

CONTINUING DANGER:

A REPORT ON
CHILD FATALITIES
IN NEW YORK CITY



Children's Rights is a national advocacy organization that works on behalf of children served by child welfare systems across the United States. Children's Rights seeks to ensure that child welfare systems appropriately intervene to protect children from abuse and neglect; provide the services that abused and neglected children and their families need; safely and quickly return children in foster care to their families whenever possible; and when children in foster care cannot return to their families, provide them with adoptive families.

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INTRODUCTION

This report focuses on 194 child deaths in New York City that occurred between 1999 and mid-2001 and that potentially involved some type of child maltreatment. The number of child fatalities in New York City during this time frame may appear to be fairly low — particularly in light of the 2.1 million children residing in the City and the 30,554 children in foster care in 2000 (New York State Office of Children and Family Services, 2001; U.S. Bureau of the Census, 2002). The death of any child, however, is the worst possible outcome. When the cause of death is attributable to abuse or neglect, the loss is further magnified because it suggests that society has failed to ensure the safety and well-being of its most vulnerable members. Fatalities resulting from abuse and neglect, in particular, highlight the importance of developing a clear understanding of the issues and the factors that are associated with child deaths and the systemic failings that need to be addressed so that, to the extent possible, fatalities can be prevented in the future. At the same time, child fatality cases illustrate critical problems in child welfare practice – practices involving the investigation of child maltreatment, assessment of child safety, and services to families that may place all children referred to the New York City child welfare system in jeopardy.

This analysis examines the circumstances of the children who died during the time period under study, the characteristics of children and their families, and the reasons for the children's deaths. Importantly, it identifies areas in which child welfare practice and policy should be improved in order to ensure that children do not die from preventable causes. The report concludes with specific recommendations to strengthen the child protection system and to protect children from maltreatment-related harm or death. These recommendations also outline specific steps that should be taken to avoid harm to children and improve the health and well-being of all children who come in contact with the child welfare service system.

Data on Child Fatalities

Nationally, between 1,100 and 1,200 children die each year as a result of child abuse or neglect. In 2000 (the most recent year for which data have been reported), 1,236 children died of maltreatment (U.S. Department of Health and Human Services, 2002). National data indicate the following:

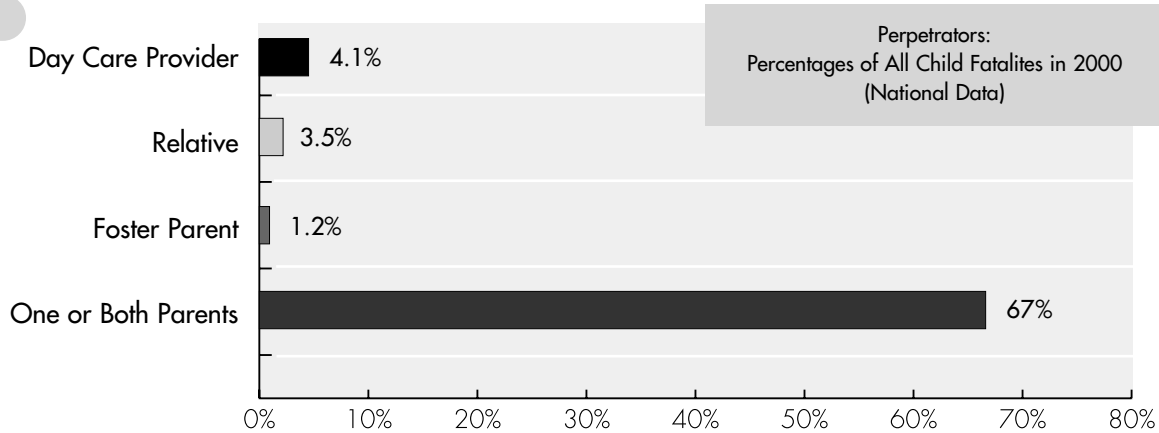
Very young children are at greatest risk of death from maltreatment. In 2000, 43.7% of the children who died were under the age of one year and 85.1% were under the age of six.

Children are most likely to die at the hands of their parents. In most cases, children die at the hands of their parents, either acting alone (in 30.2% of the fatalities, the perpetrator was the mother only and in 17.2%, the perpetrator was the father only) or acting together (19.6%). In a small percentage of the cases, the responsible party was a caregiver who was not a relative: in 1.2% of the cases, the perpetrator was a foster parent; in 3.5% of the cases, the perpetrator was another relative; and in 4.1% of the cases, the perpetrator was the child's day care provider. (See Table 1)

Children are more likely to die of neglect than abuse. Approximately a third (34.1%) of the child maltreatment deaths were the result of neglect (that is, failure to meet their basic needs), compared to the 27.8% that were the result of physical abuse. A combination of neglect and abuse led to the deaths of 22.2% of the children.

In some cases, the children and their families previously were involved with the child welfare system. In 14.9% of the child fatalities in 2000, the children’s families had received family preservation services in the five-year period prior to the child’s death.

Table 1



Data are more limited for New York State. In 2000, 79 children in New York State died of maltreatment (U. S. Department of Health and Human Services, 2002). The New York State rate of 1.68 child fatalities per 100,000 children was comparable to the national rate of 1.71 child fatalities per 100,000 children in the same year. Two of the reported 79 child fatalities occurred while the child was in foster care (2.5% of the child fatalities for the State which is comparable to the national percentage of 2.7%). New York State did not report the percentage of children who died as a result of maltreatment who had prior contact with child protective services, whose families had received family preservation services in the past five years, or who had been reunited with their families within the past five years – all of which are important indicators with implications for the identification and resolution of problems with the child protective service system.

Research on Child Fatalities

The research on child fatalities, like the national data on child deaths, indicates that very young children are at significantly higher risk of dying as a result of maltreatment. The research consistently indicates that approximately 40% of child fatalities involve children under the age of 2, and that 75% or more of maltreatment-related deaths involve children under the age of 4 (Levine, Freeman, & Compaan, 1994). Researchers have identified a number of issues associated with child fatalities as a result of maltreatment, including specific characteristics of the caregivers, the family, and the environment and the behaviors of the child (Anderson, Ambrosino, Valentino, & Lauderdale, 1983). Levine, Freeman, and Compaan (1994), for example, found that two issues closely associated with fatal child abuse among young children were colic and toilet training.

As is the case with national data, research has found that biological parents are the most likely perpetrators of fatal child abuse or neglect (Levine, Freeman, & Compaan, 1994). Mothers have been found to be the most likely perpetrators of fatal child neglect, and fathers have been found to be the most likely perpetrators of fatal child abuse (Levine, Freeman, & Compaan, 1994). Research is somewhat variable on the extent to which the families of children who died had already come to the attention of child protective services. One study estimated that roughly one-third of families in which fatal child maltreatment occurred had had prior contact with child protective services (Alfaro, 1988), as cited in Levine, Freeman, & Compaan, 1994). Another study found that well over three-fourths of the families had never come to the attention of the state's child protective services agency (Anderson, Ambrosino, Valentino, & Lauderdale, 1983).

