SYSTEMIC CHILD FATALITY REVIEW
2024 ANNUAL REPORT

Systemic Child Fatality Review - 2024 Annual Report

Table of Contents

Introduction

The New York City Administration for Children's Services (ACS) is mandated by law to investigate alleged abuse and neglect of children residing in the City of New York. ACS also provides services and supports to prevent child maltreatment and keep children safe at home. Additionally, ACS provides care for children and youth where out of home care is necessary to ensure their safety. Often these children and their families are impacted by challenging issues such as poverty, substance use, domestic violence, and mental health concerns leading to child welfare and juvenile justice involvement. In 2024, ACS received 59,922 reports alleging child maltreatment, concerning 64,305 unique children. These reports were consolidated into a total of 51,466 child protective responses.

In 2024, ACS investigated 95 child fatalities reported to the Statewide Central Register (SCR) of Child Abuse and Maltreatment. Of the 95 child deaths, a little more than half (48) occurred in a family that had no previous contact with ACS or no contact within the last decade. This report focuses on child fatalities that happened in families with ACS involvement at the time of the fatality or within the previous 10 years. The report describes 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 ACS-involved child welfare cases, readers are encouraged to view the information in this report through the following context:

- Child fatality cases are a small fraction of cases known to ACS, comprising less than 0.1 percent of all cases investigated by ACS annually. Nevertheless, the loss of a child is tragic for the family and their community, and a death where there is past or current ACS contact requires special attention and review. Those child fatalities are the focus of this report.
- The report does not discuss every child fatality in New York City that was reported to the SCR alleging child maltreatment. As noted above, it does not review the deaths of the 48 children where there was no prior child welfare history in the past 10 years. Instead, this report reviews the 47 child fatalities from calendar year 2024 which occurred in families that were "known" to ACS because of active involvement in an ACS investigation or prevention or foster care services at the time of the fatality, or because of such involvement in the preceding 10 years.
- The report is not a comprehensive analysis of ACS cases or the agency's work with children and families, and readers are cautioned against generalizing findings. The child fatality cases examined in this report are neither a random nor representative sample of all families involved in the city's child welfare system. The purpose of the case reviews and analyses is to gather insights and lessons that can be incorporated into ACS' larger quality management and improvement processes to strengthen the child welfare system, reduce child deaths and produce better outcomes for the children and families with whom ACS has contact.
- A fatality reported to the SCR does not necessarily mean that a child died from maltreatment. Of the 47 families known to ACS, an investigation substantiated the fatality allegation in 15 cases.
- Of the 47 child fatalities in families known to ACS within the previous decade, seven were determined to be homicides.

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 requirement, with a report on fatalities from each calendar year to be issued no later than 18 months after the end of the calendar year. The law requires that this report includes, but is not limited to, the following:

a. The number of fatalities of children known to ACS as defined above 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 applicable year;

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

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

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 regular 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, and modeled after child fatality review systems developed in Tennessee, Arizona, Minnesota, Wisconsin and other jurisdictions around the country. The safety science approach encourages analyzing and applying data to drive learning and system improvements. ACS' Systemic Child Fatality Review (SCFR) process emphasizes a culture of system accountability and implements systemic methods of learning that identify and address underlying issues rather than installing quick fixes. The SCFR includes a review of fatality cases that examines the complex interplay of systemic factors, such as policies, workloads, availability of resources, supervision and training, among many other influences that may impact case practice and decision-making. The process produces data-driven learning and insights, and promotes a culture of openness and shared agency-wide accountability in order to strengthen investigative practice and the New York City child welfare system as a whole. Consistent with this approach, ACS seeks to learn and ultimately improve the system's ability to support quality case practice, secure safe outcomes for children and improve services to their families.

[1] 2018 N.Y.C. Local Law No. 19, N.Y.C. Admin. Code §§ 21-915 https://intro.nyc/local-laws/2018-19

[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) of Child Abuse and Maltreatment receives all reports of suspected child abuse and neglect for any child or youth under the age of 18. Reports may come from mandated reporters (e.g., medical staff, school officials, social service workers, police officers), professionals required by law to report any suspicion of abuse or maltreatment. Family, friends, neighbors and others can also call the SCR with concerns about a child's safety, health and well-being. Among the reports 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 child 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 there is no suspicion of abuse and/or neglect surrounding the fatality.

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 force trauma or acute and chronic bronchial asthma. The manner of death is determined by the findings of the ME's autopsy examination and the circumstances of the death. The ME certifies the "manner" as having been an accident, homicide, natural, suicide, therapeutic complication, or undetermined.[3] These classifications are administratively determined and may differ from other jurisdictions, making comparisons across systems challenging. For example, the ME may classify a death as "homicide" in which a child died in a fire where s/he was left alone without adult supervision. Yet another source of variation in "manner of death" classifications relates to sleep-related injury deaths where the child's sleeping conditions or surface may have contributed to the fatality. These deaths are oftentimes classified as "undetermined" by the ME in New York City, though this classification varies for similar cases both within New York City and in other state and county systems.

Table 1, below, provides an overview of all child fatalities reported to the SCR in 2024. In 2024, there were 48 child deaths where there had been **no** prior ACS involvement or contact with the agency within the last 10 years. The most common "manners" of death as certified by the ME for these 2024 fatalities with no ACS involvement were "undetermined" (n = 25, 52%), "natural" (n = 9, 19%) and "homicide" (n = 5, 10%). There were two cases with pending autopsies at the time of this report, and two in which no autopsies were performed by the ME. In the 48 cases, 38 % (n = 18) of the mothers were Black/African American/non-Hispanic, 38% n = 18) were Hispanic and 17% (n = 8) were white. Where information was available on fathers/male involved with the family (n = 45), 33% (n = 15) were Black/African American/non-Hispanic, 47% (n = 21) were Hispanic and 13% (n = 6) were white[4].

Table 1 also shows that there were 47 child deaths among families that were "known"[5] to ACS within the past 10 years. As stated above, a fatality reported to the SCR does not necessarily mean that a child

[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" usually when a medical device failure caused the death. Please see Appendix 1 for additional details.

[4] See Appendix B, Table 9

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

died from maltreatment. Of the 47 families known to ACS, an investigation substantiated the fatality allegation in 15 cases. Seven of these were homicides. Subsequent sections of this report focus only on the 47 child fatalities involving families known to ACS within the last ten years. (see Table 2 for specific data on cases known to ACS).

