intervention.

Also, in 2019, ACS contracted with the New York State Office of Mental Health to procure an "ACS Access View" to the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database. This allows ACS to view Medicaid billing information for children in ACS care who have behavioral health needs. With the ACS Access View, key personnel are able to view child-specific data to support the most appropriate care and coordination for children with mental health challenges.

Other Child Safety and Prevention Initiatives

The Division of Prevention Services

ACS recognizes that children are safest when families have the supports they need to care for and raise their children. ACS has designed prevention services to help families care for their children safely at home. Casey Family Programs and other national experts have described ACS as "a national leader in investing in the continuum of prevention services and supports." New York City is one of the few child welfare jurisdictions in the country where families have access to a comprehensive, holistic, and fully funded continuum of intensive, clinical case management services geared to support, strengthen and stabilize families in order to prevent the need for out of home placement, expedite the return home from foster care and avert replacement of children already in the foster care system. ACS prevention and family home care services prevent child maltreatment and neglect by addressing the challenges families face, building upon caregivers' protective factors, and assisting them to provide a healthy and supportive environment in which to raise children. The ACS Division of Prevention Services (DPS) leads these efforts.

In July 2020, ACS implemented a new prevention continuum. Hallmarks of this new system include more therapeutic services for high-need families; universal access to all program models regardless of where the family lives; and a stronger emphasis on parent feedback, both in development of the models that offered and in the day-to-day service delivery on individual cases. Services are free and available citywide—in every community in all 5 boroughs. All prevention programs are required to offer case management services, including assessing needs for and connecting families to concrete services and supports such as diapers, cribs, navigating public benefits, and accessing housing support, among other supports. In addition, DPS has implemented programs to ensure family systems are strengthened where there is domestic violence (and court involvement) and in families with children aged zero to three.

- A Safe Way Forward: Demonstration project – A Safe Way Forward (SWF) is an innovative program (for families impacted by intimate partner violence, specifically families receiving court-ordered supervision. SWF works with the entire family system, offering separate and simultaneous trauma-informed case planning and research-informed therapeutic services to the survivor, child(ren), and the person causing harm. The staged rollout occurred in April 2019 in the Bronx and Staten Island, and more recently, ACS announced that the program will also be expanding to Brooklyn.
- GABI: As an enhancement to our prevention services offerings, ACS's Group Attachment Based Intervention (GABI) supports caregivers of young children under age four. GABI is a research-informed therapeutic intervention that serves families who have experienced significant trauma, housing instability, mental illness, domestic violence, and/or other challenges that make parenting a very young child difficult. The program provides

clinician-facilitated play therapy, allowing parents to strengthen attachment with their children, which research demonstrates reduces the risks of child maltreatment. The program also provides parents one-on-one clinical sessions and peer support through parent groups. Additionally, GABI provides families with concrete goods such as diapers and baby wipes.

System Recommendations

The safety science approach encourages proactively exploring systemic influences that impact decision making in the moment, with the goal of greatly reducing the likelihood of child fatalities. The review process seeks to identify systemic influences within individual cases and trends across multiple cases. The frequency of systemic influences informs recommendations for child welfare system improvement.

The Child Fatality Review Team screens each child fatality case reported to the SCR for ACS history to determine whether the family was "known" to ACS. Cases with current child protection, foster care or prevention services, or cases closed within the past three years or requested by the Office of the Commissioner are eligible for full review in the Systemic Child Fatality Review Process (SCFR) which includes completing a comprehensive case review, conducting human factors debriefing and mapping sessions, and using a Systems Analysis Scoring Tool to score systemic influences.

In addition to the many specific initiatives detailed in the previous pages, the ACS Systemic Child Fatality Review process identified systemic issues and recommended actions to enhance case practice, protect children and strengthen families. These include:

- Strengthening the engagement of fathers and males in families involved with ACS
  - The ACS Workforce Institute established an instructor-led course in the Motivational Interviewing sequence called "Motivational Interviewing: Engaging Fathers" to support child welfare state in engaging males in family.
  - The Division of Child Protection and other ACS program areas continue to implement the use of teams for key decision making and supervision, with a consistent focus on effective engagement of adult men.

- Increasing cross-divisional collaboration throughout the child welfare continuum.
  - ACS is in the midst of a multiyear project to strengthen collaborative relationships between the Division of Child Protection's Family Service Unit (FSU) and Prevention providers, which often share responsibility for families that are under Court-Ordered Supervision (COS). Careful coordination is essential to make certain that appropriate services are available and delivered to families.
  - In addition, ACS is working with foster care providers to enhance collaboration with prevention services in order to help move children to extended visits, trial discharge and reunification--safely, timely and permanently.

- Provide tools to support staff in engaging mental health providers and navigating the mental health system.
    - The ACS Workforce Institute has implemented trained child welfare staff on how to work with mental illness and the mental health system. In addition, the ACS Clinical Consultation Team supports staff in assessing mental health and accessing mental health services.
    - The State's implementation of Medicaid Managed Care for children has reshaped the way that young people in ACS care are accessing services. ACS has been working closely with its contracted providers and the State to improve access to these services.

Appendix A: Manner of Death Definitions

The New York City Office of the Chief Medical Examiner determines both the cause and manner of death for each fatality for which an autopsy is conducted. The cause of death is the injury, disease or condition that resulted in the fatality, such as asthma or blunt trauma. The manner of death is based on the circumstances under which the death occurred. The following are the classifications used by the Medical Examiner:

Homicide: The Medical Examiner determines a death is due to homicide when the death results from an act of commission or omission by another person, or through the negligent conduct of a caregiver.

