SYSTEMIC CHILD FATALITY REVIEW
2022 ANNUAL REPORT

Systemic Child Fatality Review - 2022 Annual Report

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Introduction

New York City's Administration for Children's Services (ACS) is mandated to investigate alleged abuse and neglect among children residing in the city. In 2022, ACS received more than 59,000 reports alleging child maltreatment, concerning more than 65,000 children. These reports were consolidated into a total of 44,186 Child Protective investigations and 6,901 Collaborative Assessment, Response, Engagement and Support (CARES) stages[1]. Among these, ACS investigated 74 child fatalities reported to the Statewide Central Register (SCR) of Child Abuse and Maltreatment. Of the 74 child deaths, almost half occurred in a family that had no contact with ACS within the last decade. The occurrence of a child fatality reported to the SCR with allegations of possible abuse or neglect continues to be a rare event, comprising about 0.1%of all cases investigated by ACS. Nonetheless, the loss of a child is tragic for a family and the community, and a death where there was past ACS contact requires special attention and review. Those child fatalities are the focus of this report.

This report focuses on child fatalities that occurred during calendar year 2022 in families with ACS involvement at the time of the fatality or within the previous 10 years. The report frames 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 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. The purpose of the case reviews and analyses is to gather insights from the lessons learned 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 all children and families with whom ACS has contact.

This report is published pursuant to Local Law 19 of 2018,[2] 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] *CARES (Collaborative Assessment, Response, Engagement and Support) formerly known as Family Assessment Response (FAR) is an alternative Child Protective response to some reports of child maltreatment. CARES does not require an investigation and determination of allegations and individual culpability for families reported to the SCR. It is an alternative approach to providing protection to children by engaging families in an assessment of child safety and of family needs, in finding solutions to family problems and in identifying informal and formal supports to meet their needs and increase their ability to care for their children.

[2] 2018 N.Y.C. Local Law No. 19, N.Y.C. Admin. Code §§ 21-915 https://intro.nyc/local-laws/2018-19

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[3] 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.

This report reviews the 39 child fatalities from calendar year 2022 that occurred in families that were "known" to ACS because an adult in the household has been the subject of an allegation of child abuse or maltreatment reported to the NY State Central Register (SCR) within the preceding 10 years. According to the New York City Office of the Chief Medical Examiner ("the ME"), the most common manner of death for the 2022 fatalities was "undetermined," of which there were 10 in 2022. "Undetermined" is a designation used by the ME 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. There were nine deaths in six families determined to be homicides in 2022, eight determined to be natural causes, and eight designated as accidents. The ME's manner of death determination for three fatalities is still pending, and one was classified as "other" because it did not fall under the jurisdiction of the ME.

[3] 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 maltreatment for anyone under 18 years old. Reports may come from professionals (e.g., medical staff, school officials, social service workers, police officers), who are mandated by law to report, as well as from the general public. Among the reports the SCR receives are cases of child fatalities in which maltreatment **may** have been a factor, including reports received from the ME 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 maltreatment surrounding the fatality.

The ME determines the cause and manner of a child's death. The cause of death is the injury, disease, or condition that resulted in the fatality, such as blunt trauma or acute and chronic bronchial asthma. The manner of death is determined by the findings of the ME's autopsy examination and the circumstances of the death. The ME certifies the "manner" as having been an accident, homicide, natural, suicide, therapeutic complications, or undetermined.[4] These classifications are administratively determined and may differ from other jurisdictions, therefore 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, shows that about one-half (53%) of the child fatalities reported to the SCR in 2022 alleging maltreatment in association with a child's death occurred in families that were "known"[5] to ACS within 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 2022 (see Table 2 for specific data on cases known to ACS).

[4] 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.

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

Table 1. Manners of death for all 2022 child fatalities reported to SCR

	2022 Child Deaths in Families Known* to ACS within Last 10 Years		2022 Child Deaths with No ACS History in Last 10 Years		All 2022 Child Deaths Reported to the SCR	
Manner of Death	**N**	**%**	**N**	**%**	**N**	**%**
Accident	8	21	5	14	13	18
Homicide	9[+]	23	4	11	13	18
Natural	8	21	10	29	18	24
Suicide	0	0	0	0	0	0
Undetermined	10	26	12	34	22	30
Therapeutic Complications	0	0	0	0	0	0
Pending ME determination	3	8	4	11	7	9
Other[ψ]	1	3	0	0	1	1
Total	**39**	**100**	**35**	**100**	**74**	**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.

[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 cause of death.