Table 1. Manners of death for all 2024 child fatalities reported to SCR

	2024 Child Deaths in Families Known* to ACS within Last 10 Years		2024 Child Deaths with No ACS History in Last 10 Years		All 2024 Child Deaths Reported to the SCR	
Manner of Death	**N**	**%**	**N**	**%**	**N**	**%**
Accident	**5**	**11**	**4**	**8**	**9**	**9**
Homicide	**7⁺**	**15**	**5**	**10**	**12**	**13**
Natural	**10**	**21**	**9**	**19**	**19**	**20**
Suicide	**1**	**2**	**1**	**2**	**2**	**2**
Undetermined	**20**	**43**	**25**	**52**	**45**	**47**
Therapeutic Complications	**0**	**0**	**0**	**0**	**0**	**0**
Pending ME determination	**1**	**2**	**2**	**4**	**3**	**3**
Other$^{\psi}$	**3**	**1**	**2**	**4**	**5**	**5**
Total	**47**	**100**	**48**	**100**	**95**	**100**

Percentages may not equal 100 due to rounding

*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.

⁺Includes homicides deaths where ACS has received the autopsy as well as homicides confirmed by OCME where the autopsy report has not been provided.

$^{\psi}$ The death did not fall under the jurisdiction of the Office of the Chief Medical Examiner (OCME) or no autopsy was performed. This includes children who were not autopsied for religious reasons or children where the hospital certified the manner of death.

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) to investigate and make a determination regarding the circumstances surrounding the death. When a DCP investigation finds "a fair preponderance of the evidence"[6] that abuse and/or neglect may have taken place in relation to any of the allegations, the report is defined as

[6] On January 1, 2022, New York State implemented legislation that change the evidentiary standard for indicating child protective investigations from some credible evidence to a fair preponderance of the evidence. This means that CPS must weigh the information collected in its totality and determine whether the evidence collected that supports the allegation is stronger than the evidence gathered that does not. (From 21-OCFS -ADM 26, issued Nov. 4, 2021.)

"indicated." Alternatively, if the evidence collected does not meet the aforementioned standard, the report is classified as "unfounded". 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.[7] For example, a case may involve an allegation of educational neglect being "substantiated" for the deceased child and/or a sibling, but the fatality allegation may be "unsubstantiated." Therefore, some investigations result in an indication, though not all allegations have been substantiated. In addition to DCP investigations, the New York City Police Department and District Attorney also investigate some child fatalities to determine criminal culpability, and whether or not to pursue criminal prosecution.

Case Review Criteria – Cases with ACS History

The ACS 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.[8] A family is considered "known" if it meets any of the following criteria:

a. Any adult in the household has been the subject of an allegation of child abuse or maltreatment to the SCR within 10 years preceding the fatality; OR
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 or categories:

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 ACS Office of the Commissioner requested a review.
2. A prior ACS case was closed more than 3 years ago but within 10 years.

The reviewers draft summaries of all cases in category one and these are eligible for the full ACS Systemic Child Fatality Review Process; cases in category two receive a case summary only.

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 promote the safety of any surviving siblings and/or family members. Throughout the investigation, as more information becomes

[7] 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 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."

[8] Although the family may have been known, it does not mean that the decedent was the maltreated child or alive during the prior ACS involvement.

available, DCP may take additional actions to assure child safety. The ACS fatality review team within the Division of Policy, Planning & Measurement also receives notification of each fatality. The team 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.

The review includes an examination of the family's ACS history as well as available autopsy reports and records from service providers that had contact with the family. Additionally, to understand family and child functioning prior to the fatality, the team examines the child welfare histories of all adults living in the household, whether related or not, as well as others involved with the child, such as parents, significant others, grandparents, aunts/uncles, and others with known caregiving responsibilities.

The ACS 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 discussed with an Interdivisional Team (IDT), consisting of cross-divisional ACS staff, to identify whether a more comprehensive analysis of the case would generate learning points or areas for study of internal and external systemic influences that impact child safety. When cases are selected for a comprehensive analysis, staff involved with the corresponding learning points/areas for study are invited to participate in a human factors debrief. In 2024, 37 of the 47 child fatality cases were 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' involvement. Debriefings add to the technical review by uncovering and deepening the understanding of the elements involved in decision making. Debriefings are voluntary and typically include child protection specialists and their supervisors, but may consist of other staff, such as agency attorneys. During debriefings, all efforts are made to create a safe and supportive environment for staff to provide insight and identify opportunities for learning and improvement.

Cases selected for a full review are mapped, a process whereby borough-based multidisciplinary teams (Mapping Teams) of staff from child protection services as well as other ACS divisions discuss local, regional and regulatory conditions or processes that may affect case practice and decision making. Information gathered from the completed case summary review, human factors debriefings, and mapping sessions is analyzed to identify systemic influences[9] and key findings which are used to produce recommendations that will lead to system improvements. In 2021, ACS added Systems Learning and Improvement Sessions (SLIS) to the SCFR process to further explore systemic themes as well as propose recommendations for consideration and implementation by ACS leadership.

[9] See Appendix C for list and definitions of systemic influences

2024 Cases Reviewed

Manner of Death

In 2024, there were 47 fatalities of children in families that had been the subject of an investigation or otherwise received services from ACS within the last 10 years, were receiving services, or were the subject of an investigation at the time of the fatality. The most common "manners" of death as certified by the ME for 2024 fatalities were "undetermined" (n = 20, 43%), followed by "natural" (n = 10, 21%) and "homicide" (n = 7, 15%), see Table 2.[10] At the writing of this report, there was one case pending ME determination and three in which no autopsy was performed or were out of jurisdiction.

Table 2: Manners of Death for Systemic Child Fatality Cases in 2024

Manner of Death	Total 2024	
	N	%
Accident	5	11
Homicide	7	15
Natural	10	21
Suicide	1	2
Undetermined	20	43
Therapeutic Complications	0	0
Pending ME Determination	1	2
Other[ψ]	3	1
Total	47	100

Percentages may not equal 100 due to rounding

[ψ] The death did not fall under the jurisdiction of the Office of the Chief Medical Examiner (OCME) or no autopsy was performed. This includes children who were not autopsied for religious reasons or children where the hospital certified the manner of death.

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

Undetermined and Accidental: Sleep-Related Injuries

In 2024, 43 percent (n = 20) of the 47 child fatalities in families previously known to ACS included indicators of possible 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 (see Table 5 in Appendix B). The ME often designates and records the manner of death for these cases 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 a fatality where there is bed sharing, or an infant is found alone in a crib or bassinet in which soft bedding is present.