Natural: The Medical Examiner determines a death to be natural when disease or a medical condition is the sole cause of death.

Accident: The Medical Examiner determines a death to be an accident when the death results from injury caused inadvertently.

Suicide: The Medical Examiner certifies a death as suicide when the death is the result of an action by the decedent with the intent of killing him or herself.

Undetermined: The Medical Examiner certifies a death as undetermined when the manner of death cannot be established with a reasonable degree of medical certainty.

Therapeutic Complications: The Medical Examiner certifies a death from therapeutic complications when the death was due to predictable complications of appropriate medical therapy.

Appendix B: 2020 Data Tables

Table 4. Manner of Death (2011 - 2020)

Manner of Death	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Homicide	11	15	6	9	10	10	6	10	9	5
Undetermined	14	15	20	17	16	19	16	20	19	23
Natural	11	15	4	21	7	16	28	19	11	15
Accident	7	4	12	9	6	8	11	8	9	8
Suicide	0	1	2	2	2	0	2	2	3	0
Therapeutic Complications	0	0	0	0	1	1	0	0	0	0
Pending	0	0	0	0	+1	+*2	0	0	*6	*1
Total per year	43	50	44	58	43	56	63	59	57	52

+In one 2015 case and in one 2016 case, no body was found.

*In two 2016 cases, six 2019 cases, and one 2020 case the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 5. Sleep-Related Child Fatalities in ACS Known Cases (2015 - 2020)

Year of Child Fatality	Number of ACS Known Sleep Related Fatalities	Total Number of ACS Known Fatalities	Percent of ACS Known Fatalities with Unsafe Sleep Injuries
2015	21	43	49%
2016	21	56	38%
2017	24	63	38%
2018	21	59	36%
2019	20	57	35%
2020	22	52	42%

Table 6. Homicides in ACS Known Cases (2010 - 2020)

Manner of Death	2010	2011	2012	2013	2014	2015	2016	2017	2018	*2019	*2020
Homicide	10	11	15	6	9	10	10	6	10	9	5
Total Fatalities	46	43	50	44	58	43	56	63	59	57	52
Percent of Fatalities Deemed Homicides	22%	26%	30%	14%	16%	23%	18%	10%	17%	16%	10%

* In six 2019 cases and one 2020 case the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 7. ACS Known Cases Certified as Natural Deaths (2011 - 2020)

Manner of Death	2011	2012	2013	2014	2015	2016	2017	2018	*2019	*2020
Natural	11	15	4	21	7	17	28	20	11	15
Total Fatalities	43	50	44	58	43	56	63	59	57	52
Percent of Fatalities Deemed Natural Deaths	26%	30%	9%	36%	16%	30%	44%	34%	19%	29%

* In six 2019 cases and one 2020 case the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 8. Race and Ethnicity Demographics of Parents in 2020 Child Fatalities Reported to SCR ǂ

Race/Ethnicity	Families Known to ACS		Families With no Prior ACS Involvement	
	Mother	Father	Mother	Father
Asian	0	0	2	2
Black	30	34	14	14
Multi-racial	2	1	0	0
Hispanic	17	12	9	9
Other	1	0	2	2
N/A*	0	3	0	0
Unknown	0	0	0	0
White	0	0	7	7
Total	50	50	34	34

ǂ 2020 New York City child fatalities reported to the SCR alleging maltreatment associated with the fatality

*N/A = no information is available about the male in the family

Systemic Child Fatality Review – 2020 Annual Report

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Introduction

The New York City's Administration for Children's Services (ACS) is charged with investigating alleged abuse and neglect among children residing in the city. ACS is also responsible for providing services and supports to New York City's most vulnerable children and families impacted by challenging issues such as poverty, substance use, mental health concerns and the COVID-19 pandemic. During 2020, ACS responded to more than 51,000 reports of child maltreatment, concerning more than 66,100 children. These reports were consolidated into 43,881 investigations or Collaborative Assessment, Response, Engagement and Support (CARES) cases.

In 2020, ACS investigated 86 child fatalities reported to the Statewide Central Register (SCR) with about 40% of these children having no history of prior contact with ACS. Following the investigations, the investigative teams concluded that the large majority of child fatalities reported to the SCR were unrelated to abuse or neglect. As noted in prior reports, the occurrence of a child fatality due to maltreatment is a rare event, comprising about 0.1 percent of all cases investigated. Nonetheless, the death of a child with whom ACS has had contact requires special attention.

This report focuses on child fatalities during calendar year 2020. It outlines how ACS responds to child fatalities, summarizes demographic data, and provides systemic findings from cases reviewed. Due to the small number of fatalities when compared to the larger pool of child welfare cases touched by ACS, readers are cautioned against generalizing findings in this report. 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. However, the purpose of the case reviews and analyses is to learn lessons that will help to strengthen the child welfare system for all families with whom ACS has contact.

This report is published pursuant to Local Law 19 of 2018[1], which requires ACS to issue a report on 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 applicable year;

b. The manner and/or cause of death in such fatalities;

c. The age, gender, race and ethnicity of children with fatalities for the previous year;

d. Any relevant trends and systemic recommendations, including opportunities for inter-agency collaboration; and

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

e. A summary of any case practice findings and agency policy changes made in response to child fatalities in the previous 12 months.

The New York State Office of Children and Family Services (OCFS) and the New York City Department of Health and Mental Hygiene (DOHMH) also produce annual reports on child fatalities using other criteria for inclusion.