When the SCR receives a report of a child's death in New York City, the state forwards the report to the ACS Division of Child Protection (DCP) to investigate and make a determination regarding the circumstances of the deaths. When a DCP investigation finds "a fair preponderance of the evidence"[6] that abuse or neglect may have taken place in relation to any of the allegations, the report is defined as "indicated." Alternatively, if the evidence collected does not meet the aforementioned standard, 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.[7] Such cases may involve an allegation of educational neglect being "substantiated" for the deceased child and/or a sibling, but the

[6] On January 1, 2022, New York State enacted legislation that changed the evidentiary standard for indicating child protective investigations to fair preponderance of the evidence.

[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 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."

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 criminal culpability, and whether or not to pursue criminal prosecution.

Case Review Criteria

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 following an investigation.

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 ACS Office of the 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.

[8] Although the family may have prior history, it does not mean that the decedent was the maltreated child 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 promote the safety of any surviving siblings and/or family members. Throughout 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, and 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.

When a child fatality is determined to fall within the review purview, 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 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 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 discussed with the ACS Interdivisional Team, 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 full review (comprehensive analysis), staff involved with the corresponding learning points/areas for study are invited to participate in a human factors debrief. In 2022, there were 30 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' involvement with the family. 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 direct service staff and their supervisors, but may consist of 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 facilitated process whereby borough-based multidisciplinary teams made up of staff from the borough offices and other ACS divisions, including those in direct service, discuss local, regional and regulatory conditions or processes that affect case practice and decision making. The Child Fatality Review Team analyzes information gathered from the completed case summary review, human factors debriefs, and mapping sessions to identify systemic influences and key findings which they use to produce recommendations that will lead to system improvements. In 2021, ACS added Systems Learning and Improvement Sessions to the SCFR process to further explore systemic themes as well as brainstorm possible recommendations for consideration and implementation by ACS leadership.

2022 Cases Reviewed

Manner of Death

In 2022, there were 39 fatalities of children in 34 families (two cases where three children died in each, and one case with two deceased children) 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 for 2022 fatalities were "undetermined" (n = 10, 26%), followed by "homicide" (n = 9, 23%), "natural" (n = 8, 21%), and "accident" (n = 8, 21%) (See Table 2).[9] There were three cases with pending autopsies at the writing of this report.

Table 2: Manners of Death for Systemic Child Fatality Cases in 2022

Manner of Death	Total 2022	
	N	%
Accident	8	21
Homicide	9	23
Natural	8	21
Suicide	0	0
Undetermined	10	26
Therapeutic Complications	0	0
Pending ME Determination	3	8
Other$^{\psi}$	1	3
Total	39	100

Percentages may not equal 100 due to rounding

$^{\psi}$ 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 cause of death.

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 including the

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

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 shelter at the time of the fatality;
c. Extent of history with ACS, including the parents' history with child welfare as a child 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 2023 fatalities (n = 39); Table 3 provides demographic information for the 34 cases (two cases where three children died in each, and one case with two deceased children).