While unsafe sleep is not a manner or cause of death certified by the ME, the ME may note the presence of contributing unsafe sleep factors when determining the manner of death. Unsafe sleep conditions can include factors such as bed sharing with an adult or sibling; infants sleeping with pillows, blankets, or other objects in the crib (which can create a risk of entanglement and/or asphyxia); and defective or unsuitable sleeping furniture for an infant, such as an air mattress, couch, or car seat. Of the 20 child fatalities with unsafe sleep conditions noted, the ME certified ninety percent (n = 18) as having an undetermined manner of death. In addition, a review of case records and autopsy findings indicate that the most common unsafe sleep conditions were bed sharing with an adult and/or a sibling and objects such as blankets and pillows on the sleeping surface. Of the 20 sleep-related fatalities, all but three were of children less than six months old. More than half of the 20 children were male (n = 11, 55%) and 45% (n = 9) were female. Eight of the sleep-related fatalities occurred in families with an open ACS investigation or an open case at the time of the death.

Natural Deaths

In 2024, 21 percent (n = 10) of child fatalities in families known to ACS were determined by the Medical Examiner to be natural (see Table 8 in Appendix B). The ME determines the manner of death to be natural when disease or a medical condition is the cause of death. Examples of common natural causes in child fatalities include acute and chronic bronchial asthma, pneumonia, and congenital conditions.

Of the 10 natural deaths, four had open cases with ACS at the time of death. Seven of the children were male, and five of the 10 children were noted to have had chronic medical conditions. Across all fatality types, the average age at death in 2024 was 2.9 years of age, while on average, children who experienced natural deaths were older, 4.7 years old. Natural causes of death in 2024 were linked to multiple reasons such as acute viral and bacterial infections, congenital anomalies, diabetic ketoacidosis, and acute exacerbation of asthma.

Homicides

In 2024, the Medical Examiner classified seven child deaths (15%) in families known to ACS as homicides. The ME classifies a death as homicide when the fatality results from an act of commission (such as physical assault) or omission (such as leaving toxic drugs or medication where it is accessible to a young child) by a perpetrator. The number of fatalities due to homicide varies from year to year (for a longitudinal view, see Table 7 in Appendix B). Children in this category varied in age from two months to eight years old. Three of the deaths occurred in open cases. In four of the cases, either the mother or father had a history of mental health concerns and/or substance use. Among the seven fatalities, perpetrators included parents, relatives and unrelated individuals.

Case Demographics and Family Characteristics

The 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 including the race and/or ethnicity of the parents/caretakers; the number and ages of children in the family; and the gender of the children.

The review team also gathers information on the presence of potential risk factors, such as:

a. Whether the child had any documented developmental, medical or mental health conditions;
b. Whether the family had a history of homelessness within four years prior to the fatality, and whether the family was residing in a shelter at the time of the fatality;
c. Extent of history with ACS, including the parents' history with child welfare as children and the number of previous investigations of the family;
d. 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;
e. Identification in the case record of parent or caregiver mental health condition;
f. Identification in the case record of parent or caregiver substance use;
g. Identification in the case record of household domestic violence within the last four years;
h. Whether the family had an open case at the time of the fatality.

The following is a review of case characteristics for the 2024 fatalities (n = 47); Table 3 provides demographic information for the 47 children.

Table 3: Demographics

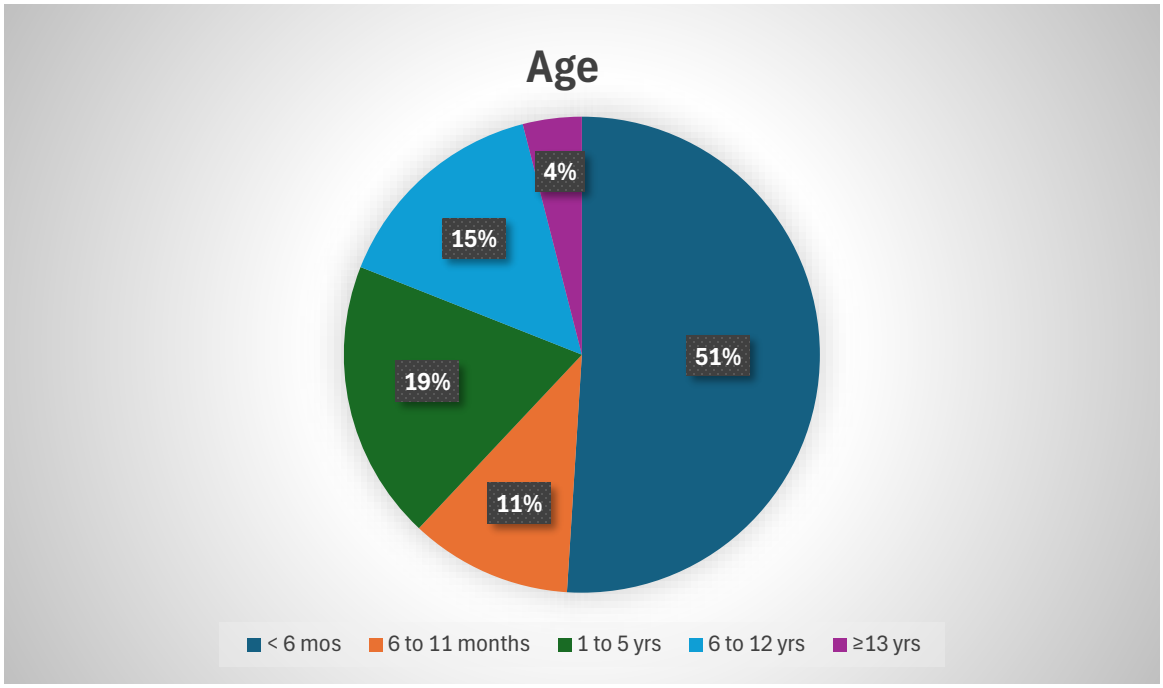
Demographics	n	%
Race (of mother, n = 47)		
Asian	0	0
Black	26	55
Hispanic	19	40
Pacific Islander	0	0
American Indian/Alaska Native	0	0
Biracial/Multiracial	0	0
White Non-Hispanic	2	4

Not Available	0	0
Other	0	0
Unknown	0	0
Gender (of child, n = 47)		
Female	18	38
Male	29	62
Age (of child, n = 47)		
<6 months	24	51
6 to 11 months	5	11
1 to 5 yrs	9	19
6 to 12 yrs	7	15
≥13 yrs	2	4

Percentages may not equal 100 due to rounding

Mothers were most likely to be Black/African American/non-Hispanic (55%) or Hispanic (40%). Data was also collected on the fathers or males involved with the family. Of the 47 fathers/involved males, 53% (n = 25) were identified as Black/African American/non-Hispanic, 38% (n = 18) were Hispanic, two were White and the remaining two were of mixed race.[11]

Figure 1. Child's Age at Time of Fatality



Percentages may not equal 100 due to rounding

As in previous years, the most vulnerable children at risk of fatality were of the youngest ages. In 2024, the average age of the children was 2.9 years and the median age at death was 6.0 months, slightly

[11] Data on race and ethnicity of mothers, fathers and males involved with the family is based on information available in CONNECTIONS.

lower than the 6.6 months recorded in 2023. Children's ages ranged from zero months to 15.5 years of age. Almost two-thirds (62%, n = 29) of the fatalities were of infants under the age of one, and of these, eighty-three percent (n = 24) were less than six months of age. Children under the age of six, including infants, made up 81% (n = 38) of the 2024 fatalities. Of the 47 child fatalities in 2024, males accounted for 62% while females were 38%. For the 29 fatalities where the children were less than one year of age, 18 (62%) were male and 11 (38%) were female.