In 2018, ACS adopted a safety science approach[2] to reviewing fatalities, based on innovations in aviation, health care and other industries to improve safety. ACS's Systemic Child Fatality Review (SCFR) process, modeled after systems developed in Tennessee, Arizona and other jurisdictions around the country, reviews fatality cases, thoroughly examining the complex interplay of systemic factors, such as policies, workloads, availability of resources, supervision and training, among many other issues that may impact case practice and decision-making. The safety science approach encourages analyzing and applying data to drive learning and insight. It promotes a culture of openness and shared agency-wide accountability, in order to strengthen investigative practice and the child welfare system as a whole. Using a safety science approach, ACS's objective is to carefully investigate child fatalities to learn and ultimately improve the system's ability to support quality case practice, safe outcomes for children and improve services to their families.

Consistent with the safety science approach, the SCFR process emphasizes a shift from a culture of blame to a culture of system accountability and implements systemic methods of learning from all investigations to identify and address underlying systemic issues rather than deploying quick fixes.

This report reviews 52 child fatalities from calendar year 2020 that occurred in families that were "known" to ACS because of active involvement in an ACS investigation or services at the time of the fatality, or because of such involvement in the preceding 10 years.

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[2] Technical assistance to implement the model in ACS was provided by Collaborative Safety LLC, and the Center for Innovation in Population Health at the University of Kentucky through The National Partnership for Child Safety, established in partnership with Casey Family Programs.

New York City's Review of Child Fatalities Alleging Maltreatment

The New York Statewide Central Register (SCR) receives all reports of suspected child abuse and maltreatment for anyone under 18 years old. Reports may come from professionals mandated by law to report (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 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, smoke inhalation, or bronchopneumonia. 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.[3] 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. Another source of variation in "manner of death" classifications, relates to sleep related injury deaths where the child's sleeping conditions or surface may have contributed to the fatality. These deaths are often classified as "undetermined" by the ME in New York City, though this classification varies for similar cases both within New York City and in other state and county systems.

Table 1, below, shows that about 60% of the child fatalities reported to the SCR in 2020 alleging maltreatment in association with a child's death occurred in families that were "known"[4] to ACS in the past 10 years. Subsequent sections of this report focus only on those fatalities. Table 1 also provides an overview of all fatalities reported to the SCR and investigated by ACS in 2020 (see Table 2 for data on cases "known" to ACS).

[3] As noted, the manner of death is an administrative distinction made by the Office of the Chief Medical Examiner. In New York City, the Medical Examiner uses the undetermined category when the manner or cause of death cannot be established with a reasonable degree of medical certainty. Deaths are determined to be from therapeutic complications when a medical device failure caused the death. Please see Appendix 1 for additional details.

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

Table 1. Manners of death for all 2020 child fatalities reported to SCR

	2020 Child Deaths in Families Known* to ACS		2020 Child Deaths with No Prior ACS History		All 2020 Child Deaths Reported to the SCR	
Manner of Death	N	%	N	%	N	%
Accident	8	15	8	24	16	19
Homicide	5	10	6	18	11	13
Natural	15	29	10	29	25	29
Suicide	0	0	0	0	0	0
Undetermined	23	44	10	29	33	38
Therapeutic Complications	0	0	0	0	0	0
Pending ME determination	1	2	0	0	1	1
Total	52	100	34	100	86	100

* A family is considered "known" to ACS if an adult in the household has been the subject of an allegation of child abuse or maltreatment reported to the NY State Central Register within the last 10 years.

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.[5] Such cases 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.

[5] 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."

Case Review Criteria

The Child Fatality Review Team, consisting of specially trained Case Reviewers, screens each child fatality case reported to the SCR for ACS history to determine whether the family was "known" to ACS[6]. A family is considered "known" if it meets any of the following criteria:

a. Any adult in the household that has been reported to the SCR as the subject of an allegation of child abuse or maltreatment within 10 years preceding the fatality;
b. When the fatality occurred, ACS was investigating an allegation against an adult in the household; OR
c. When the fatality occurred, a household family member was receiving ACS services such as foster care or prevention services.

If the family is "known", the Case Reviewers assess the case to determine the appropriate review track. There are two possible tracks.

1. There is an open investigation or an open case with prevention and/or foster care services; or there was a prior ACS case within the past 3 years; or the Office of the ACS Commissioner requested a review.
2. A prior ACS case was closed more than 3 years ago but within 10 years.

Cases that fall within category one receive a summary and are eligible for the ACS Systemic Child Fatality Review Process, while cases in category two receive a case summary only.

[6] Although the family may have prior history, it does not mean that the deceased child(ren) was the maltreated child(ren) or alive during the prior ACS involvement.

ACS Systemic Child Fatality Review (SCFR) Process

Upon notification of a child fatality from the SCR, the Division of Child Protection (DCP) takes immediate action, in accordance with OCFS guidelines, to initiate the investigation and ensure the safety of any surviving sibling(s) and/or family members. During the investigation, as more information becomes available, DCP may take additional actions to assure child safety. The Child Fatality Review Team (CFRT), within the ACS Division of Policy, Planning & Measurement, also receives notification of each fatality. The CFRT assesses the fatality to determine whether it falls within the review criteria. If it does, the team implements the Systemic Child Fatality Review (SCFR) process.