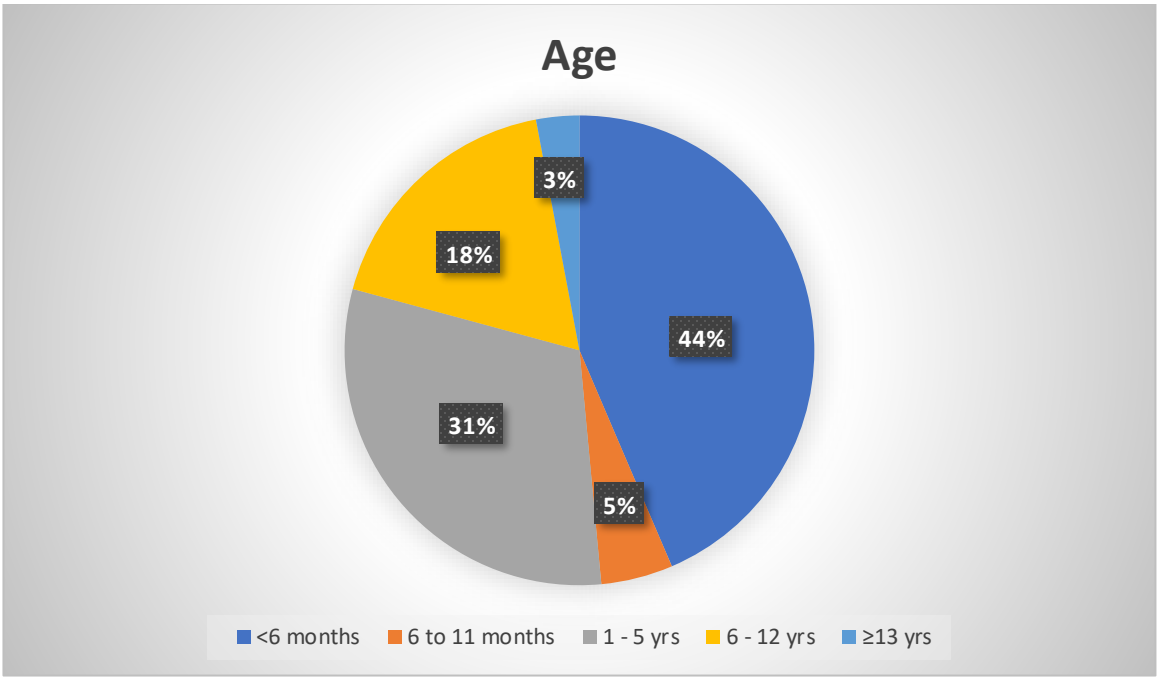
Table 3: Demographics

Demographics	n	%
Race (of mother, n = 34)		
Asian	0	0
Black	23	68
Hispanic	9	26
Pacific Islander	0	0
Native American	0	0
Biracial/Multiracial	1	3
White Non-Hispanic	1	3
Not Available	0	0
Other	0	0
Unknown	0	0
Gender (of child, n = 39)		
Female	18	46
Male	21	54
Age (of child, n = 39)		
<6 months	17	44
6 to 11 months	2	5
1 to 5 yrs	12	31
6 to 12 yrs	7	18
≥13 yrs	1	3

Percentages may not equal 100 due to rounding

Mothers were disproportionately Black/African-American/non-Hispanic (68%) and Hispanic (26%). When available, data was also collected on the fathers or males involved with the family. Of the 36 fathers/involved males, 69% (n = 25) were identified as Black/African American/non-Hispanic while 25% (n = 9) were Hispanic and two were White. No race or ethnicity data was available on the father/male involved with the family in one case.[10]

Figure 1. Age at Time of Fatality



As in previous years, children at greatest risk of fatality were of the youngest ages. In 2022, the average age of children was 3.3 years, a little below the average age of 3.6 years in 2021. Also in 2022, the median age at death was 1.7 years, which was higher than the median age of 1.1 years in 2021. Looking back further, children who died in 2022 were older and had a higher median age of death than in 2020 (2.3 years and 3.9 months, respectively) and 2019 (3.2 years and 6.8 months, respectively). Children's ages ranged from one month to 15 years of age. Almost half (49%, n = 19) of the fatalities were of infants under the age of one, and of these, 89% (n = 17) were less than six months of age. Children under the age of six, including infants, accounted for 79% of the 2022 fatalities. Of the 39 child fatalities, males accounted for 54% while females were 46%. Male (n = 9) and female (n = 10) deaths were about the same for children who were less than one year of age.

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

Exactly half of the cases (n =17, 50%) were open with ACS at the time of the fatality; this includes open investigations and families receiving foster care and 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. Of the 34 cases, 13 (38%) were unfounded, i.e., no allegation was substantiated (see table 5 in Appendix B). However, 62% (n = 21) were indicated for at least one allegation, with the fatality allegation being substantiated in 12 of the 21 indicated cases. While a fatality allegation may be substantiated, this does not mean the ME deemed the death a homicide or that the parent/caretaker intentionally harmed the child. A close reading of the case circumstances is necessary to fully understand the substantiation decision made by the child protection team. For example, in 2022, fatality allegations were substantiated in some cases where the ME ruled the manner of death as an Accident or Undetermined.

Many of the families known to ACS prior to the fatality faced multiple challenges, such as recent or ongoing homelessness (35% of families in cases reviewed), and a recent history of domestic violence (within the last four years), which was noted in 59% of the cases reviewed. Seventy-four percent (n = 25) of the mothers had histories of ACS involvement as children and of those, seven had a history of foster care placement as children. For the males involved with these families (where information was available, n = 36), 14 had histories of ACS involvement as children, and eight had a history of foster care placement. There were seven families residing in a shelter at the time of the fatality; five of these had an active ACS case at the time of the fatality.

The review of the case records indicated that the average age of mothers in the 2022 child fatality cases was around 27.6 years at the time of the child's death, more than two years younger than the 31.0 years recorded in 2021. The median age of these mothers was 28 years. All of the mothers of children who died in 2022 were 18 years old or older, with four of the 34 being less than 20 years of age. Consistent with previous years, the mothers had, on average, three children. The case records for these families noted that 44% (n = 14) of the mothers had current or prior substance use issues, and 56% (n = 19) had current or ongoing mental health concerns (diagnosed or undiagnosed).

Data was available on the father/male involved with the family in all but one case. Of the 36 males identified, 81% (n = 29) 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 47% 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 28% of the cases.