Child Fatality Reviews

States have responded to maltreatment-related child fatalities in two ways. First, states have developed tools to better assess the safety risks to children, improve safety decision-making, and develop more effective safety plans for children who are at risk of harm (National Data Archive on Child Abuse and Neglect, 2001). Second, states have focused on developing a better understanding of the factors associated with child fatalities, an approach that typically has involved the creation of multi-disciplinary child fatality review teams (Rimsza, Schackner, Bowen, & Marshall, 2002; Crume, DiGuseppi, Byers, Sirotnale, & Garrett, 2002). These teams examine each child fatality brought to the team's attention, as directed by state law, with three principal goals in mind: (1) to ensure that all deaths attributable to child maltreatment are identified and are not inaccurately attributed to accidental or natural causes; (2) to assess the circumstances surrounding the child's death; and (3) in those cases in which the public child welfare agency was involved with the family prior to the child's death, to identify any omissions or actions on the part of the agency that may have contributed to the child's death, with the goal of improving practice in the future (Rimsza, Schackner, Bowen, & Marshall, 2002; Crume, DiGuseppi, Byers, Sironale, & Garrett, 2002).

In New York State, the law requires that the State of New York's Office of Children and Family Services ("OCFS") prepare child fatality review reports when: (1) the care and custody and guardianship of the deceased child has been transferred to an authorized agency (that is, all fatalities of children in foster care, regardless of the reason or suspected cause of death); or (2) when a report has been made to the New York State Central Registry of Child Abuse and Maltreatment alleging possible abuse or neglect in connection with a child's death. OCFS is responsible for investigating or providing for the investigation of the cause and circumstances surrounding each such death and reviewing each investigation; preparing and issuing a report on each such death; and preparing and issuing an annual cumulative report concerning investigated deaths (New York State Office of Children and Family Services, 2000). Annual statistical reports are issued, documenting the statistical parameters of child fatalities for the year, both for children in foster care and with their biological families at the time of death (see New York State Office of Children and Family Services, 2001). The data are analyzed for New York City and the "rest of the state."

New York law allows local or regional child fatality review teams approved by OCFS to play a role similar to that of OCFS – that is, to prepare and issue a report on the death of each child that the law requires to be reviewed (New York State Office of Children and Family Services, 2000). Under State law, these local and regional teams must include representatives from the child protective service office, the Office of Children and Family Services, the office of the District Attorney or local law enforcement, the office of the medical examiner or coroner, and a physician or comparable medical professional. Teams may include representatives from public health agencies, mental health agencies, schools and medical facilities, including hospitals or other appropriate agencies or institutions (New York State Office of Children and Family Services, 2000). New York City currently does not have a local, independent child fatality review team as permitted by State law.¹

Under New York State law, each child fatality report must be completed no later than 6 months after the death of the child (New York State Office of Children and Family Services, 2000). The law specifically requires that each child fatality report contain the following information: (1) the cause of death, specifically whether from natural or other causes; (2) an identification of the child protective or other services provided or actions taken regarding the child and family; (3) any extraordinary or pertinent information concerning the circumstances of the child's death; (4) information concerning whether the child's family had received assistance, care or services from a social service district prior to the child's death; (5) any action or further investigation taken by the OCFS or its social services districts since the death of the child; and (6) as appropriate, recommendations for local or State administrative or policy changes (New York State Office of Children and Family Services, 2000). The reports prepared by OCFS – which, since 1996, are public records — are summaries of the original child fatality case files documenting the activities of the local child protective services agencies. As such, they offer a synopsis of the case practice associated with individual child fatalities.

THIS STUDY: THE FOCUS AND THE METHODOLOGY

This report – unlike the annual cumulative child fatality reports issued by OCFS which focus on demographic data and the circumstances surrounding children's deaths — examines child fatalities in New York City for the purpose of assessing the quality of child protective services provided by New York City's child welfare agency — the Administration for Children's Services (ACS) — and the quality of child fatality investigations. The study involved a review of individual child fatality review reports prepared by OCFS concerning 194 New York City children who died during the period 1999 through mid-2001. The child fatality review reports, as public records, were obtained through a Freedom of Information Act request. The individual reports were reviewed by Children's Rights research staff; by Dr. Diana English, a child welfare consultant with expertise in child protective services and, in particular, safety and risk assessments and practices; and by three pediatricians through Doctors of the World, U.S.A. — Medical Advocacy Project, all of whom have extensive pediatric and emergency medicine expertise and experience — Dr. Ramona Sunderwirth, Dr. Josephine Kerr, and Dr. Kathleen Reichard.

¹ New York City currently has an Accountability Review Panel administered by the City's child welfare agency, the Administration for Children's Services. The Accountability Review Panel periodically issues reports that examine child fatalities only in New York City families that are known to the child welfare system. It does not function as a local child fatality review team.

The child welfare and medical experts were asked to assess practice issues on three groups of children and families: (1) cases in which ACS had no previous involvement with the deceased children or their families until the time of the child's death (76 children); (2) cases in which the family was known to ACS and the child was living in the custody of his or her biological family at the time of death (49 children); and (3) cases in which the child died while in foster care (69 children).²

This report, based on the researchers' and experts' review of the OCFS child fatality review reports, discusses:

- Key demographic characteristics of children who died and their families;
- The manner of the children's deaths;
- Child welfare practice considerations associated with child maltreatment and child fatality outcomes; and
- Specific issues related to children's medical conditions and health care that are associated with fatality.

The report identifies overarching issues that affect the quality of child fatality investigations and the quality of risk and safety assessments and protective services responses. Finally, the report provides practice and policy recommendations to strengthen child fatality investigations and child protective services and, most importantly, to minimize the extent to which children are placed at risk of extreme harm.

SPECIFIC FINDINGS ON THE CHILDREN AND FAMILIES

Each category of children whose cases were examined in this study presented unique practice and policy issues. The primary issue in cases involving the death of children when ACS had no previous involvement with the family was the safety of surviving siblings and service provision to the family. In cases involving the death of children when ACS had previous involvement with the family, the issues also included sibling safety and service provision, but extended to the adequacy of the initial safety and risk assessments, case planning/services, and case monitoring. In cases involving the death of children in foster care, some of the same issues that were evident in cases in which children died while with their biological families were present but in these cases, there were also issues associated with the quality of monitoring and services and supports provided to foster families.

For each of these three groups of children, this report discusses the general characteristics of the children and their families; the manner of the children's deaths; and the practice issues that were identified.

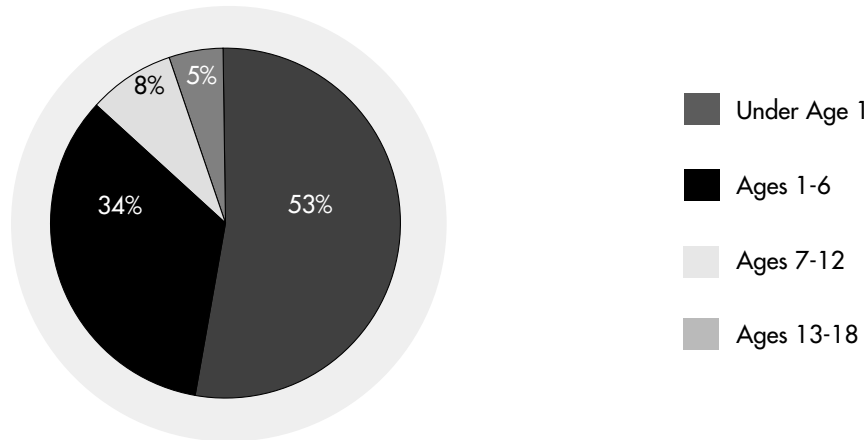
² Not included in this report are cases in which the identity of the child could not be determined. Three cases involved deceased infants with no identifying information: two infants appeared to have been killed soon after their births, and the third appeared to be stillborn as a result of excessive alcohol consumption by the birth mother.