Once a child fatality is determined to fall within the review purview, for each SCFR case, the Child Fatality Review Team examines the family's history with ACS as well as available autopsy reports and records from service providers that had contact with the family. Additionally, in order to understand family and child functioning prior to the fatality, the team examines the child welfare histories of all adults known to be related to or involved with the child, such as parents, significant others, grandparents, aunts/uncles, and others with known caregiving responsibilities.

The Child Fatality Review Team completes a case summary which includes a technical review of the case history from available databases. Upon summary completion, the case is presented to the ACS Interdivisional Team (IDT), consisting of cross divisional ACS staff, where key learning points or areas of study are discussed and the decision is made on whether a more comprehensive analysis of the case will surface internal and external systemic influences that impact child safety. When cases are selected for a full review, staff involved with the corresponding learning points are invited to participate in a "human factors debrief." In 2020, there were 40 cases eligible for the SCFR process.

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

Cases selected for a full review are mapped, a process whereby local multidisciplinary teams (Mapping Teams) made up of staff from the various ACS divisions, including those in direct service, discuss local, regional and regulatory conditions or processes that affect case practice and decision making. Information gathered from the case review, human factors debriefs and mapping sessions is analyzed to identify systemic influences and key findings which are used to produce recommendations that will lead to system improvements.

2020 Cases Reviewed

Manner of Death

In 2020, there were 52 fatalities of children in 50 families (there were two families where two children died in each) 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 "undetermined" (n = 23, 44%), followed by "natural" (n = 15, 29%), "accident" (n = 8, 15%) and "homicide" (n = 5, 10%) (See Table 2)[7]. There was one case with a pending autopsy at the writing of this report.

Table 2: 2020 Manners of Death for Children in Families Known to ACS

	Total 2020	
Manner of Death	**N**	**%**
Accident	**8**	**15**
Homicide	**5**	**10**
Natural	**15**	**29**
Suicide	**0**	**0**
Undetermined	**23**	**44**
Therapeutic Complications	**0**	**0**
Pending ME Determination	**1**	**2**
Total	**52**	**100**

Case Demographics and Family Characteristics

The Child Fatality Review Team examined the child welfare case record of each family in which a fatality occurred and for each case collected information on family demographics, characteristics, and the presence of potential risk factors, including:

a. Race and/or ethnicity of the parents/caretakers;
b. Number of children in the family;

[7] Appendix A provides a description of what the Medical Examiner consider when making a manner of death determination.

c. Whether the mother was under eighteen when her first child was born, as well as the ages of the mother and father/male involved at the time of the fatality;
d. Whether the child had any documented developmental, medical or mental health conditions;
e. 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;
f. 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;
g. Identification in the case record of parent or caregiver mental health condition;
h. Identification in the case record of parent or caregiver substance use;
i. Identification in the case record of household domestic violence within the last four years;
j. Whether the family had an open case at the time of the fatality.

The following is a review of case characteristics for the 2020 fatalities (n = 52); Table 3 provides demographic information for the 50 cases (there were two cases where two children died in each).

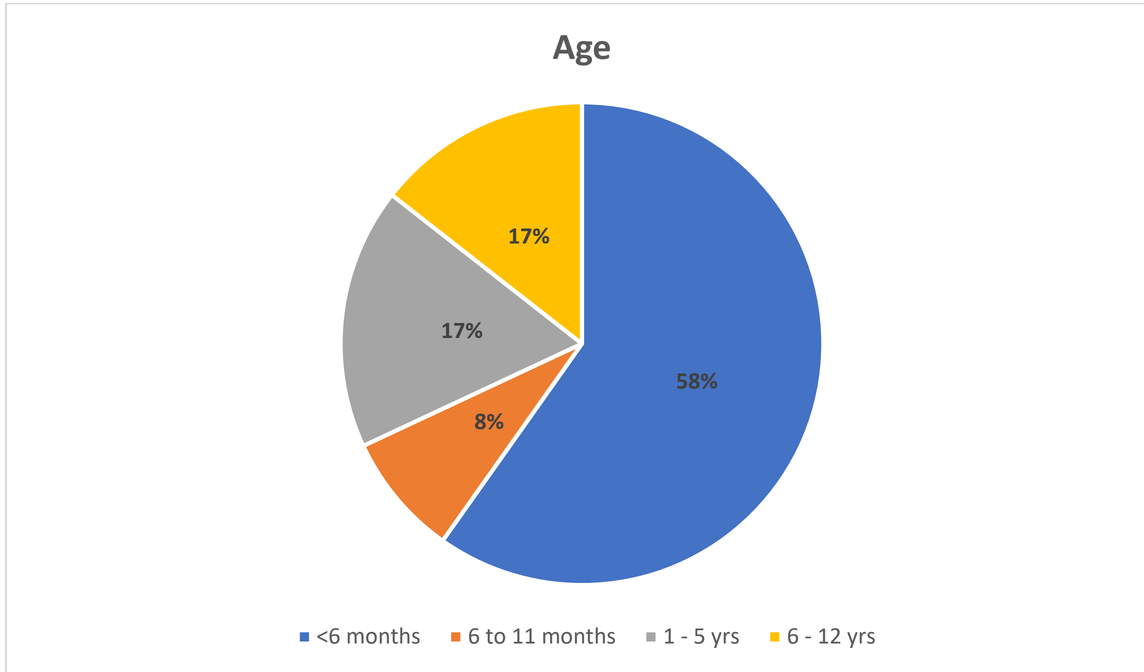
Table 3: Demographics

Demographics		
	n	%
Race (of mother, n = 50)		
Asian	0	0
Black	30	60
Hispanic	17	34
Pacific Islander	0	0
Native American	0	0
Multiracial	2	4
White Non-Hispanic	0	0
Not Available	0	0
Other	1	2
Unknown	0	0
Gender (of child n = 52)		
Female	20	38
Male	32	62
Age (of child n = 52)		
<6 months	30	58
6 to 11 months	4	8
1 to 5 yrs	9	17
6 to 12 yrs	9	17
≥13 yrs	0	0