More than a third of the cases (n =16, 34%) were open with ACS at the time of the fatality; this includes open investigations and families receiving foster care and/or prevention services.

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 regarding the deceased child(ren) and/or surviving siblings. Of the 47 cases, almost a third (n = 15, 32%) were unfounded, i.e., no allegation was substantiated (see Table 5 in Appendix B). Of the 32 cases where one or more allegations were substantiated, the fatality allegation was substantiated for 15 of the 32 indicated cases. While a fatality allegation may be substantiated, this does not mean the Medical Examiner deemed the death a homicide or that the parent/caretaker intentionally harmed the child. A close reading of case circumstances is necessary to fully understand the substantiation decision made by the child protection team. For example, fatality allegations may be substantiated in some cases where the Medical Examiner ruled the manner of death as an Accident or Undetermined, yet child protection services concluded that the adult caregiver's actions or inactions placed the child at risk of death.

Many of the families known to ACS prior to the fatality faced multiple challenges. These included recent histories of reported domestic violence within the previous four years, which was noted in 57 percent (n = 27) of the cases reviewed. Recent or ongoing housing instability was noted in nine cases with three families residing in a shelter at the time of the fatality. Fifty-one percent (n = 24) of the mothers had histories of ACS involvement as children and of those, 42 percent (n = 10) had a history of foster care placement as children. For the males involved with these families where information was available (n = 47), 28 percent (n = 13) had histories of ACS involvement as children, and eight had a history of foster care placement.

Case records indicated that the average age of mothers in 2024 was 29.7 at the time of the child's death, similar to the average age of 30.1 years recorded in 2023. The median age of mothers was 30 years in 2024, the same as 2023. Eleven of the mothers of children who died in 2024 were under the age of 18 at the birth of their first child. Consistent with previous years, the mothers had, on average, three children. The youngest recorded age of a mother was 16 years old. A review of the case records for the 47 families where a child died shows that 55 percent (n = 26) of the mothers had documented current or prior substance use. In addition, 45 percent (n = 21) also had current or ongoing mental health concerns (diagnosed or undiagnosed and apparent in child protection services assessments), which sometimes co-occurred with past or current substance use.

Data collected and available on the 47 father/male involved with the family at the time of the fatality showed that 87 percent (n = 41) 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 45 percent (n = 21) of the cases, current or prior substance use was recorded. Current or past mental health concerns specific to the father/involved male were noted in nine cases. The average age of the father/involved male was 33.1 years of age, with the youngest being 14 years old.

The Multidisciplinary Review Panel

In 2025, ACS launched the Multidisciplinary Review Panel (MRP), a New York State Office of Children and Families (OFCS) approved Child Fatality Review Team (CFRT). The panel brings experts external to ACS into the child fatality review process to help identify systemic solutions and offer recommendations for improving the City's ability to protect children and support families. The MRP includes child welfare stakeholders as well as representatives from other City and State government agencies and other professions, including leaders in the fields of child abuse pediatrics, the criminal justice system, mental health, accident prevention, parent advocacy, and community-based services. Through this state-approved process, the panel has access to confidential case information that helps panelists gain insight into child welfare practices and enhance cross systems learning and improvements.

The Multidisciplinary Review Panel meets at least three times yearly to discuss trends and patterns (systemic influences), including the intersection of child welfare and other public/private agencies and systems that interact with families or that provide services to families experiencing circumstances similar to those in which a child fatality has occurred. The panel reviews case documentation on fatalities in families recently involved with ACS services, as well as aggregate trend data related to critical issues identified in the systemic child fatality review process such as sleep-related injuries, mental illness, homelessness, substance and alcohol misuse, intimate partner violence, investigative practices and staffing challenges. Systemic elements explored may include: ACS' operations, policies, practices, training and fiscal resources; coordination and/or collaboration with entities external to ACS, such as law enforcement, courts, health care, mental health care and social services, and related cross-system challenges; and government and regulatory bodies, including city, state, and federal oversight and accreditation bodies, including laws, regulations, policies and other mandates that impact decision making and service delivery.

During 2025, the MRP reviewed detailed case information related to child fatalities that involved families with repeated involvement in the child protection, health care, behavioral health and homeless shelter systems; teens struggling with serious mental illness; and young children with profound developmental disabilities. The panel offered several recommendations to improve cross-system collaboration to support families and young people. These included establishing more comprehensive and collaborative discharge planning from hospital for ACS-involved children and youth with special medical needs; improving information sharing between ACS and the Department of Homeless Services to obtain the most appropriate services for ACS-involved families that have extensive shelter history and substantiated child abuse and/or maltreatment; and enhancing team conferencing across service providers and with families for youth with highly complex needs.

Recent Initiatives to Strengthen Child Safety Efforts and Reduce Child Fatalities

Maintaining Manageable Child Protection Workloads

The top priority for ACS is child safety. In all child protection cases, the ACS Division of Child Protection (DCP) determines whether or not a child is in immediate danger of serious harm and in those circumstances where a child is assessed not to be safe, ACS immediately intervenes to protect the child.

This requires child protection teams to respond quickly to reports of possible maltreatment; to visit and interview family members named in reports; to speak with others who know the family such as school staff, medical providers, and friends and relatives; and to constantly assess for child safety.

ACS continued its efforts to maintain manageable workloads for child protection staff so that their work is completed both timely and well. Factors that impact workload include the number of new case assignments each team receives; the nature and complexity of the cases assigned; hiring and attrition rates of staff; and the many practice requirements mandated by city and state policy and regulation.

ACS has substantially reduced caseloads for child protective staff in recent years. As of April 2026, the average caseload for ACS Child Protective Specialists (CPS) was just 7.6—down from 10.6 in April 2023, and almost 50 percent below the most recent high of 14.4 in April 2018. The national standard for child protection investigations is 12 cases.

ACS achieved its caseload reduction through a variety of strategies, including hiring and training new child protection staff well ahead of attrition. In 2024, ACS onboarded and fully trained 491 new CPS. In 2025, 428 new CPS completed training and joined teams working in communities across the city. This means a total of 919 new CPS joined investigative teams over the last two years**.**

In addition, ACS has eliminated duplicative and outdated policies and guidance, and simplified case documentation requirements, including for transfers of court ordered supervision cases from child protection investigative teams to family service units, so that the investigative teams can spend more time focused on the assessment of child safety and support for families, and less time on administrative tasks.