GROUP I:

CASES IN WHICH THE CHILD DIED WHILE LIVING WITH THE BIOLOGICAL FAMILY AND THE FAMILY WAS NOT PREVIOUSLY KNOWN TO ACS

The Characteristics of the Children and the Families

The following pie chart provides the age composition of children in this group of children and families.



In addition, the following were noted regarding child deaths in families who previously were not known to ACS:

The children were most often very young. A little over half of the children in this group who died were below the age of one. Moreover, nearly nine out of ten children were 6 years old or younger.

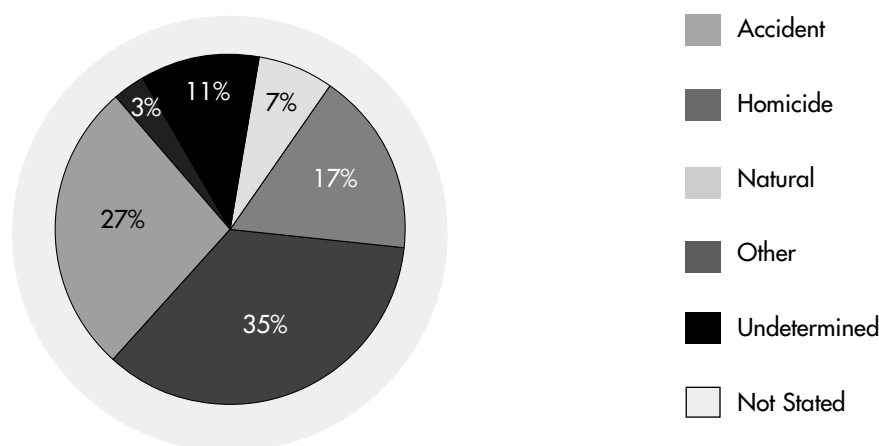
When homicide was the cause of the child's death, mothers were more often responsible for newborns' deaths, and fathers were more often responsible for deaths of children who were somewhat older. Mothers (frequently, a teen mother whose pregnancy was hidden from others in the household, who gave birth at home, and who attempted to dispose of the child) were most often the perpetrators when newborns were killed.³ Fathers (or mothers' boyfriends) were more likely to be the perpetrators when children age 2 years or older were the victims of homicide.

Compared to the group of families who were known to ACS at the time of the child's death, the families in this group tended to have more risk factors and had younger children. Consistent with the research (see Anderson, Ambrosino, Valentino, & Lauderdale, 1983), these families often were characterized by small family size, young parents, and under-utilization of community support services. In a large number of these cases, the children were young (under 1 year of age) and their surviving siblings were 3 years old or younger.

³ "Newborns" are defined as infants from birth through 4 weeks of age.

The Manner of Children's Deaths

The following pie chart shows the manner of death for children in this group of families. “Undetermined” refers to the Medical Examiner’s final conclusion that the manner of the child’s death could not be determined. “Not stated” refers to the fact that the report on the child’s death did not state the manner of death. In some cases, the Medical Examiner had not yet made a final conclusion as to manner of death. In other cases, the absence of this information was not explained in the report. The relatively large number of cases with a “not stated” manner of death is important as it suggests that the percentages of cases in the other specified categories reflect a possible undercount of cases.



In addition, the following were noted with regard to the manner of children’s deaths:

A large proportion of young children who died were the victims of homicide. More than one third of the children age 6 or younger (23 children) were victims of homicide. Six of these children were newborns. (See Table 2)

Some infants died as a result of homicide, while others died because of inadequate supervision, inadequate or unsafe housing, or inadequate/unsafe caregivers. In this group of families, 14 infants died as a result of homicide, and others died because of failure to supervise the child’s status, housing conditions that put the child at risk, and inattention by caregivers.

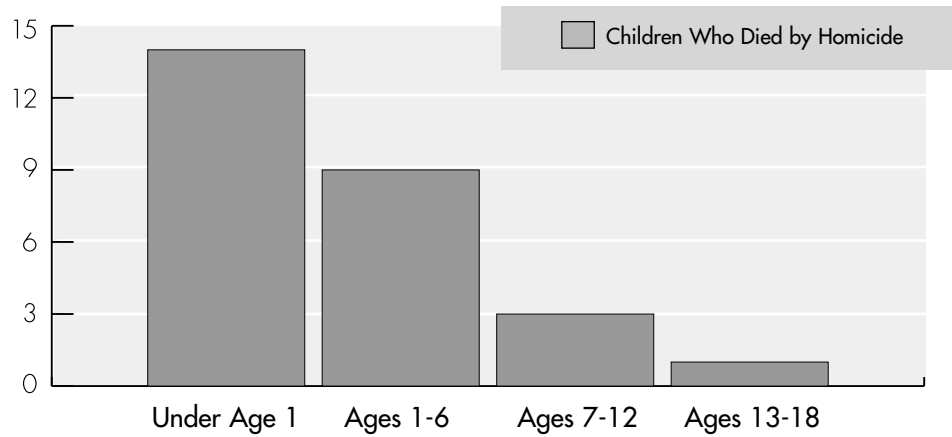
Children who died as a result of accidents were very young. Of the children age 6 and younger whose deaths were identified as “accidental” (such as drowning, smoke inhalation, scalding, falling, and car accidents), most were between 1 and 2 years of age.

Most children who died of natural causes were young. Almost 90% of the children who died of natural causes were 2 years old or younger. Natural causes, the manner of death for 21 children, included medical conditions such as SIDS and asphyxia and medical complications such as viral infection.

Homicide was the cause of death of three children in the age range of 7 through 12 years. Of the 6 children ages 7 through 12 who died, three children were murdered, one died of natural causes, one child's manner of death was undetermined, and one child's manner of death was unstated.

Of the small number of teens in this group, three died violently. Of the four teens in this group, one died of homicide, two committed suicide, and one died of natural causes.

Table 2



Practice Concerns

Because these cases involve children and families who were not known to ACS prior to the child's death, the practice issues focus on the quality of ACS's assessment and decision-making after the child's death. Of particular concern with regard to this group of children and families are the extent to which risk factors in evidence at the time of the child's death were appropriately identified and the extent to which the safety of surviving siblings was appropriately assessed during the fatality investigation.

The child fatality review reports indicated that a range of risk factors were present in these families, including:

- Domestic violence
- History of prior abuse/neglect
- Caregiver history of victimization as a child
- Caregiver criminal history
- Adolescent mother at the time of the first birth
- Failure to recognize problem(s) in their own families
- Parental medical or mental health problems
- The child's physical vulnerability at birth
- Physical hazards in the home

An analysis of the reports revealed that for this group of families, the following practice issues were of concern:⁴

⁴ In each "Practice Concerns" section, specific cases are cited and are referred to by the OCFS identifying number.

1. ACS often conducted inadequate safety assessments.

In many of the cases that were reviewed, it was not clear whether safety assessments for surviving siblings were done at all. When it was clear that assessments were done, the quality of many assessments was questionable. In a number of cases, the only documented information was an unexplained conclusion about lack of safety. Decisions to remove surviving siblings from their parents' custody often were made with no explanation of the factors that were believed to put the children at imminent risk of harm. Having already experienced the trauma of losing a sibling, these children may have been unnecessarily removed from their parents' custody and placed in foster care.