Percentages may not equal 100 due to rounding

Mothers were disproportionately Black/African-American/non-Hispanic (60%) and Hispanic (34%). When available, data was also collected on the fathers or males involved with the family. Of the 47 males where information was available, seventy-two percent (n = 34) were identified as Black/African American/non-Hispanic while 26% (n = 12) were Hispanic. One male was identified as biracial and no race/ethnicity data was available on males in three cases.[8] (See Table 8 in Appendix B for parents' race/ethnicity in 2020 child fatalities in families known to ACS, as well as fatalities reported to the SCR for which there was no prior ACS involvement.)

Figure 1. Age of Child at Time of Fatality



Children at greatest risk of fatality were of the youngest ages, consistent with prior years. However, in 2020, the average and median ages of children were lower than the preceding three years. In 2020 cases, the average age of children was 2.3 years, almost a year younger than the 3.2 average in 2019, the 3.1 average in 2018 and the 2017 average of 3.4 years. The median age was 3.9 months, significantly lower than the 2019 median age of 6.8 months, the 2018 median age of 6.6 months and the 2017 median age of 9.1 months. Children's ages ranged from newborn to just under 13 years. Fifty-eight percent (n = 34) of the fatalities were of infants under the age of one, and of these, 88 percent (n = 30) were less than six months of age. Children under the age of six, including infants, accounted for 83% of 2020 fatalities. A significantly larger proportion of the children were male (62%) than female (38%). Male deaths accounted for 59% (n = 20) of the 34 children who were less than one year of age.

[8] All race and ethnicity data is based on information available in CONNECTIONS.

A fatality investigation concludes with the child protective investigative team making a determination regarding the fatality allegation made in the SCR report, as well as any additional allegations included in the report, such as inadequate guardianship or lack of supervision. A little more than half of the cases were indicated for at least one allegation (n = 27, 54%), with 22 percent of the cases indicated for the fatality itself. Forty-four percent (n = 23) of the fatalities occurred among families with open ACS cases at the time of death, and 44 percent of the deaths occurred in families that had a case closed either in or between 2017 and 2020.

Many of the families known to ACS face multiple challenges, such as recent or ongoing homelessness (36 percent of families in cases reviewed), and a recent history of domestic violence (within the last four years), which was noted in 46 percent of the cases reviewed. Sixty-two percent (n = 31) of the mothers had histories of ACS involvement as children and of those, a little more than half (52%, n = 16) had a history of foster care placement as children. For the males involved with these families (where information was available, n = 47), 30 percent (n= 14) had histories of ACS involvement as children, and six had a history of foster care placement. Seven cases reviewed involved families residing in a shelter at the time of the fatality; five of the seven had an active ACS case at the time of the fatality.

Reviews of the case records indicated that the average age of mothers was 27.7 years of age at the time of the child's death, three years younger than the 31.3 years recorded for mothers in 2019. Two of the mothers of children who died in 2020 were 17 years old or younger. The median age of these mothers was 26.5 years, below the 32.0 and 30.7 rates for 2019 and 2018, respectively, for this data point. On average, the mothers had three or more children, similar to previous years. Sixty percent (n = 30) of the mothers had current or prior substance use issues, and 44 percent had current or ongoing mental health concerns (diagnosed or undiagnosed) noted in the case record. An adult male was involved with the family in 94 percent of the cases reviewed. Of the identified males, 84 percent (n = 42) were fathers of the deceased child. Where information was available on the male known to be a part of the household and/or in a caregiving role, in 40 percent of the cases, current or prior substance use was recorded. Current or past mental health concerns were noted on five of the cases.

Additional Case Characteristics and Related ACS Initiatives

Sleep-Related Injury Deaths

In 2020, there were 28 fatalities in families known to ACS that included notations of sleep-related injuries or unsafe sleep conditions, either from the Medical Examiner (ME) autopsy findings or from a review of the ACS investigation of the fatality. 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. In 22 of these cases,

the ME included language consistent with sleep-related death on the autopsy (see Table 5 in Appendix B). For the other six deaths, the fatality investigation uncovered sleeping hazards that may have contributed to the child's demise; the ME classified these deaths as "natural".

The ME often designates and records the manner of death for sleep-related injury deaths as "undetermined" or "accident." In New York City, the ME 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 when an infant is found unresponsive after bed-sharing with an adult or alone in a crib or bassinet in which blankets or pillows are present. For the 22 cases noted on Table 5, "boppy"-type pillows were noted in six of the cases. Other unsafe sleep conditions included bed-sharing with adults, soft bedding in the crib or bassinet, sleeping on an adult bed surrounded by pillows, and positional asphyxia. Of the 22 cases with unsafe sleep conditions noted, the ME certified more than 80 percent of them (n = 18, 82%) as having an undetermined manner of death. Of the 22 sleep-related fatalities noted on Table 5, only two were over six months of age. More than half (n = 13, 59%) of the children were male and 41% (n = 9) were female.