ACS has also been working closely with the public schools and other city human services systems to help mandated reporters better assess when a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR) is necessary and when it is not, so that our child protection teams are able to focus more closely on situations where children are at risk of harm. Since January 2023, ACS has conducted more than 450 sessions for over 29,000 mandated reporters from the social services, education and the health and mental health sectors as of June 2026.

These ACS sessions are based on the mandated reporter training produced by the New York State Office of Children and Family Services (OCFS), and explain the legal standard for appropriate reports to the SCR, i.e. that a report is required when a professional has reasonable cause to suspect child abuse or

maltreatment by a parent or other person legally responsible for a child.[12] The sessions encourage individuals to reach out to the ACS Support Line (212-676-7667) to connect a family to appropriate supports, when they know a family is facing challenges but there is no serious concern about a child's safety. The Support Line is staffed by licensed social workers and acts as a resource and "warm line" connecting families to free, voluntary, in-home support services, assistance with basic needs (like diapers and food), mental health resources, and substance use support.

As a result of this work, SCR reports from the social services, education and health/mental health sectors declined by 14% between 2023 and 2025. Reports from schools, one of the categories least likely to result in an investigative finding of abuse or maltreatment, decreased by 17% from 2023 to 2025. Last year, the percentage of reports from schools that resulted in a finding of abuse or maltreatment increased, from 13.7% in 2024 to 16.0% 2025, reflecting greater scrutiny when making reports. The Support Line now receives more than 4,000 inquiries per year. These results suggest this work is resulting in fewer unnecessary investigations and continued reports when necessary. Reducing the time spent on unnecessary investigations enables ACS child protection teams to identify and respond to the highest priority cases, where children are most at risk.

Enhanced Oversight of High-Risk Cases

The Quality Assurance team within the Division of Child Protection (DCP QA) reviews hundreds of the City's highest risk cases each month, in the initial phase of the investigation, to flag potential risks or signs of abuse/neglect and make certain that investigators have followed required protocols. These QA reviews include real-time coaching and support for child protection teams and identify any needed training or workforce development needs for staff. Cases for review are identified in part through the use of a predictive risk model developed by ACS. The model uses data already known to ACS in the case record to identify children at elevated risk of serious physical or sexual harm.

The ACS Heightened Oversight Process (HOP) remains a key procedure for promoting child safety during high-risk cases involving young children. Implemented in 2017, HOP provides a structure for collaboration and consultation among child protection investigative teams and the Investigative Consultants, an ACS team of former NYPD detectives and supervisors housed with the ACS Office of Investigations. The HOP is initiated on SCR reports containing allegations of a fatality, serious injury, or sexual abuse of children three years old or younger, as well as any reports that contain children three years of age or younger where the parent/caregiver named in the report has had one or more children removed and placed in ACS foster care prior to the current investigation, and the child(ren) and parent have not been reunified. The HOP team identifies an investigative strategy at the initiation

[12] Appropriate reports to the SCR must include a related concern or suspicion of a safety risk to the child, wherein the reporter has "reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent or other person legally responsible comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child" (NYS SSL § 413(1)). ACS is obligated to open a case, either by initiating an investigation or Family Assessment Response (FAR), whenever the SCR accepts a report and transmits it to ACS. In all child protective cases, including those with substance misuse allegations, CPS are responsible for assessing child safety and a family's service needs on a case-by-case basis, looking at actual or potential harm to a child and the parent's capacity to care for the child

of the investigation and provides guidance through conferencing to determine whether additional investigative steps are needed.

Recently, ACS shifted the role of the Investigative Consultants to focus their time and resources more acutely on investigations where they are most likely to be able to assist in assessing and addressing safety and the risk of harm to children. Child protection teams now request their involvement on the higher risk investigations, rather than referring every investigation for clearances and review. The Investigative Consultants work with child protection to support risk and safety assessments when heightened safety concerns are present and provide guidance on cases involving law enforcement. Additionally, the Investigative Consultants support child protection teams to receive timely responses from police when needed, including when law enforcement is the source of an SCR report. Since May 2025, the ACS Office of Investigations has used a hotline number to NYPD to request expedited police involvement when needed, which has resulted in improved response times for police assistance. The Office of Investigations continues to train NYPD investigators as well as newly promoted supervisors on child protection services.

Supporting Families that have Complex Needs

The ACS Clinical Support Program (CSP) connects licensed and/or credentialed mental health and addiction counseling professionals to child protection teams as they work with families who are experiencing complex mental health, intimate partner violence, and substance misuse related challenges. CSP clinicians enhance each child protection team's ability to appropriately respond to related challenges and engage families who may be otherwise reluctant to share information with the CPS team.

CSP clinicians are embedded within ACS's child protection borough offices and offer the following supports:

- Direct consultations with the child protection team to discuss presenting concerns, engagement strategies, clinical insights, and/or service planning on individual cases.
- Direct engagement with families to discuss presenting concerns, clinical insights, and/or service planning.
- CASAC screenings and/or brief interventions to support engagement, identify possible presence or extent of substance use concerns, and raise awareness for a need for change.
- CASAC assessments with family members to identify patterns of substance use, routine, frequency, and duration, and provide feedback on related impact to functioning and family child safety.
- Participation in family team conferences to support safety and service planning.
- Referrals of families to services and facilitating of a warm handoff with service providers.

In 2026, ACS launched the new CSP as an improvement on its previous Clinical Consultations Program (CCP). In the prior model, CPS teams requested support in most cases, and clinicians were highly specialized. The high volume of requests limited the frequency and level of direct engagement with

families. It also affected the timeliness of guidance. Child protection teams expressed that they needed consultations to be quicker, more individualized, and more involved.

The CSP model targets a smaller number of cases that are especially complex and need a deeper level of support, with a goal of supporting around one-third of child protection cases annually. Supervisors and managers are required to review and authorize all requests for CSP support and otherwise support child protective specialists for cases that have less complex needs. Except for a Certified Alcohol and Substance Abuse Counselor (CASAC) intervention, a single clinician can now provide support for cases with multiple presenting concerns. These improvements allow clinicians to provide more individualized services, and they can engage deeper and longer with a family for those cases that need it. This improves the quality and depth of support and partnership, and transfers some work, like service referrals and warm handoffs, to clinical experts.