- In one case involving the death of a 7-month old who drowned in a bathtub, the child lived with her mother and 3-year old brother. The risk rating for the family was documented as "Moderately Low," but the surviving sibling was determined to be "unsafe" and was removed from the mother's care and placed in foster care. The safety assessment did not identify the family risk factors that placed the child at imminent risk of harm nor did it explain why placement in foster care was the appropriate safety intervention. (#95-01-025)
- In another case, a 7-year old with a history of asthma and respiratory problems died. ACS determined that the child's 13-year old surviving sibling was "unsafe" and listed "other" as the intervention to ensure her safety, providing no further explanation of how the child would be protected. It was not possible to determine why the child was considered "unsafe" nor how "other" interventions would protect her. (#95-01-021)
- In another case, a 4-year old with disabilities drowned in a tub. The surviving siblings (ages 2 years and 13 months) were taken into foster care with no explanation as to the reason for the children's removal from the home other than the listing of "protective removal" as the Safety Intervention. The reason given for the intervention was "children were removed from the home for their own protection." The only safety factors that were listed related to the incident itself with no explanation as to how the incident placed the surviving siblings in danger of serious harm. (#95-99-028)
- In yet another case, a 4-year old child died of head trauma following an automobile accident in which the child's mother and 6-year old sibling also were passengers. The driver was the mother's boyfriend who was determined to be intoxicated at the time of the accident and who was found to be responsible for the collision that caused the children's injuries. The surviving sibling was placed in foster care with no indication in the safety assessment that the child was unsafe in the mother's care. There was no evidence that the mother was intoxicated at the time of the accident, that she had a history of drug or alcohol use, or that she otherwise presented a risk to the child. (#95-99-008)

In other cases, the information contained in the reports suggested that the safety of the surviving children was an issue of serious concern, but the case decisions indicated that only limited attention was paid to those safety issues.

- In one case, following the death of a 5-day old infant, ACS removed and placed into foster care the child's surviving siblings, ages 2 and 3 years. The child's mother (a former ward of ACS) was found to be developmentally delayed, and the father was described as hostile and uncooperative. Shortly after the removal, the children were returned to the parents (without any explanation as to the basis for this decision) with a plan of unannounced home visits by ACS. The report indicated that the parents "refused services," although it was not clear which, if any, services were offered to them. When the Medical Examiner found the cause of death to be SIDS, ACS determined that the children were "safe" solely on the basis that the manner of death was determined to be natural causes. (#95-99-018)
- In a case involving the death of a 2-year old who died of burns after he fell into scalding water in a bathtub, the child lived with two sisters (ages 3 and 11) and one brother (age 9). ACS documented that the surviving siblings were "safe" in their parents' care, but also noted at different times in the investigation: unsafe conditions in the house (the home had missing window guards, faulty wiring, and vermin); a lack of food; and the parents' failure to obtain medical care for the children. None of these issues appeared to have been addressed. (#95-00-022)

2. Decisions regarding the needs of surviving siblings often were inconsistent in light of the results of safety assessments.

A variety of inconsistencies were found in these cases between the safety assessment conclusions and the steps that ACS subsequently took. In some instances, children were assessed as "safe," but, nonetheless, were removed from their parents' custody.

- In one case, three safety assessments were conducted and all three assessments indicated that the five surviving siblings of a 9-year old who died of a ruptured appendix (and whose parents were determined to be responsible for not appropriately seeking medical care for the child) were "safe." Nine weeks after the child's death, despite the parents' compliance with all of the requests by ACS (including medical examinations of all children), ACS removed the children from the home on an "emergency" basis with no documentation as to the reasons for this decision. (#95-99-027)

In other cases, children were determined to be "unsafe," but no protective interventions were taken.

- In one case, a 10-year old who was one of a set of male triplets died from starvation and dehydration. ACS determined the surviving siblings to be "unsafe" on March 1, 2000. ACS did not seek judicial or other protective interventions until two and one-half months later – on May 16, 2000. No services were provided to the family between March 1 and May 16 despite documentation that the children were at risk because of the parents' failure to obtain medical treatment in a timely manner and their failure to provide for the children's basic needs (their clothing, for example, was found to be dirty and smelled). (#95-00-007)

In yet other cases, the surviving sibling was determined to be "unsafe," but the interventions addressed issues of ongoing risk as opposed to the safety of the child – such as bereavement counseling in one case (#95-01-014) and parenting skill classes in another (#95-01-009).

3. In some cases, ACS inappropriately intervened into families' lives.

In some cases, ACS refused to return children to their parents despite the absence of any legal authority which allowed the agency to keep the parents and children apart.

- In one case, ACS determined that the 3-year old sibling of an 8-day old infant who died from overlay (while sleeping with the child, the parent rolled over and suffocated the child) was “unsafe” although no risk factors were specifically identified. The toddler was placed with the grandmother. Both the grandmother and the mother were led to believe that the child had to stay with the grandmother when ACS had no legal or protective authority to keep the child and mother separated. (#95-00-047)
- In another case, a 3-year old died from drowning in a bathtub when left unattended by her mother. The surviving sibling was a 4-year old sister who also was in the tub at the time of the child's death. During the investigation, the surviving sibling moved to live with her father at his residence. The safety assessment indicated that the child was “unsafe” with the mother, but it did not explain how the child would be in immediate danger of harm, particularly given earlier documentation that the mother appeared to provide adequate care and supervision of her children and did not pose a threat to them. When the mother requested that her daughter be returned to her from the father's home, ACS refused her request, although it had no legal authority to keep the mother and child separated. Finally, three months after the child's death, the 4-year old was returned to her mother's care. (#95-01-028)

In other cases, there was questionable casework practice reflecting a lack of sensitivity to the family and/or responsiveness to the circumstances of the case.

- In one case, a court hearing was scheduled on the day of the child's funeral (#95-99-018), and in another case, ACS required the mother to attend parenting skills classes and to have her interactions with a surviving sibling observed by a voluntary agency when her child had died in a car accident. (#95-99-008)

4. Frequently, ACS failed to contact the deceased child's physician.

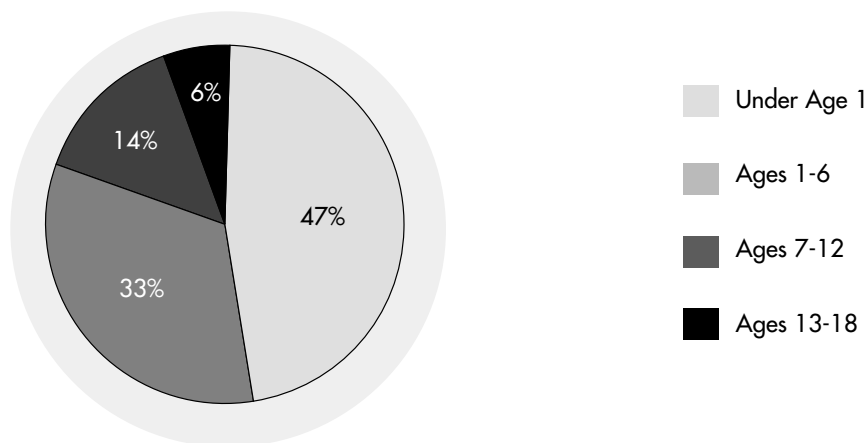
- In a number of cases, ACS did not contact the child's physician to obtain information on the deceased child's medical history, health status or health care, even when such information was suggested by non-medical collateral contacts during the investigation. (See #95-99-005; #95-99-014; #95-99-032)

GROUP II:

CASES IN WHICH THE FAMILY WAS KNOWN TO ACS AND THE CHILD DIED WHILE IN THE CUSTODY OF THE BIOLOGICAL FAMILY

The Characteristics of the Children and the Families

The following pie chart provides the age composition of children in this group of families.