Additional Case Characteristics and Related ACS Initiatives

Safe Sleep and Injury Prevention

Thirty-eight percent (n = 15) of the 2022 fatalities included indicators of possible sleep-related injuries or unsafe sleep conditions either from the ME's 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 an infant is found alone in a crib or bassinet in which soft bedding is present. (When ACS or a provider agency identifies that a family lacks a crib or other safe sleep option for an infant, ACS or the provider agency will request and deliver one to the family at no cost, along with other resources. ACS also routinely provides information on safe sleep to families with infants.)

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. Unsafe sleep conditions can include factors such as bed-sharing with an adult or sibling; infants sleeping with pillows, blankets, or other objects in the crib, (which can create a risk of entanglement and/or asphyxia); and defective or unsuitable sleeping furniture, such as an air mattress, couch, or car seat. Of the 15 cases with unsafe sleep conditions noted, the ME certified a little more than half (n = 8, 53%) as having an undetermined manner of death. In addition, a review of case records and autopsy findings indicate that the most common unsafe sleep condition was bed-sharing with an adult and/or a sibling (10 of the 15 cases). Of the 15 sleep related fatalities, all but one were of children under six months of age. More than half of the 15 children were female (n = 9, 60%) and 40% (n = 6) were male. Nine of the sleep related fatalities occurred in families that had an open ACS case at the time of the death.

ACS Safe Sleep Strategy

Between 40 and 50 babies in New York City die from a sleep-related injury each year.[11] 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 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.[12]

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. The initiative focuses on community engagement, public awareness campaigns, free training and resources, collaborations and stakeholder partnerships to increase infant survival in NYC. In addition, since 2017, the initiative has convened an annual summit of professionals and advocates to inform and unite a community of action focused on preventing the tragic loss of children to sleep-related infant injury deaths.

In August 2021, ACS established the Office of Child Safety and Injury Prevention (OCSIP) within the Division of Child and Family Well-Being, where efforts have continued on the agency's deep work to promote infant safe sleep practices. In addition to housing the NYC Infant Safe Sleep Initiative, OCSIP's efforts include public education, training, and resource distribution to help parents and child-serving

[11] Infant Sleep Safety - NYC Health

[12] The Centers for Disease Control Vital Signs: Trends and Disparities in Infant Safe Sleep Practices – United States, 2009-2015, https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6701e1-H.pdf

professionals reduce or eliminate preventable child injuries and fatalities that primarily affect children under age six, specifically, Shaken Baby Syndrome and unintentional child poisoning caused by exposure to inadequately stored cannabis-infused edibles, medications, household cleaners and other substances. OCSIP offers free resources, supplies, trainings and public campaigns to heighten awareness about how to keep children safe.

Infant Safe Sleep Initiative

During 2023, OCSIP continued its promotion of 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 in-person and virtual training for parents, caregivers and child-serving professionals and highlighting parental stress, fatigue, and sleepiness as potential barriers to safeguarding infants during sleep.
- Provided virtual and in-person infant safe sleep training to more than 4,361 parents and caregivers and 1,089 child-serving professionals. In addition, more than 738 child welfare professionals completed the Safe Sleep e-Learn 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 a strengths-based conversation with parents and caregivers around implementing infant safe sleep practices.
- 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 during 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.
- In October 2023, during Infant Safe Sleep Awareness Month, 1) released an Op-Ed with guidance for parents and caregivers, 2) held Safe Sleep Information and Resource Fairs to distribute free information and resources across NYC, and 3) partnered with the ACS Division of Family Permanency Services' Older Youth Services to deliver annual Safe Sleep Symposium for expectant and parenting foster youth.
- 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.
- 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 community stakeholders to deliver infant safe sleep training and distribute educational materials and resources to the parents and caregivers they serve.

Child Safety and Injury Prevention

In 2023, OCSIP's guidance for parents and caregivers of infants and child-serving professionals was strengthened with the addition of new public awareness campaigns, expanded educational efforts and deeper collaborations with Mayoral agencies and community-based organizations to promote child injury prevention.

In March 2023, in recognition of National Poison Prevention Week, OCSIP collaborated with the NYC Department of Health and Mental Hygiene and Cannabis NYC to develop language for a Poison Prevention Social Media Campaign to raise awareness among parents, caregivers and other trusted adults about: 1) the poisoning risks associated with unintentional consumption of cannabis-infused edible products; 2) symptoms of cannabis intoxication in children; and 3) guidance on how to safely store cannabis out of sight and reach of children. OCSIP further collaborated with Cannabis NYC, Harlem Hospital, Health + Hospital Gotham Health Clinics, the Southern Queens Park Association, and three licensed cannabis dispensaries—Dazed Cannabis, the Union Square Travel Agency Cannabis Store, and Housing Works Cannabis Company—to promote poisoning prevention in communities across NYC. In partnership with these organizations, over 2,750 lockboxes were distributed to New Yorkers to keep cannabis products, medications and other potential poisons out of sight and reach of children.