ACS Safe Sleep Strategy

Between 40 and 50 babies in New York City die from a preventable, sleep-related injury each year. The Centers for Disease Control and Prevention (CDC) estimates that nationally about 3,400 babies in the US are lost to sleep-related deaths each year. The CDC's analysis also shows that placing babies on their side or stomach to sleep was more common among mothers who were Black/non-Hispanic, younger than 25, or had 12 or fewer years of education.[9]

In 2015, A Mayoral Initiative established the NYC Infant Safe Sleep Initiative to prevent sleep-related infant injury deaths and address long-standing disparities to promote and protect the health and well-being of the youngest and most vulnerable New Yorkers. Data at the time revealed that Black families were twice as likely to have their baby die before their first birthday than white families, and infants living in the Bronx and Brooklyn die at higher rates than other boroughs in the first year of life. The initiative focused on primary prevention, collaborations and stakeholder partnerships to increase infant survival in Black families.

In August 2021, ACS established the Office of Child Safety and Injury Prevention (OCSIP) within the Division of Child and Family Well-Being. The office supports efforts to reduce or eliminate preventable child injuries and fatalities. The NYC Infant Safe Sleep Initiative, housed in the OCSIP, serves all of NYC with a priority focus on communities with high rates of sleep-related infant injury deaths.

[9] *CDC/NCHS, National Vital Statistics System, Mortality Files online publication,* Data and Statistics for SIDS and SUID | CDC

The Safe Sleep Initiative continued its outreach and education efforts throughout 2020, 2021 and 2022, despite the many challenges and limitations associated with the COVID-19 pandemic. During this period, the Safe Sleep team:

- Continued to distribute Safe Sleep Toolkits to discharging maternity patients at all 11 NYC H+H medical centers.
- Strengthened the Safe Sleep training curriculum to further highlight parental stress, fatigue and sleepiness as potential barriers to safeguarding infants during sleep.
- Adopted a hybrid training model—providing both in-person and virtual trainings for parents, caregivers and child-serving professionals.
- Established a monthly virtual training calendar with training offerings in both English and Spanish.
- Distributed free resources, including the safe sleep brochure, video, "Breath of Life: The How and Why of Infant Safe Sleep," wearable blankets (sleep sacks), and portable cribs to support NYC parents and caregivers in safeguarding infants while they sleep.
- Conducted crib demonstrations at in-person community events and in trainings of parents and caregivers to model a safe sleeping environment and simulate the suffocation risks associated with stomach/side sleeping and use of excess bedding like blankets, quilts, and comforters.
- Partnered with several NYC government agencies, including the NYC Department of Health and Mental Hygiene, NYC Department for Homeless Services, NYC Housing Authority, NYC Health and Hospitals, NYC Department for the Aging, NYC Fire Department, NYC Police Department and NYC Department of Transportation, and other stakeholders, including the Bronx District Attorney's Office, Queens Borough Community Affairs Unit, and the Kings Borough Community Fatherhood Academy, to deliver safe sleep training, educational materials and resources to the parents and caregivers they serve.
- Partnered with ACS Division of Family Permanency Services' Older Youth Services to co-design a peer-to-peer training module for credible messengering of infant safe sleep among parenting youth.

In 2021, the Safe Sleep team provided training to 4,881 parents and caregivers (virtually and in-person) and virtually to 2,455 child-serving professionals. In addition, more than 3,900 child welfare professionals completed the eLearn course, "Communicating Infant Safe Sleep Practices."

Homicides

In 2020, the Medical Examiner classified 5 fatalities (10%) in cases known to ACS as homicides. The ME classifies a death as homicide when the fatality results from an act of commission or omission by the perpetrator. The number of fatalities due to homicide varies from year to year (for a longitudinal view, see Table 6 in Appendix B). 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. All of the children in this category were less than 24 months old. Of note, two fatalities involved children who died of starvation and malnourishment.

ACS Enhanced Oversight of High-Risk Cases

ACS remains committed to strengthening its efforts to protect children who are at the greatest risk of physical abuse, including the use of the Accelerated Safety Analysis Protocol (ASAP) and the Heightened Oversight Process (HOP), initiatives that enhance everyday child protective investigative practices by leveraging additional levels of consultation, oversight and supervisory support.

The Accelerated Safety Analysis Protocol (ASAP) is a proactive process for evaluating safety practice in the early stages of select investigations, including those in which a child may be at high risk of physical harm. It is one component of a comprehensive quality management program at ACS that includes frequent oversight of outcomes and process data as well as qualitative case reviews. Through ASAP, a quality assurance review team identifies possible safety concerns in potentially high-risk investigations, examines documentation on the case, and, when necessary, meets with the investigative team to provide coaching around appropriate safety practices and interventions.

ACS implemented the Heightened Oversight Process (HOP) in 2017 and strengthened it in 2019. The HOP combines the expertise of the Child Protection Manager and the Investigative Consultant Supervisor on the most high-risk cases involving young children. It provides a structure for collaboration and consultation among child protection investigative teams and the Investigative Consultants, an ACS team of former NYPD detectives. The HOP is initiated when an SCR report contains allegations that include a fatality, a serious injury, or sexual abuse of children three years old or younger, as well as any reports that include children three years of age or younger where the parent/caregiver named in the report has had one or more children residing elsewhere, or removed and placed in ACS foster care prior to the current investigation, and the child(ren) and parent have not reunified. The HOP team identifies an investigative strategy at the beginning of the investigation and requires the Child Protection Manager and IC Supervisor to jointly review the case 25 days later to ensure all investigative steps have been completed and assess if any additional actions are needed.