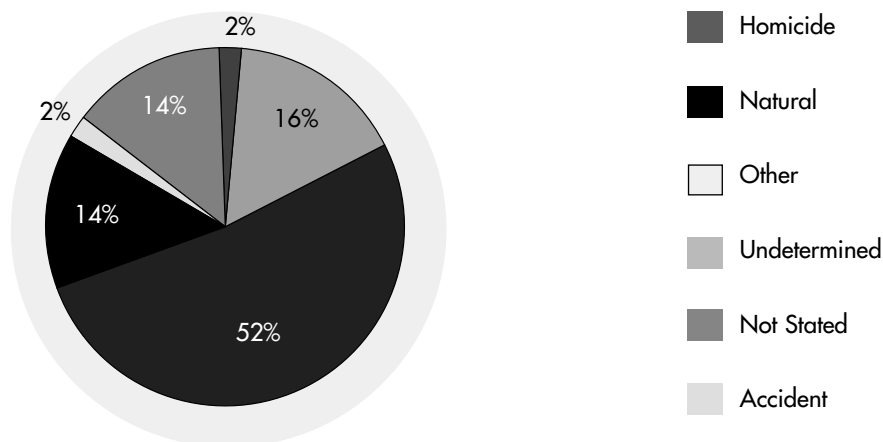
In addition, the following were noted in relation to child deaths in families who were known to ACS at the time of the children's deaths:

The children were most often young. Four-fifths (80%) of the children who died in this group were 6 years old or younger. Moreover, close to half of the children were under the age of one year.

Certain risk factors were prominent in this group of families. Prominent risk factors in this group of families were domestic violence, parental substance abuse, and caregiver history of victimization.

The Manner of Children's Deaths

The following pie chart shows the manner of death for children in this group of families.⁵



⁵ As indicated earlier, "undetermined" refers to the Medical Examiner's final conclusion that the manner of the child's death could not be determined. "Not stated" refers to the fact that the report on the child's death did not state the manner of death.

In addition, the following were found with regard to the manner of children's deaths:

Despite the fact that the families were known to ACS, one-half of the children in this group were murdered. Homicide was the manner of death for 52% of the children in this group.

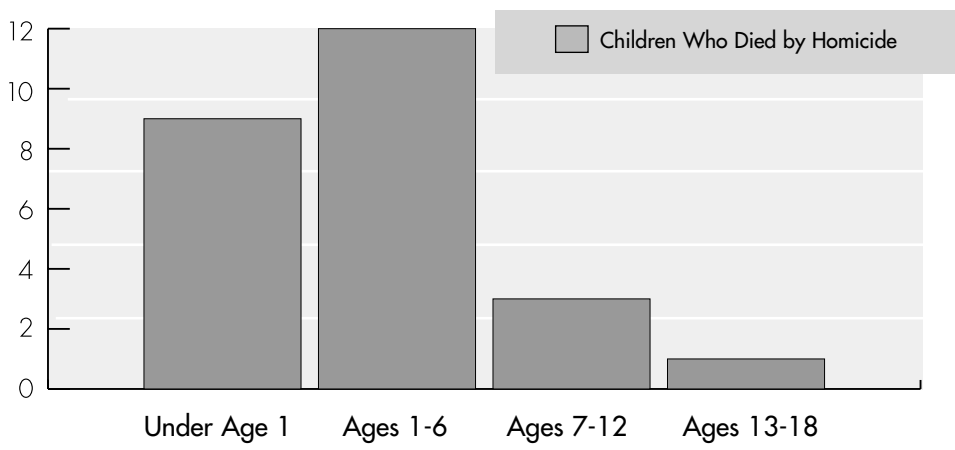
The majority of children who died as a result of homicide were young. The overwhelming majority of children who were murdered were age 6 years or younger (84%). Slightly more than one-third (36%) of the children who died of homicide were under the age of one year. (See Table 3)

Compared to older children, younger children were more likely to die of accidents, respiratory problems, and infection. Compared to older children, children age 6 or younger were more likely to die from fire, drowning, asphyxiation, pneumonia, infection, and SIDS.

The manner of death for older children (ages 7 through 12 years) varied. Of the 7 children in this age group who died, 3 were murdered, 3 died of accidental causes, and 1 died of natural causes.

Few of the children in this group were adolescents, making it difficult to note any trends regarding the manner of death. Two adolescents died of brain cancer, and one adolescent was stabbed.

Table 3



Practice Concerns

The practice concerns in this group of families – who were known to ACS before the children's deaths — include the same issues discussed in connection with the first group of cases (families not known to ACS prior to the children's deaths). In addition, concerns extend to the quality of ACS' safety and risk assessments prior to the children's deaths and the appropriateness of the interventions taken in relation to the safety risks posed to the children at the time of ACS' original contacts. Several themes emerged from the review of these cases:

1. The response often was inadequate to the interaction of multiple risk factors and to patterns of multiple referrals.

Common to the families in this group were risk factors that indicated an elevated risk of harm to children: domestic violence, substance abuse, and/or parents' history of child maltreatment (all of which have been shown in the child maltreatment research literature to be predictive of re-referral/recurrence of maltreatment, although not necessarily, child fatality) (McKay, 1994; National Center for Children in Poverty, 2002; Reid, Marcchetto, & Foster, 1999; Semidei, Radel, & Nolan, 2001; Waldfogel, 1998). In many cases, domestic violence was the primary risk factor that interacted with other risk factors. The reports, however, did not indicate that caseworkers assessed the interaction of risk factors or took into consideration the elevation of risk as a result of combinations of risk factors.

- In one case, ACS was aware of the father's history of domestic violence and substance abuse. Between 1995 and 2001, there were eight reports of child maltreatment that alleged inadequate guardianship, lack of supervision, domestic violence, lacerations, bruises, welts and excessive corporal punishment. ACS found that six of the reports regarding domestic violence were "indicated." Despite these findings, ACS closed the case and documented that the family would be engaged in counseling and domestic violence services on a voluntary, not mandatory, basis. In May 2001, the 17-year old son, described as a quiet child who regularly attended school and played on the basketball team, was stabbed and killed by his father during an argument. The deceased child's two siblings were in the apartment at the time, blowing up balloons for the 11-year old child's birthday. (#95-01-029)
- In another case, a report was made in October 1999 that a 16-year old was beaten by her mother and her stepfather. Allegations of inadequate guardianship and lacerations, bruises and welts were substantiated, and it was determined that the child was "unsafe" in the home. The maternal grandmother petitioned for and received custody of the 16-year old child. ACS, however, left the 9-year old half-brother in the home, without any documentation of the reasons for this decision. The parents were referred for mental health evaluations and anger management, among other services, but the case record did not indicate whether the family followed through with any of the recommended services. In March 2000, the teenager had her monthly visit with her mother. During that visit, the stepfather, after drinking throughout the evening, beat the mother and step-daughter with a hammer and then took his 9-year old biological child and jumped off the roof, killing them both. (#95-00-010)

2. There often was inadequate monitoring of and follow-up services for families based on the identification of risk factors.

As was the situation with families not previously known to ACS, these cases often showed a disconnection between identified risk and decision rationales. At the same time, the level of risk presented (based on the risk factors identified and documented) was not consistently met with an adequate level of monitoring and follow-up services. These deficiencies appeared to be particularly problematic in cases in which the caregiver's lack of cooperation and/or lack of compliance with the case plan had been identified and documented. Although it cannot be said with certainty that a higher level of monitoring and assurance

that families participated in services would have prevented the death of the child, more intense monitoring or reassessment of risk based on the caregiver's lack of compliance may have resulted in protective interventions, including possible placement of the child outside the home.