In June 2023, OCSIP convened child-serving professionals, advocates, and parents at its First Annual NYC Child Safety and Injury Prevention Summit. The goals of the summit were to enhance understanding, coordination and strategic partnership around child injury prevention and promote strategies and interventions to prevent severe and fatal injuries, including related to unsafe sleep practices, Shaken Baby Syndrome and child poisoning caused by exposure to cannabis-infused edibles.

From June through August 2023, OCSIP launched its Summer Safety Campaign—providing safety information and tips to prevent hot car/heatstroke, window falls, water, bicycle, scooter, and playground injuries from occurring. OCSIP also added guidance to prevent severe and fatal injuries related to Shaken Baby Syndrome. The new guidance provides prevention tips, including how to manage inconsolable crying in infants and strategies to manage caregiver frustration and exhaustion.

In November 2023, in recognition of National Injury Prevention Day, OCSIP hosted its Annual Child Injury Prevention Resource Fair to increase awareness of the leading causes of unintentional child injuries and how to prevent them. OCSIP and its partners at the NYC Department of Health and Mental Hygiene, the Fire Department of New York (FDNY), the NYC Department for the Aging, the CORE Family Enrichment Center, and several community-based organizations, distributed injury prevention information and resources to more than 150 families.

Fire Safety

Since 2019, ACS' Division of Child Protection (DCP) has maintained a partnership with the Fire Department of New York (FDNY) to coordinate directly with its Fire Safety Education Unit to offer and co-deliver the FDNY & ACS Fire Safety Training, including during the pandemic. As part of the training, the FDNY Fire Safety Educator addresses:

- Installation of Smoke Alarms and Carbon Monoxide Detectors including how and where devices should be positioned and placed.
- Maintenance of Smoke Alarms and Carbon Monoxide Detectors including testing frequency and suggested time to change batteries.
- Sound Patterns of Smoke Alarms and Carbon Monoxide Detectors including when the device "chirps" and its meaning.

Additionally, during the training, the DCP facilitator provides agency-specific context to child protection teams on the importance of checking that smoke/carbon monoxide detectors are operable and for including findings in the CONNECTIONS (case record) documentation. Also, child protection teams are informed that when smoke/carbon monoxide detectors are not observed/operable, follow up is to occur immediately to provide the family with a detector the same day if time permits, or with the support of their leadership team, request that DCP's Emergency Children Services (which operates nights, weekends and holidays) deliver one to the family. Since 2021, ACS also has a process for child protection teams to request installation of the detectors through the American Red Cross (excluding those living in the New York City Housing Authority which equips each apartment with smoke/carbon monoxide).

Homicides

In 2022, the ME classified nine child deaths (23%) as homicides. The ME classifies a death as homicide when the fatality results from an act of commission or omission 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 three months to seven years old. All but one of the children were less than five years old. Five of the deaths occurred in two families (three in one case and two in the other).

ACS Enhanced Oversight of High-Risk Cases

The Accelerated Safety Analysis Protocol (ASAP) and the Heightened Oversight Process (HOP) are indicative of ACS' commitment to strengthening efforts to protect children at the greatest risk of physical abuse. These initiatives provide additional levels of consultation, oversight and supervisory support in everyday child protective investigative practice.

The Accelerated Safety Analysis Protocol (ASAP) is a 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 a component of ACS' comprehensive quality management program 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 that have been flagged by a predictive risk model. The team examines documentation on these cases, and, when necessary, meets with investigative teams to provide coaching around appropriate safety practices and interventions. During these case reviews--and on any other review by the quality assurance team—any gap in the investigation is immediately addressed.

The Division of Child Protection (DCP) is in the process of expanding the quality assurance team to increase the number of monthly ASAP case reviews by 50%. It is also supplementing the predictive risk model with other data related to child outcomes and systemic factors. This automated data, along with the team expansion will support greater monitoring and tracking of quality practice.

In 2017, ACS implemented the Heightened Oversight Process (HOP) and it remains a key mechanism for promoting child safety on high risk cases involving young children. The HOP 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 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 reunified. The HOP team identifies an investigative strategy at the beginning of the investigation and conducts conferences to assess and reassess whether additional investigative steps are needed. In addition to the HOP, ACS Investigative Consultants support prevention services provider agencies, teaming up with the Office of Prevention Technical Assistance (OPTA) within ACS' Division of Prevention Services to provide guidance on complex domestic violence cases.