ACS also provides medical expertise to its child protection teams. The ACS Office of Child and Family Health (OCFH) and the Chief Medical Officer are charged with ensuring that all children in the care of ACS have access to physical and mental/behavioral health care that is comprehensive, appropriate, and in-line with current best practice standards. OCFH also oversees the ACS Medical Consultation Program, which is a decade-long pioneer effort that adds the medical expertise of nurse practitioners from NYC Health + Hospitals/Bellevue (Bellevue) as medical consultants in high priority child welfare investigations involving medically related issues. They are supervised by Bellevue Physicians with expertise in child abuse and who have access to the hospital's subspecialty network. Medical Consultants are stationed on-site at child protection borough offices to assist child protection staff with education and support during investigations involving medical concerns, including assistance when communicating and interacting with medical personnel.

OCFH has also expanded the ACS Developmental Disabilities Unit (DDU), hiring additional staff to serve as liaisons to the DCP borough offices to ensure that children, youth, parents, caregivers and/or other adults involved in the child welfare system who are suspected of or diagnosed with an intellectual or developmental disability receive the necessary attention and service. The liaisons provide case consultation, technical support, resources, and guidance to child protection teams. Liaisons also participate in multi-disciplinary team meetings, child safety conferences and other types of family conferences when appropriate given case circumstances. In addition, the liaisons facilitate regular DDU trainings for child protection staff.

ACS Safe Sleep Strategy

Between 40 to 50 babies in New York City die from sleep-related injury each year[13]. The U.S. Centers for Disease Control and Prevention (CDC) estimates that there are about 3,500 sleep related deaths reported nationally; this rate has been increasing since 2020[14]. An earlier CDC analysis[15] also shows that the high-risk practice of 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. In addition, the American Academy of Pediatrics published a 2022 report which noted that sleep related

[13] Sudden Infant Death Syndrome - NYC Health
[14] Trends in SUID Rates by Cause of Death, 1990—2022 | SUID and SIDS | CDC
[15] Vital Signs: Trends and Disparities in Infant Safe Sleep Practices — United States, 2009–2015 | MMWR

fatalities have notable and persistent racial, ethnic and socioeconomic disparities[16], which aligns with New York City findings, published in April 2025[17].

ACS implements the NYC Infant Safe Sleep Initiative through the Division of Child and Family Well-being (CFWB) to prevent sleep-related infant injuries and deaths and to promote and protect the health and well-being of the youngest New Yorkers, including by addressing long-standing disparities. The initiative focuses on community engagement, public awareness campaigns, free training and resources, collaborations and stakeholder partnerships to increase infant survival in NYC. The initiative has also convened child-serving professionals and advocates to share information about strategies on preventing the tragic loss of infants to sleep-related injury deaths.

In addition to housing the NYC Infant Safe Sleep Initiative, ACS' efforts include public education, training, and resource distribution to support parents and child-serving professionals to understand the risks of and prevent injuries and fatalities that affect children under age six, including those related to parental stress; inadequate supervision near water and windows; and unintentional poisoning caused by exposure to toxins, medication, or cannabis-infused edibles. ACS offers free resources, supplies, trainings and public campaigns to heighten awareness about how to keep children safe.

Infant Safe Sleep Initiative Activities

During 2025, the ACS Office of Child Safety and Injury Prevention (OCSIP) continued its work to address infant safe sleep practices. Most notably, OCSIP:

- Distributed more than 17,000 Safe Sleep Toolkits to discharging maternity patients at all 11 NYC Health + Hospitals medical centers.
- Sustained a hybrid training model—providing both free in-person and virtual trainings for parents, caregivers and child-serving professionals. The interactive caregiver workshops highlight potential barriers to adopting safe sleep practices such as housing quality concerns (i.e. lack of heat, vermin), explores caregiver stress and fatigue, and encourages peer-to-peer support, where caregivers brainstorm strategies and practical solutions on how to manage inconsolable infant crying and feelings of being overwhelmed. The child-serving professionals training provides tips on leading a strengths-based conversation with caregivers that build trust, address resistance and help families understand the life-saving importance of adopting infant safe sleep practices.
- Provided virtual and in-person infant safe sleep training to more than 5,400 parents and caregivers and over 1,000 child-serving professionals, including the NYC Department of Homeless Services staff. In addition, more than 850 child welfare professionals completed the Safe Sleep eLearn Course, "Communicating Infant Safe Sleep Practices," designed to dispel common myths and misconceptions about infant sleep, identify the behaviors that may contribute to sleep-related injury deaths, establish and practice Safe Sleep habits, and guide child-serving professionals on how to lead strengths-based conversations with parents and caregivers around implementing infant safe sleep practices.

[16] Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment | Pediatrics | American Academy of Pediatrics

[17] infant-sleep-2025

- 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 shelters, modeling a safe sleeping environment for parents and caregivers and simulating the suffocation risks associated with stomach/side sleeping and the use of excess bedding like blankets, quilts, and comforters.
- In October 2025, during Infant Safe Sleep Awareness Month, ACS 1) released an Op-Ed with guidance for parents and caregivers[18], 2) conducted weekly virtual Infant Safe Sleep workshops in both English and Spanish for parents and caregivers across New York City, including those residing in New York City Housing Authority (NYCHA) housing, and 3) partnered with the ACS Division of Family Permanency Services' Older Youth Services to deliver an annual Infant Safe Sleep Symposium for expectant and parenting foster youth.
- In October 2025, released on a series of 14 educational videos for parents and caregivers on various social media platforms highlighting infant safe sleep recommendations, cold weather guidance for infant sleep, crib and car seat safety, and tips for addressing caregiver overwhelm and fatigue.
- Issued a Press Release during the winter months—between December and February—to remind parents caregivers to use a sleep sack in place of a blanket to keep infants warm during the cold winter months.
- Continued to partner with several Mayoral agencies, including the NYC Department of Health and Mental Hygiene, NYC Department for Homeless Services, the NYC Housing Authority, NYC Health and Hospitals, NYC Department for the Aging, NYC Fire Department, NYC Police Department, the NYC Department of Transportation, and community stakeholders across NYC to deliver infant safe sleep training and resources.
- Conducted crib demonstrations at in-person community events and shelters, modeling a safe sleeping environment for parents and caregivers and simulating the suffocation risks associated with stomach/side sleeping and the use of excess bedding like blankets, quilts, and comforters.

Strengthening Engagement with Fathers

Fathers play a pivotal role in children's physical, cognitive, emotional and social development, and research has shown that fathers' engagement led to improved outcomes for their children in many areas.

In 2026, to encourage greater integration and enhancement of fathers' involvement with services and supports, ACS launched the Office of Fatherhood Engagement to lead and manage fatherhood initiatives at ACS. The Office provides consultation to the various ACS divisions about best practices for engaging fathers, spreading awareness about resources available to fathers, and engaging community stakeholders to develop father/child initiatives.