- In one case, the case manager at a shelter referred a mother of a 2-year old for preventive services to improve her parenting skills. A child maltreatment report was made several months later regarding the mother's lack of supervision and inadequate guardianship of her child and drug/alcohol misuse. ACS only substantiated the drug misuse allegation after failing to interview any collateral contacts regarding the other allegations. The mother had a second child within eight months of the first maltreatment report. At that point, ACS assessed the children as unsafe and referred the family for preventive services, but the mother refused to cooperate with the service plan. The 2-year old did not attend the Early Intervention Program in which he was enrolled. The last documented home visit was a year and five months after the initial report, three months before the mother gave birth to twins. The case worker documented attempts to visit the family but also documented that the family's whereabouts were unknown. The preventive services agency terminated services, and ACS closed the case. Later that same year, approximately two years after the first maltreatment report and referral for services, the middle child, then 16-months old, was battered to death in his home. The medical examiner reported that the child had had several fractured ribs, an arm fractured in two places, a fracture to his first and second vertebrae and injuries to his aorta and spleen (some of which had occurred prior to the child's death). At the time of her son's death, the mother, who had been adopted from the foster care system herself, was caring for a 3-year old, the 16-month old, and 4-month-old twins. (#95-00-050)
- In another case, the mother was known to ACS as a child from the age of eight. Both she and her brother spent time in foster family and group homes as children. As an adult, the mother was the subject of three child maltreatment reports before her 2-year old child was beaten to death. The mother and boyfriend were present at the time of the child's death, but the perpetrator had not been determined at the time of the fatality review report. Only one previous report on the mother was substantiated, although thorough and complete investigations were not done for all reports. One of the unsubstantiated reports, for example, was made when the deceased child, then a 1-year old, came to the hospital with two fractured ankles and ACS accepted the explanation that the 4-year old sibling inflicted the injuries while the mother was sleeping. Despite the pattern of referrals, the nature of the child's injuries, and the mother's history of failing to follow through with referrals, ACS took no further action to protect the children. (#95-00-031)

3. *The needs of the surviving siblings often were not appropriately assessed, resulting in arbitrary decisions that did not appear to be in children's best interests.*

Similar to the pattern observed with families not previously known to ACS, surviving siblings in these cases typically were removed from their parents' custody following the death of a child. There appeared to be little connection among: the identified risk to the surviving siblings, the plan for risk reduction, and the relationship of the identified risk to plans for return of the surviving siblings to the parents.

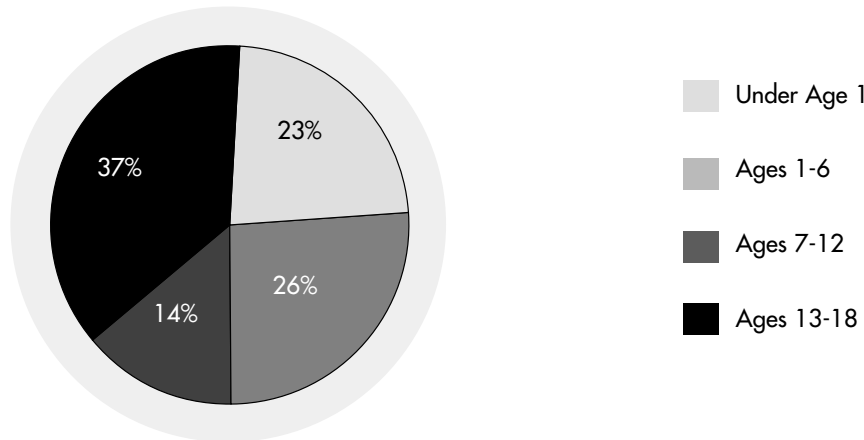
- In one case, a half-sibling of a child who died of a medical condition (Prader-Willi Syndrome) was removed from his paternal grandmother's home for several days even though the child who died had lived in a different home with the children's other grandmother. ACS failed to document prior to the removal that the surviving half-sibling was in imminent danger, and, in fact, ACS subsequently determined that the boy was not at risk. (#95-01-008)
- In another case, a 9-year old sibling was removed from her parents' custody and placed into foster care following the death of her 7-month old sibling (for which the manner of death could not be determined). There was no documentation that the 9-year old was unsafe. The child was placed in foster care on the same day that she attended her sibling's funeral. She remained in care for approximately six weeks. (#95-00-002)

GROUP III:

CHILDREN IN FOSTER CARE OR IN KINSHIP PLACEMENTS

The Characteristics of the Children

The following pie chart provides the age composition of children in this group of children.

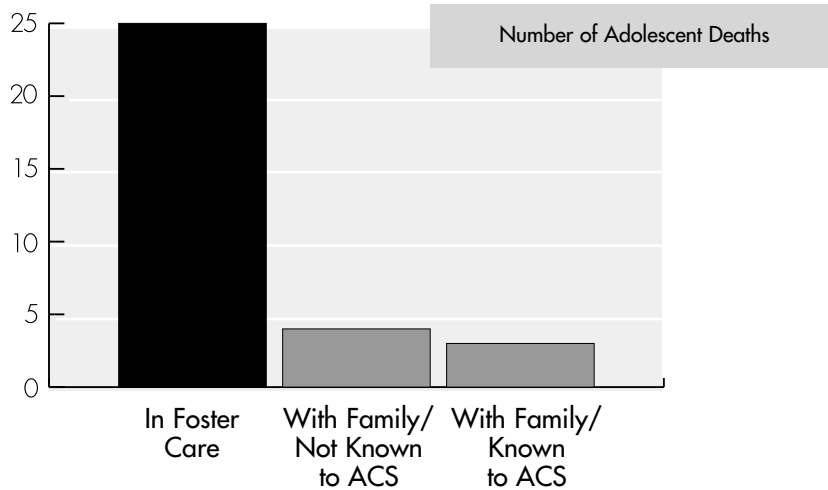


In addition, the following were noted in relation to deaths of children in foster care:

The large majority of children who died while in foster care were placed because of neglect. The overwhelming majority of children in this group were placed because of parental drug and/or alcohol use which led to neglect and foster care entry.

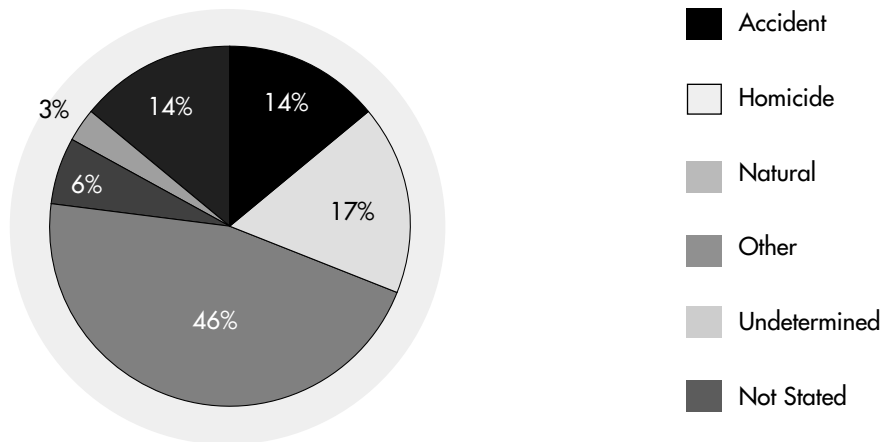
The ages of children who died in foster care were more broadly distributed than children who died while living with their biological parents. Approximately one quarter (23%) of the children who died in foster care were under the age of one year; another quarter (26%) were age 1 year through 6 years; about 15% were ages 7 through 12 years; and more than one-third (36%) were adolescents. Particularly striking, as illustrated in Table 4, was the large number of adolescents in this group (25) — particularly when compared to 4 adolescents in the group of families who were not previously known to ACS and 3 adolescents in the group of families known to ACS at the time of the children's deaths.