ACS has a comprehensive quality management system that includes ChildStat, a weekly collaborative discussion of performance data and a case review. The focus of ChildStat is always on child safety, and the structured discussion is geared toward identifying key insights and opportunities for learning and improvement, and informing agency quality improvement. At ChildStat, the ACS Commissioner and executive leadership lead the conversation with leadership from the DCP borough offices. Lessons learned from ChildStat form the basis for recommendations that support zone, borough, and system-wide performance and improvements. ACS uses quality management, inclusive of continuous quality improvement processes, to promote an agency-wide culture of learning and accountability.

Natural Deaths

In 2022, 21% (n = 8) of child fatalities were determined by the ME 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 eight natural deaths, five had open cases with ACS at the time of death. One of the eight deaths was indicated for the fatality allegation (and at least one other allegation) and two other cases were indicated for other allegations, but not for the fatality allegation. Exactly half to the children were male and female, and five of the children were noted to have had chronic medical conditions and/or developmental issues. Across all fatality types, the average age at death in 2022 was 3.3 years of age, while on average, children who experienced natural deaths were 4.8 years old. Natural causes of death in 2022 included acute asthma exacerbation, COVID-19 and Leukemia.

Services for Children and Families with Complex Medical and Developmental Needs

ACS is committed to securing high-quality health care for all children with whom the agency and its contracted providers have contact. The ACS Office of Child and Family Health (OCFH) manages health care issues throughout ACS, providing expert technical assistance to child welfare, juvenile justice, and child care programs, in addition to developing and implementing strategies to enhance the understanding of medical issues throughout ACS systems in order to improve case practice and outcomes. OCFH continues to lead the agency's efforts to provide access to quality health services as well as educate agency staff and foster care and prevention service providers on assessing whether children and adolescents medical needs are being met.

Since 2019, OCFH has worked with NYC Health + Hospitals medical consultants to support DCP offices across the five boroughs 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 consultation is prioritized so that children with the most complex and acute medical needs receive immediate intervention.

In addition, OCFH has expanded the ACS Developmental Disabilities Unit (DDU), recruiting and hiring additional staff to serve as liaisons to the DCP borough offices to ensure that children, youths, parents, caregivers and/or other adults suspected of or diagnosed with an intellectual or developmental disability and involved in the child welfare system receive the necessary attention and service. The role of the liaison includes providing 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 on as needed basis. In addition, the liaisons facilitate DDU trainings.

Supporting Success for Adults who Experienced Foster Care as Children

Intergenerational involvement with ACS is a common factor among families in fatality cases. Seven of the mothers and eight fathers and other adult men in 2022 fatality cases had histories of foster care placement. In order to promote stability, independence and success among young people in foster care as children and after they become adults, ACS has instituted supportive strategies including Fair Futures coaching until age 26 for youth who have been in care as teens; housing supports—including rent vouchers, supportive housing, or public housing—for hundreds of ACS-involved young adults each year; and other resources such as transition support to community-based health care.

ACS, in partnership with the Center for Fair Futures and our contracted foster care providers, has implemented the Fair Futures model to provide enhanced educational, vocational, and coaching support for children and youth ages 11-21 in foster care. In Fiscal Year 2022, ACS increased Fair Futures funding so that young adults up to the age of 26 who were in foster care after the age of 11 are eligible for continued support from Fair Futures coaches. These coaches provide individualized, dedicated social and emotional support to build life skills, set academic and career goals, facilitate connections to

programs and services that support goal attainment, and plan for successful transitions from foster care. Support is also available from tutors, education and employment specialists and housing specialists, to support transitions to permanency or independent living.

ACS also provides support to connect young adults leaving foster care and families reunifying after foster care to appropriate, stable and affordable housing. This includes connections to supportive housing, NYCHA, and to multiple housing voucher options according to availability, including section 8 and City FHEPS vouchers. ACS also contracts with a housing navigation and stability provider to support youth and families to locate, move into and remain in stable housing.

System Recommendations

The safety science approach encourages proactive exploration of systemic influences that impact caseworker decision making and other factors in the moment, with the goal of 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 ACS, foster care or prevention services, cases closed within the past three years, or those cases requested by the Office of the Commissioner are eligible for full review, which includes producing a case summary and conducting human factors debriefing and mapping sessions with child protection teams and other relevant stakeholders, and using a Systems Analysis Scoring Tool to assess 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:

1) *Address workload challenges for child protection teams.* Among the most common concerns raised in human factors debriefs and during mapping sessions on 2022 cases was the challenge of managing high workloads and caseloads, which sometimes led to incomplete documentation of essential casework activities and limitations on time available for follow-up on referrals and other appointments with a family. During 2022, in the wake of hiring delays and attrition during the COVID-19 pandemic, average Child Protective Specialist (CPS) caseloads peaked above 11 cases per worker in some boroughs. While this average remained below the national standard of 12 cases per worker, there were times when some staff carried more than 12 cases. Beginning in 2022, ACS returned to its pre-COVID practice of hiring new CPS ahead of attrition, and as a result caseloads have declined to an average below 9 cases as of June 2024. Other workload reduction efforts underway or completed include:
    - Streamlining of documentation requirements: DCP implemented a new structured documentation outline for case practice that replaced templates and checklists that had been in place for more than 15 years. The new method encourages critical thinking and supports the agency's approach to workforce development and training.