In addition, ACS quality management includes collaborative efforts to improve child safety, identify key insights and opportunities for learning and improvement, and inform agency initiatives. Among these is ChildStat, in which the ACS Commissioner meets with his executive leadership and DCP borough leadership and managers to discuss performance metrics and case practice. Lessons learned from ChildStat spur recommendations for zone, borough, and system-wide improvements. ACS's continuous quality improvement processes help leadership identify

staff development needs and flag challenges to be addressed in management, technology, policies and standards. ACS uses these quality management and continuous quality improvement processes to promote an agency-wide culture of learning and accountability.

Natural Deaths

In 2020, 29 percent (n = 15) of the child fatalities were determined by the Medical Examiner to be natural (see Table #7 in Appendix B). 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.

Of the 15 natural deaths, four had open cases with ACS at the time of death. Only one of the 15 cases was indicated for the fatality allegation at the conclusion of the investigation; five others were indicated for other allegations. Slightly more than 50 percent of the children were male (n= 8), and less than half of the 15 (n = 7) had chronic medical conditions and/or developmental issues. Across all fatality types, the average age of death in 2020 was 2.3 years of age; however, children who experienced natural deaths were older, averaging 4.3 years old, and almost half of them (n = 7, 47%) were less than six months old.

Services for Children and Families with Complex Medical Needs

The ACS Office of Child and Family Health (OCFH) leads the agency's efforts to provide access to quality health services as well as educate staff and foster care and prevention service providers on assessing whether children and adolescents' medical needs are being met.

Since 2019, OCFH and the Health + Hospitals medical consultants stationed in DCP offices across the five boroughs have utilized a Complex Needs Protocol on cases in which a child is identified as having a diagnosis or suspicion of a significant cognitive delay, neurological disorder, developmental disability, neurosensory limitation, significant neuromotor limitation, or organ system failure. In these cases, the medical consultant is required to schedule a consultation within 1-2 business days, thereby prioritizing children with the most complex and acute medical needs for immediate intervention.

Also, in 2019, ACS contracted with the New York State Office of Mental Health to procure an "ACS Access View" to the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database. This allows ACS to view Medicaid billing information for children in ACS care who have behavioral health needs. With the ACS Access View, key personnel are able to view child-specific data to support the most appropriate care and coordination for children with mental health challenges.

Other Child Safety and Prevention Initiatives

The Division of Prevention Services

ACS recognizes that children are safest when families have the supports they need to care for and raise their children. ACS has designed prevention services to help families care for their children safely at home. Casey Family Programs and other national experts have described ACS as "a national leader in investing in the continuum of prevention services and supports." New York City is one of the few child welfare jurisdictions in the country where families have access to a comprehensive, holistic, and fully funded continuum of intensive, clinical case management services geared to support, strengthen and stabilize families in order to prevent the need for out of home placement, expedite the return home from foster care and avert replacement of children already in the foster care system. ACS prevention and family home care services prevent child maltreatment and neglect by addressing the challenges families face, building upon caregivers' protective factors, and assisting them to provide a healthy and supportive environment in which to raise children. The ACS Division of Prevention Services (DPS) leads these efforts.

In July 2020, ACS implemented a new prevention continuum. Hallmarks of this new system include more therapeutic services for high-need families; universal access to all program models regardless of where the family lives; and a stronger emphasis on parent feedback, both in development of the models that offered and in the day-to-day service delivery on individual cases. Services are free and available citywide—in every community in all 5 boroughs. All prevention programs are required to offer case management services, including assessing needs for and connecting families to concrete services and supports such as diapers, cribs, navigating public benefits, and accessing housing support, among other supports. In addition, DPS has implemented programs to ensure family systems are strengthened where there is domestic violence (and court involvement) and in families with children aged zero to three.

- A Safe Way Forward: Demonstration project – A Safe Way Forward (SWF) is an innovative program (for families impacted by intimate partner violence, specifically families receiving court-ordered supervision. SWF works with the entire family system, offering separate and simultaneous trauma-informed case planning and research-informed therapeutic services to the survivor, child(ren), and the person causing harm. The staged rollout occurred in April 2019 in the Bronx and Staten Island, and more recently, ACS announced that the program will also be expanding to Brooklyn.
- GABI: As an enhancement to our prevention services offerings, ACS's Group Attachment Based Intervention (GABI) supports caregivers of young children under age four. GABI is a research-informed therapeutic intervention that serves families who have experienced significant trauma, housing instability, mental illness, domestic violence, and/or other challenges that make parenting a very young child difficult. The program provides

clinician-facilitated play therapy, allowing parents to strengthen attachment with their children, which research demonstrates reduces the risks of child maltreatment. The program also provides parents one-on-one clinical sessions and peer support through parent groups. Additionally, GABI provides families with concrete goods such as diapers and baby wipes.

System Recommendations

The safety science approach encourages proactively exploring systemic influences that impact decision making in the moment, with the goal of greatly reducing the likelihood of child fatalities. The review process seeks to identify systemic influences within individual cases and trends across multiple cases. The frequency of systemic influences informs recommendations for child welfare system improvement.

The Child Fatality Review Team screens each child fatality case reported to the SCR for ACS history to determine whether the family was “known” to ACS. Cases with current child protection, foster care or prevention services, or cases closed within the past three years or requested by the Office of the Commissioner are eligible for full review in the Systemic Child Fatality Review Process (SCFR) which includes completing a comprehensive case review, conducting human factors debriefing and mapping sessions, and using a Systems Analysis Scoring Tool to score systemic influences.