[18] october-infant-safe-sleep.pdf

Fathers can also play a critical role in supporting pregnant or postpartum partners experiencing perinatal mood and anxiety disorders (PMADs) that might interfere with their ability to care for the child and the family. ACS continues to partner with a comprehensive treatment center to address maternal mental health. Services include support groups, therapy, and medication management as well as training for child welfare staff on how to work with families impacted by mental illness and navigating the mental health system. In late winter 2024-2025, ACS recorded six videos in the "Fathers and Mental Health: Unspoken Conversations" series to hear directly from fathers about their journeys to fatherhood. These unspoken conversations may interfere with a father's ability to care for the child and family; but with supportive resources fathers can get the help they need, build confidence, and become "life preservers" to their families. In 2025-2026, ACS also offered educational webinars focused on Maternal Mental Health - Intersection of Trauma, Perinatal Substance Use and Interpersonal Violence.

System Recommendations

The safety science approach to reviewing child fatalities encourages proactively exploring systemic influences that impact decision making in the moment, with the goal of reducing the likelihood of future deaths due to abuse and/or neglect. The 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.

In addition to the many specific initiatives detailed in the previous pages, the ACS Systemic Child Fatality Review process identified recurrent systemic themes noted in the review of 2024 cases. The most prevalent themes were Teamwork/Coordinating Activities within the agency and across other systems, Knowledge Gaps around assessing and safety planning with families where there are children with special medical needs and Family Conflicts, particularly working with families where there is intimate partner violence. Other themes included child/adolescent medical concerns, and caregivers' mental health and substance use concerns. The ACS Multidisciplinary Review Panel also flagged concerns related to child and adolescent medical concerns.

Strengthening Teamwork/Coordination

Child welfare practitioners collaborate and partner with many individuals, service providers, and other systems every day to keep children safe. Families known to ACS encounter many individuals and systems over the course of a child's life, including health care, schools, youth services, housing services, and many others. A large portion of child welfare work depends on contacting and fostering relationships with these collaterals for assistance to make sure families are supported and decisions are informed by the most relevant information. During reviews conducted in 2024, child protective teams conveyed difficulty connecting with collaterals to help ensure comprehensive assessments of children and their caretakers/families. During 2025 and 2026, ACS child protection teams across the city devised and implemented continuous quality improvement plans to strengthen the timely gathering of information from critical collateral contacts during the initial safety assessment on each investigation. These efforts included developing stronger relationships with local schools, police precincts and other mandated reporters to increase the timeliness of responses to ACS investigators' contacts.

The MRP recommended implementing enhanced conferencing for youth with highly complex needs, to improve the ability to support families and children engaged with multiple systems and provider agencies. As a result, ACS is developing criteria and a protocol for facilitation of case conferences to support service planning for teens with especially complex health and mental health needs. And ACS is partnering with other systems to develop a joint protocol for timely well-supported access to appropriate services for teens with very challenging mental illness—including perinatal wrap-around supports for pregnant and parenting youth with serious mental illness.

Addressing Knowledge Gaps

During reviews conducted in 2024, child protective teams discussed challenges with implementing the agency's Assessment and Safety Planning with Special Medical Needs Children policy. The ability of child protection teams to complete all required tasks related to this policy were impacted by several factors, including fully understanding the policy, uncertainty about what medical conditions fell into this classification as well as the length of service and experience of the staff linked to staff attrition and high caseloads.

In addition to implementing strategies to manage caseloads and better clarifying the policy through trainings and supervision, the agency has also enhanced coaching and support in these areas and implemented the new Clinical Support Program described above.

Additionally, the Project Management and Data Innovation (PMDI) Unit serves as the Division of Child Protection's internal unit with a mission of providing support to the boroughs and programs by streamlining the effectiveness and efficiency of DCP objectives and initiatives. This includes infusing data to inform staff strengths in practice, identify areas that need attention and provide leadership with performance metrics that directly link to improving assessments and the caliber-of-service delivery to children and families we encounter.

Better Supporting Children in Homes with Family Conflict

Family Conflict, and in particular intimate partner violence, touched many of the children in families that experienced a child fatality, as it does children generally involved with the child welfare system. The data indicates that recent or current intimate partner violence was present in 57% of the 2024 child fatalities. Domestic Violence Incident Reports (DIRs) revealed a history of violence with previous partners and in current relationships for both the person causing harm and for survivors. In many cases, children were impacted by witnessing a great deal of violence and familial discord.

To support safety, child protection teams continue to access NYPD liaisons who serve as points of contact for the ACS Office of Investigations staff. In addition to a liaison in the Chief of Departments and the Domestic Violence Unit, ACS has a liaison in each of the eight NYPD Patrol Boroughs to assist with investigative concerns, including promoting contact when the NYPD is the source of a report to the SCR.

And to strengthen service planning and access to resources for families experiencing intimate partner violence, the new Clinical Support Program provides child protection teams with focused expertise through training, consultations and hands-on support during investigations and family service cases. While ACS has had clinical consultants in place for many years, in 2026, after an RFP and contracting process, ACS reoriented the services offered to provide targeted clinical expertise and support for child

protective teams working with families and children that have especially complex challenges related to mental health, substance misuse and/or family conflict. The new program includes working directly with families, when appropriate.

ACS continues to contract with providers of A Safe Way Forward. This innovative program serves families where intimate partner violence has been identified. The program works closely with intimate partner violence survivors, the persons causing harm and children, providing trauma-informed case planning and research-informed therapeutic services.

ACS continues to partner with the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV) to collaborate on best practices to support families experiencing intimate partner violence, including exploring effective training models for child protection staff. The two agencies meet quarterly with the goal of strengthening relationships among service providers including NYC's Family Justice Centers which provide gender-based violence survivors with legal, economic and other supports, as well as provide training to child protective staff working with families experiencing violence.

The ACS Office of Training and Workforce Development (OTWD) continues to offer training on identifying and addressing intimate partner violence, building skills and knowledge to assess and engage the survivor, the person causing harm and their children, as well as safety planning.

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: 2024 Data Tables

Table 4. Manner of Death for Child Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2015 - 2024)

Manner of Death	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Accident	6	8	11	8	9	8	11	9	7	5
Homicide	10	11	6	10	11	5	10	9[+]	8	7[+]
Natural	7	16	28	20	15	16	12	9	8	10
Suicide	2	0	2	2	3	0	0	0	1	1
Therapeutic Complications	1	1	0	0	0	0	0	0	0	0
Undetermined	16	19	16	19	18	23	19	11	17	20
Body not Located	1	1	0	0	0	0	0	0	0	0
Pending	0	0	0	0	0	0	1*	0	2*	1*
Other[Ψ]	0	0	0	0	1	0	0	1	2	3
Total	43	56	63	59	57	52	53	39	45	47

[+]Includes homicides deaths where ACS has received the autopsy as well as homicides confirmed by Office of the Chief Medical Examiner (OCME) where the autopsy report has not been provided.