- Eliminating duplicative or outdated policies and guidance: Policies and guidance that accumulated over many years have been consolidated and shortened.
- Simplifying documentation requirements for case transfers: The case details required for transitioning a family on Court Ordered Supervision to the DCP Family Services Unit have been simplified.

2) *Strengthen work to improve response to family violence, including services for the persons causing harm in intimate partner relationships as well as engaging fathers/males involved with the family*.
   - In 2023, ACS Division of Prevention Services expanded A Safe Way Forward, which is now available in Brooklyn, the Bronx and Staten Island. This innovative program serves the entire family, including intimate partner violence survivors, the persons causing harm and children, providing trauma-informed case planning and research-informed therapeutic services.
   - ACS has partnered 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. The two agencies continue to explore models for child protection work with intimate partner violence survivors and have reinstated quarterly meetings to bolster relationships among service providers.
   - With the support of our partners at Casey Family Programs, ACS is developing an Office of Fatherhood Engagement to better serve fathers and male caregivers in families involved with ACS. Among several initiatives, the Office will work to ensure ACS policies and practices are intentionally inclusive of fathers.
   - The ACS Office of Training and Workforce Development (OTWD) continues to provide an instructor-led course, "Motivational Interviewing: Engaging Fathers", to support child welfare staff in engaging males in the family. In addition, OTWD continues to offer training on identifying and addressing intimate partner violence, building skills and knowledge on assessing and engaging the survivor, the person causing harm and their children, as well as safety planning. In addition, the New York State Office of Children and Family Services (OCFS) offers a training course on involving the fathers of children in child welfare cases.

3) *Enhance mental health services, communication and collaboration with mental health providers and the mental health system, and strengthen child protection and provider agency staff's skills and knowledge to better support adults, children and families impacted by mental illness.*
   - ACS continues advocacy to the State Office of Mental Health (OMH) to ensure NYC staff can access services for youth, as well to identify gaps in services that can be brought to the attention of state and city policymakers for resolution.
   - ACS remains committed to working with OMH to train ACS and contracted agency staff on the services available through the OMH continuum and how to access them. ACS and provider staff received trainings from OMH and the NYC Department of Health and Mental Hygiene (DOHMH) on Children's Single Point of Access (CSPOA), a centralized referral system for children and youth with serious emotional disturbance who need intensive mental health services to remain at home.

- The ACS Clinical Consultation Program supports casework decision making through consultants with specialized knowledge and skills in areas that often come to the agency's attention, these include intimate partner violence, mental health, and substance misuse. The ACS Clinical Consultation Team supports child welfare staff in assessing mental health needs and accessing mental health services. Additionally, efforts are underway to explore a refined approach to engaging the clinical consultant that will best support the child protective team in assessing child safety, families service needs and intervention strategies.
- The ACS Office of Training and Workforce Development (OTWD) continues training child welfare staff on how to work with families impacted by mental illness, and navigating the mental health system.
- ACS, in consultation with The Motherhood Center, is developing a comprehensive, culturally competent, validated set of practice changes to improve maternal mental health outcomes for low-income women experiencing Perinatal Mood and Anxiety Disorders and who are known to child welfare in New York City. The Motherhood Center, a clinical treatment facility, provides therapeutic services to new and expecting mothers and birthing people experiencing Perinatal Mood and Anxiety Disorders—otherwise known as postpartum depression, as well as postpartum psychosis. Along with patient treatment, the Motherhood Center also provides education and training to medical providers and city/state agencies to better equip them with maternal mental health best practices. ACS will continue to provide resources and training support for child welfare practitioners in ACS and contracted agencies to align with these best practices for responding to Perinatal Mood and Anxiety Disorders.
- In 2022 and 2023, ACS, in partnership with the Motherhood Center, NYU McSilver Institute - Training & Technical Assistance Center (TTAC) and the NY Center for Child Development, offered trainings to ACS and contracted providers staff and DHS shelter providers, on Perinatal Mood and Anxiety Disorders, including a focus on perinatal depression, Post-Traumatic Stress Disorder (PTSD) and psychosis. The learning objectives included for participants to gain a basic understanding of the signs and symptoms of Perinatal Mood and Anxiety Disorders, acquire an understanding of how to screen for and where to refer clients that appear to be experiencing a Perinatal Mood and Anxiety Disorder, and to become familiar with effective treatment interventions. The facilitators also noted practice recommendations.
- Access to appropriate child care services not only provides safe and educational programming for children outside of the home while parents work; it also gives parents time to address other needs, including their own mental health. This critical support for families also helps to reduce social isolation, a common factor in family instability and crisis. ACS has dramatically expanded provision of child care vouchers, with an 134% increase between January 2023 and January 2024 in the number of children enrolled in child care with the support of an ACS-issued voucher for low income families.