Table 4



The Manner of Children's Deaths

The following pie chart shows the manner of death for children in this group.⁶



In addition, the following were noted regarding the manner of children's deaths:

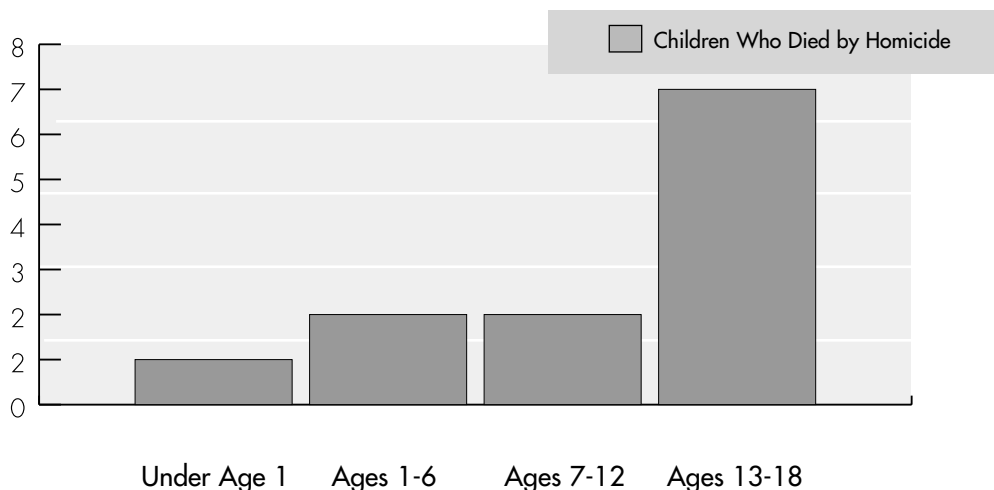
Most children age 6 or younger died from natural causes. The cause of death for the majority of children in this age group (59%) was either a medical condition that predated the child's entry into foster care or a medical condition that the child developed while in foster care.

No clear trend was evident in the manner of death for children ages 7 through 12 years. Children in this age group died of accidents (3 children), natural causes (4 children), and homicide (2 children). The manner of one child's death was undetermined.

More than one-half of the 12 homicides of children in foster care involved adolescents. Of the 12 children who died as a result of homicide while they were in foster care, 3 were age 6 or younger, 2 were between the ages of 7 and 12, and 7 were teenagers. (See Table 5)

⁶ As indicated earlier, "undetermined" refers to the Medical Examiner's final conclusion that the manner of the child's death could not be determined. "Not stated" refers to the fact that the report on the child's death did not state the manner of death.

Table 5



Practice Concerns

The review of this group of the child fatality reports for these children and youth – most of whom were placed with relatives, unrelated foster parents, or in congregate care but some of whom were with biological parents on trial discharge status at the time of their deaths – revealed a number of key concerns. The principal practice concerns involved questions about the adequacy of training for caregivers; the quality of services and supports provided to foster families and kinship caregivers and their children; the level of supervision of children and youth in the custody of ACS; and the outcomes for youth on AWOL status. The following issues were identified:

1. Foster parent training was found to be inadequate in several safety areas.

In several cases, it appeared that foster parents were not provided with training that might have averted children's deaths.

- In one case, a child's death might have been prevented had the foster parent known CPR. The baby girl died at the age of 3 months of sepsis and pneumonia. The foster mother called the 911 operator and was told to perform CPR, but she did not know the technique and had to run to a neighbor's home to find someone who knew CPR. The delay was a key factor in the child's death. OCFS suggested in its corrective action plan for this case that ACS add CPR training to foster parent training requirements. (#97-00-005)

In yet other cases, training on appropriate sleep positioning for infants may have provided a safer environment for young children.

- In the case described above (#97-00-005), the infant was laid to sleep on her side the night that she died. The medical assessment of the case indicated that the foster parent should have been told that lying an infant on his/her side to sleep causes a risk for SIDS and that pediatricians routinely advise care givers to put children on their back(s) to sleep. Similarly,

in another case, a male infant, also age 3 months, died as a result of being positioned inappropriately in his crib. His foster mother laid him to sleep on his side, and he subsequently rolled over onto a pillow in the crib and smothered. (#97-01-001)

In other cases, lack of training and preparation combined with other factors to place the child at high risk.

- In one case, a foster mother left her 3-year old child alone in the bathtub, and he sustained severe burns. When the foster mother heard the child's screams, she attempted to treat the burns with cold water and baby lotion. When she noticed the child's skin was still very red, she called her husband and then called the agency's emergency numbers. She could not reach anyone at the agency. She then dressed the child and called the agency again. When she finally reached someone, she was advised to take the child to the hospital, and her husband did so at that time. The child went into cardiac arrest and died three hours later. During the investigation of this fatality, it was discovered that the foster care training that the foster mother had received did not include the topics of supervision and safety of children while bathing them. Other factors were also noted during the investigation. First, ACS knew that the child who died and his sibling had behavioral challenges that resulted in "mischievous" behavior (in fact, it was believed that the child moved the water valve on the tub to hot while unsupervised). Second, the home did not have a safety valve for the water temperature. Finally, as noted above, time was lost in responding to the emergency when the foster parents made repeated unsuccessful calls to the agency to obtain authorization to take the child to the hospital. (#95-99-001)

2. ACS often inadequately documented and communicated children's serious health concerns.

There were a number of cases in which ACS did not make foster parents aware of children's medical conditions or the health services that children would need. In many of these cases, a lack of knowledge prevented foster parents from communicating information to health care providers about the children's medical status. Without an adequate medical history, the children's physicians were placed at a disadvantage in diagnosing and treating the children's conditions effectively. In other situations, foster parents had no information about the children's medical conditions and were not aware of the need for treatment that may have prevented their deaths.

- A 4-month old male child died because of complications of a chronic lung disease. Although the child was born 12 weeks premature and taken into custody by ACS at birth, ACS failed to communicate the child's medical condition and history to the private foster care agency to which ACS referred the infant. ACS, in fact, informed the agency that the child was healthy and developing normally. The foster care agency submitted a written request to the hospital for the child's medical information, but the hospital did not respond to the request until after the child died. The foster parents took the child to his well baby appointments, and he was deemed healthy. Within the last month of the child's life, the foster parents took him to the emergency room three times for various symptoms, including improper digestion, fever, and congestion. Once, the emergency room physician diagnosed him as functioning normally, and twice he was diagnosed as having a cold. Because the foster parents were not given critical

information on the child's health and medical history, they could not provide the physicians with information that might have facilitated an accurate diagnosis. The child died three days after his last emergency room visit. (#95-01-022)