*Represents cases where the OCME has yet to provide the completed autopsy or determine the manner and cause of death.

[Ψ]The death did not fall under the jurisdiction of the OCME, or no autopsy was performed. This includes children who were not autopsied for religious reasons or children where the hospital certified the cause of death.

Table 5. Investigation Decision on Fatality Allegations in Families Known to ACS in Previous Decade with Fatality Reported to SCR (2015 - 2024)

Year	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Fatality Allegation Substantiated	13	21	23	24	21	11	16	11	12	15
Other Allegation Substantiated (excluding fatality)	13	13	15	13	21	15	10	9	10	17
Unfounded Investigation	17	19	25	20	14	24	27	14	22	15
Total Investigations*	43	53	63	57	56	50	53	34	44	47

*Some investigations involved families with more than one child fatality

Table 6. Sleep-Related Child Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2015 - 2024)

Year of Child Fatality	Number of ACS Known Sleep Related Fatalities	Total Number of ACS Known Fatalities	Percent of ACS Known Fatalities that had 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%
2021*	20	53	38%
2022	15	39	38%
2023*	20	45	44%
2024*	20	47	43%

*Denotes years where the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death on case(s).

Table 7. Homicides in Families Known to ACS in Previous Decade and Reported to SCR (2015 - 2024)[+]

Manner of Death	2015	2016	2017	2018	2019*	2020	2021*	2022	2023*	2024*
Homicide	10	11	6	10	11	5	10	9[+]	8	7[+]
Total Fatalities	43	56	63	59	57	52	53	39	45	47
Percent of Fatalities Deemed Homicides	23%	20%	10%	17%	19%	10%	19%	23%	18%	15%

[+]Includes homicides deaths where ACS has received the autopsy as well as homicides confirmed by OCME where the autopsy report has not been provided.

*****Denotes case(s) where the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 8. Fatalities reported to SCR and Certified as Natural Deaths in Families Known to ACS in Previous Decade (2015 - 2024)

Manner of Death	2015	2016	2017	2018	2019*	2020	2021*	2022*	2023*	2024*
Natural	7	16	28	20	15	16	12	9	8	10
Total Fatalities	43	56	63	59	57	52	53	39	45	47
Percent of Fatalities Deemed Natural Deaths	16%	29%	44%	34%	26%	31%	23%	23%	18%	21%

*****Denotes years where the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death on case(s).

Table 9. Race and Ethnicity Demographics of Parents in 2024 Child Fatalities Reported to SCR[ǂ]

Race/Ethnicity	Families Known to ACS Within Previous Decade*		Families With no Prior ACS Involvement*	
	Mother	Father	Mother	Father
American Indian/ Alaska Native	0	0	0	0
Asian	0	0	3	3
Black/African American	26	25	18	15
Biracial/Multiracial	0	1	0	0
Hispanic	19	18	18	21
Pacific Islander	0	0	0	0
White Non-Hispanic	2	2	8	6
Other	0	1	1	0
N/A[ǂ]	0	0	0	3
Unknown	0	0	0	0
Total	47	47	48	48

[ǂ]2024 New York City child fatalities reported to the SCR alleging maltreatment associated with the fatality.

*There were multiple fatalities in one or more cases.

[ǂ]N/A = no information is available about the male in the family

Appendix C: Systemic Influences Definitions

Systemic influences are identified within and across cases. The frequency of the systemic influences informs opportunities for learning and improvement.

Cognition: A faulty understanding of a situation due to cognitive fixation or intrinsic biases (e.g., confirmation bias, focusing effect, tunneling, transference).

Knowledge Gap: An absence of requisite experience and/or knowledge and/or difficulties applying knowledge and integrating it into practice (e.g., absence of knowledge regarding policy or practice).

Documentation: Absent, incomplete or inconsistent documentation. (Documentation was completed according to policy timeframes, clearly recorded with relevant and necessary details of case activities.)

Stress/Fatigue: Professional or personal stress or tension. Fatigue as a result of casework and/or other life circumstances. (e.g. staff express or exhibit difficulty managing the strains of casework, staff morale, vicarious trauma, and/or other life circumstances.)

Demand-Resource Mismatch: A lack of internal resources or programs (e.g. lack of preventive and community-based service slots, inadequate staffing-including consultants) to meet the needs of staff to carry out their work.

Equipment/Tools/Technology: An absence or deficiency in the equipment, tools and/or technology utilized to carry out safe work practices.

Training: The absence or ineffectiveness of formal instruction.

Policies/Prescribed Practice: When practice prescribed by policy or practice standards is absent, conflicting, vague or does not adequately support work.

Service Availability: The absence, ineffectiveness of or difficulty accessing a particular external service or support.

Teamwork/Coordinating Activities: Ineffective collaboration between two or more internal and/or external entities (e.g., CPS and Law Enforcement, CPS and Preventive Services, Foster Care, Mental Health/Medical Providers and other entities).

Medical and Mental Health Collaboration: Difficulties in communicating with medical/mental health providers, obtaining or understanding medical records and/or integrating medical information into assessment(s).

Production/Efficiency Pressure: Demands to increase production and/or efficiency (workload, economics-including cuts to workforce).

Supervisory Support: Difficulties in carrying out supervisory functions. Supervision is often unavailable, provides ineffective support, communication, does not foster teamwork or create a safe environment for staff.

Supervisory Knowledge Transfer: Supervision provided guidance/directives that were inconsistent with policy, procedure and/or best casework practice.

Procedural Drift: A gradual departure away from written procedure due to system constraints and influences, and the workforce/local team has experienced success.

Family Conflict: This item refers to fighting and arguing between family members. Domestic violence refers to physical fighting which might lead to injury as well as verbal or emotional abuse.

Caregiver Development: This item refers to developmental disabilities including autism and intellectual disabilities of the caregiver.

Caregiver Medical Challenges: This item refers to physical/medical disabilities and/or diagnosis of the caregiver.

Caregiver Mental Health: This item refers to the evidence of or confirmed diagnosis of mental illness.

Caregiver Substance Use: This item includes problems with alcohol, illegal drugs and/or prescription drugs.

Child/Adolescent Medical Health: This item is used to describe the child/youth's current medical/physical health.

Child/Adolescent Development/Intellectual: This item describes the child/adolescent's physical and intellectual development as compared to standard developmental milestones. Rate this item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.

Child/Adolescent Mental Health: Refers to the child/adolescent's mental health. A formal mental health diagnosis is not required to score this item.