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: 2021 Data Tables

Table 4. Manner of Death, Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2013 - 2022)

Manner of Death	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Accident	12	9	6	8	11	8	9	8	11	8
Homicide	6	9	10	11	6	10	10	5	10	9[+]
Natural	4	21	7	16	28	20	14	16	12	8
Suicide	2	2	2	0	2	2	3	0	0	0
Therapeutic Complications	0	0	1	1	0	0	0	0	0	0
Undetermined	20	17	16	19	16	19	19	23	19	10
Body not Located	0	0	1	1	0	0	0	0	0	0
Pending	0	0	0	0	0	0	1*	0	1*	3*
Other[Ψ]	0	0	0	0	0	0	1	0	0	1
Total	44	58	43	56	63	59	57	52	53	39

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

*In one 2019 case, one 2021 case, and three cases in 2022, the Office of the Chief Medical Examiner (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 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 cause of death.

Table 5. Investigation Decision on Fatality Allegations in Families Known to ACS in Previous Decade with Fatality Reported to SCR (2013 - 2022)

Year	2013	2014	2015	2016	2017	2018	2019Ψ	2020	2021Ψ	2022Ψ
Fatality Allegation Substantiated	25	27	13	21	23	25	21	11	17	12
Other Allegation Substantiated (excluding fatality)	9	13	13	13	15	13	21	15	10	9
Unfounded Investigation	8	18	17	19	25	19	14	24	26	13
Total Investigations†	42	58	43	53	63	57	56	50	53	34

†Some investigations involved families with more than one child fatality

*For one case in 2019 and 2021 and three cases in 2022, the Office of the Chief Medical Examiner (OCME) has yet to provide the completed autopsy or determine the manner and cause of death.

Table 6. Sleep-Related Child Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2015 - 2022)

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%

*For one case in 2019 and 2021 and three cases in 2022, the Office of the Chief Medical Examiner (OCME) has yet to provide the completed autopsy or determine the manner and cause of death.

Table 7. Homicides in Families Known to ACS in Previous Decade and Reported to SCR (2013 - 2022)

Manner of Death	2013	2014	2015	2016	2017	2018	2019*	2020	2021*	2022*
Homicide	6	9	10	11	6	10	9	5	10	9[+]
Total Fatalities	44	58	43	56	63	59	57	52	53	39
Percent of Fatalities Deemed Homicides	14%	16%	23%	20%	10%	17%	16%	10%	19%	23%

*For one case in 2019 and 2021 and three cases in 2022, the Office of the Chief Medical Examiner (OCME) has yet to provide the completed autopsy or determine the manner and cause of death.

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

Table 8. Fatalities reported to SCR and Certified as Natural Deaths in Families Known to ACS in Previous Decade (2013 - 2022)

Manner of Death	2013	2014	2015	2016	2017	2018	2019*	2020	2021*	2022*
Natural	4	21	7	16	28	19	14	16	12	8
Total Fatalities	44	58	43	56	63	59	57	52	53	39
Percent of Fatalities Deemed Natural Deaths	9%	36%	16%	29%	44%	32%	25%	31%	23%	21%

*For one case in 2019 and 2021 and three cases in 2022, the Office of the Chief Medical Examiner (OCME) has yet to provide the completed autopsy or determine the manner and cause of death.

Table 9. Race and Ethnicity Demographics of Parents in 2022 Child Fatalities Reported to SCR[†]

Race/Ethnicity	Families Known to ACS Within Previous Decade		Families With no Prior ACS Involvement	
	Mother	Father	Mother	Father
Asian	0	0	1	1
Black/African American	23	25	19	18
Biracial/Multiracial	1	0	1	1
Hispanic	9	9	10	11
Other	0	0	0	0
N/A*	0	1	1	1
Unknown	0	0	0	0
White	1	2	3	3
Total	34	37[±]	35	35

[†]2022 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

[±] There were two cases with multiple fathers