In addition to the many specific initiatives detailed in the previous pages, the ACS Systemic Child Fatality Review process identified systemic issues and recommended actions to enhance case practice, protect children and strengthen families. These include:

- Strengthening the engagement of fathers and males in families involved with ACS
  - The ACS Workforce Institute established an instructor-led course in the Motivational Interviewing sequence called “Motivational Interviewing: Engaging Fathers” to support child welfare state in engaging males in family.
  - The Division of Child Protection and other ACS program areas continue to implement the use of teams for key decision making and supervision, with a consistent focus on effective engagement of adult men.

- Increasing cross-divisional collaboration throughout the child welfare continuum.
  - ACS is in the midst of a multiyear project to strengthen collaborative relationships between the Division of Child Protection’s Family Service Unit (FSU) and Prevention providers, which often share responsibility for families that are under Court-Ordered Supervision (COS). Careful coordination is essential to make certain that appropriate services are available and delivered to families.
  - In addition, ACS is working with foster care providers to enhance collaboration with prevention services in order to help move children to extended visits, trial discharge and reunification--safely, timely and permanently.

- Provide tools to support staff in engaging mental health providers and navigating the mental health system.
    - The ACS Workforce Institute has implemented trained child welfare staff on how to work with mental illness and the mental health system. In addition, the ACS Clinical Consultation Team supports staff in assessing mental health and accessing mental health services.
    - The State's implementation of Medicaid Managed Care for children has reshaped the way that young people in ACS care are accessing services. ACS has been working closely with its contracted providers and the State to improve access to these services.

Appendix A: Manner of Death Definitions

The New York City Office of the Chief Medical Examiner determines both the cause and manner of death for each fatality for which an autopsy is conducted. The cause of death is the injury, disease or condition that resulted in the fatality, such as asthma or blunt trauma. The manner of death is based on the circumstances under which the death occurred. The following are the classifications used by the Medical Examiner:

Homicide: The Medical Examiner determines a death is due to homicide when the death results from an act of commission or omission by another person, or through the negligent conduct of a caregiver.

Natural: The Medical Examiner determines a death to be natural when disease or a medical condition is the sole cause of death.

Accident: The Medical Examiner determines a death to be an accident when the death results from injury caused inadvertently.

Suicide: The Medical Examiner certifies a death as suicide when the death is the result of an action by the decedent with the intent of killing him or herself.

Undetermined: The Medical Examiner certifies a death as undetermined when the manner of death cannot be established with a reasonable degree of medical certainty.

Therapeutic Complications: The Medical Examiner certifies a death from therapeutic complications when the death was due to predictable complications of appropriate medical therapy.

Appendix B: 2020 Data Tables

Table 4. Manner of Death (2011 - 2020)

Manner of Death	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Homicide	11	15	6	9	10	10	6	10	9	5
Undetermined	14	15	20	17	16	19	16	20	19	23
Natural	11	15	4	21	7	16	28	19	11	15
Accident	7	4	12	9	6	8	11	8	9	8
Suicide	0	1	2	2	2	0	2	2	3	0
Therapeutic Complications	0	0	0	0	1	1	0	0	0	0
Pending	0	0	0	0	[+]1	[+]*2	0	0	*6	*1
Total per year	43	50	44	58	43	56	63	59	57	52

[+]In one 2015 case and in one 2016 case, no body was found.

*In two 2016 cases, six 2019 cases, and one 2020 case the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 5. Sleep-Related Child Fatalities in ACS Known Cases (2015 - 2020)

Year of Child Fatality	Number of ACS Known Sleep Related Fatalities	Total Number of ACS Known Fatalities	Percent of ACS Known Fatalities with Unsafe Sleep Injuries
2015	21	43	49%
2016	21	56	38%
2017	24	63	38%
2018	21	59	36%
2019	20	57	35%
2020	22	52	42%

Table 6. Homicides in ACS Known Cases (2010 - 2020)

Manner of Death	2010	2011	2012	2013	2014	2015	2016	2017	2018	*2019	*2020
Homicide	10	11	15	6	9	10	10	6	10	9	5
Total Fatalities	46	43	50	44	58	43	56	63	59	57	52
Percent of Fatalities Deemed Homicides	22%	26%	30%	14%	16%	23%	18%	10%	17%	16%	10%

* In six 2019 cases and one 2020 case the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 7. ACS Known Cases Certified as Natural Deaths (2011 - 2020)

Manner of Death	2011	2012	2013	2014	2015	2016	2017	2018	*2019	*2020
Natural	11	15	4	21	7	17	28	20	11	15
Total Fatalities	43	50	44	58	43	56	63	59	57	52
Percent of Fatalities Deemed Natural Deaths	26%	30%	9%	36%	16%	30%	44%	34%	19%	29%

* In six 2019 cases and one 2020 case the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 8. Race and Ethnicity Demographics of Parents in 2020 Child Fatalities Reported to SCR ǂ

Race/Ethnicity	Families Known to ACS		Families With no Prior ACS Involvement	
	Mother	Father	Mother	Father
Asian	0	0	2	2
Black	30	34	14	14
Multi-racial	2	1	0	0
Hispanic	17	12	9	9
Other	1	0	2	2
N/A*	0	3	0	0
Unknown	0	0	0	0
White	0	0	7	7
Total	50	50	34	34

ǂ 2020 New York City child fatalities reported to the SCR alleging maltreatment associated with the fatality
*N/A = no information is available about the male in the family