- A similar case involved a baby boy who also died of a chronic lung disease. The child was diagnosed with bronchial pulmonary dysplasia at birth, and he remained in the hospital for his first month of life. The child was placed with foster parents and began to manifest respiratory problems. Because ACS and the private foster care agency had not obtained his medical information, they were unaware of and unable to communicate the severity of his condition to his foster parents. The foster parents were attentive to the child and sought medical attention, taking him to the emergency room on three different occasions and administering Tylenol at the doctors' directions. As in the previous case, the emergency room physician misdiagnosed the child as having a cold. The child died of lung disease shortly after being seen in the emergency room on the last occasion. (#97-00-021)
- In another case, a 15-year old in foster care with no documented chronic health concerns died of cardiac arrest. ACS reported to the private agency that provided foster care services to the teen that his last medical diagnosis was at the age of 14 and that he was found to be within normal limits. A school report that same year, however, indicated that he had an undetermined problem that caused him to lose consciousness. ACS had the school report but did not send it to the private foster care agency. The private agency repeatedly requested that the teen's foster parent submit medical reports on the child, but the foster parent failed to do so. Despite the foster parent's failure to obtain a medical assessment of the child, the private foster care agency did not make any effort to have the child examined or provided with medical services. ACS, when notified by the private agency of the situation, also failed to take steps to ensure that the child was medically assessed. (#97-99-015)

3. *The safety of children's home environments often was not sufficiently monitored.*

Several young children in foster care died or were murdered as a result of ACS's inadequate attention to their safety in the settings in which they were placed. These situations presented themselves in a variety of ways.

In some cases, foster parents who needed supports to meet their children's special needs did not receive necessary services. At the same time, it was not uncommon to find that children did not receive the attention and emotional support they needed (particularly from caseworkers) to address or disclose the risky behaviors that ultimately led to their deaths.

- In one case, a child, age 7, died of smoke inhalation after being placed in a foster home that was not licensed for a child of his age or level of need. The foster mother expressed concerns about the child's fire-setting behaviors and her ability to handle this behavior. ACS documented that the child had set several fires and was hyperactive. ACS, however, did not provide services to address the child's behavior nor did it provide resources/supports for the foster mother. The police detectives investigating the case concluded that the fire was consistent with a child playing with matches. (#95-00-045)

- In another case, an 18-year old in foster care died of AIDS-related complications one month after being hospitalized for the disease. Although it became clear after her death that she knew that she was HIV-positive, no one in authority – ACS, the private agency, or the foster parent – had any indication that she was HIV-positive and needed medical services. Her case history reflected multiple social workers, several changes in the permanency goal during her 11 years in care, and an absence of service plans and services to address at-risk behaviors (such as violating curfew and spending excessive time on the streets). Her foster mother often did not respond to calls or letters from caseworkers. Four months before the young girl's death, a caseworker counseled her about safe sex, but the girl, who knew that she was HIV-positive, insisted that she had not engaged in any risky sexual behaviors and had nothing to be concerned about. (#97-00-010)

In other cases, ACS did not adequately monitor children's foster care and kinship care placements.

- After an argument, a 19-year old child in foster care murdered a 17-year old child in the same foster home. Each girl had a troubled past, missed school excessively, and stayed out late (sometimes the entire night). Both girls had histories of multiple placements. The 17-year old was known to be violent and to have a bad temper. The girls had separate, frequently changing caseworkers. The foster mother contacted one caseworker one month before the incident to discuss the 19-year old's behavior. The girl was not attending school, was not employed, and was not attending independent living workshops. She refused counseling and was not eating well or taking care of herself. In response to these concerns, the caseworker advised the foster mother to withhold the 19-year old's allowance. Of equal concern was the fact that the foster mother worked very long hours, a factor that apparently was not taken into account when determining the appropriateness of placing a 17-year old teen with significant problems in a home where there was already another troubled teenager (the 19-year old) and two teenage boys (biological children of the foster family). (#95-99-007)
- A 9-year old girl died as a result of a gunshot wound she received accidentally in her kinship foster home. The gun was in the home unbeknownst to the girl's maternal grandmother. The girl found the gun late one night and handed it to her 12-year old cousin. He cocked the gun and handed it back to the girl, and she shot herself. Among the foster mother's frequent overnight guests were a family friend (and former paramour of the girl's biological mother) who had a criminal background and had been living in the home for a year; the foster mother's brother who also had a criminal background (but who, nevertheless, had been approved as a babysitter for the children and who, later, was arrested for having brought the gun into the home); and the foster mother's current paramour. ACS had not cleared any of these men to live in the home. Despite supervision requirements, neither ACS nor the private foster care agency ever became aware that the men were living in the home. (#95-01-033)

- In another case, a female child, age 11 months, died of acute cocaine intoxication. Although her caseworker was required to make monthly visits to the home, the child's foster care case record contained no progress notes and very little other information. When the last documented home visit occurred approximately three weeks prior to the child's death, the caseworker discovered that the foster mother was out of town and that the children were in the care of an unauthorized caregiver, whom, it was determined, had a history of drug use. There was no documentation that the caseworker assessed the safety of the children under these circumstances. It also appeared that no steps were taken with regard to the foster mother's boyfriend who lived in the house on and off, abused drugs in the home, and sold drugs and stolen goods out of the home. (#95-00-028)

In yet other cases, there was a failure to adequately monitor children's trial discharges to their biological parents.

- A 7-year old died of complications related to Sickle Cell Anemia (with which she was diagnosed as an infant) while on a trial discharge from foster care to her biological mother. There was no casework contact with the family during the entire nine months of the trial discharge to her home. Upon planning the trial discharge with the mother, ACS knew of the child's condition, which likewise affected her brother who also was discharged on a trial basis to the mother; knew that both of the children required prescription medication; and knew that the children required ongoing medical attention. Nonetheless, the children were placed on trial discharge with the mother without ensuring that the mother had health insurance to cover the children's medical care and medication. Because she lacked insurance, the mother did not obtain the prescription medication that the children needed. She instead attempted to treat the children with over-the-counter medications such as Nyquil and Tylenol. She also did not take the children to the doctor. The mother had stated upon the children's trial return to her that she would obtain health insurance through Medicaid and/or private insurance, but she did not do so, and the caseworker did not follow up on this issue. Within a few days of the little girl's death, her brother was hospitalized with complications related to Sickle Cell Anemia. (#96-00-009)

4. A disturbing number of adolescents died violently while on AWOL status.

Most striking in connection with the deaths of adolescents in foster care was the violent nature of the deaths of youth who were on AWOL status from their placements. In each of these cases, the child's placement appeared to be problematic and unstable, and in several instances, the private foster care agency had not reported the young person's AWOL status to ACS. Furthermore, most of the adolescents had serious behavioral and/or emotional problems that were not being adequately addressed. Although it cannot be said with certainty that additional services would have prevented these deaths, individualized services that addressed the instability and/or unsuitability of these placements may well have made a difference. Also, in many situations, there is a question as to whether diligent efforts on the part of the private foster care agency to locate the children and place them more securely according to their needs would have protected them from their eventual violent deaths.

Some of the cases involved violent deaths of young people shortly after they went AWOL.

- A girl, age 16, was found murdered, strangled to death, two days after running away from her group home. The group home workers had not filed a missing person's report. The girl had a history of drug abuse, prostitution, and running away. She was initially placed in foster care because she ran away from her mother often, and her mother feared she could not control her. The group home, which was not a locked facility, did not implement a plan to respond to these behaviors. A few weeks before the child's death, a social worker at the group home saw the girl and suggested she be moved to a Residential Treatment Center, but no follow-up steps were taken. (#95-99-023)
- In another case, a girl, age 17, was murdered while AWOL from her residential facility. There had been repeated recommendations to place her in a more secure facility to deal with her criminal behavior and history of running away. ACS and/or the court, however, either denied the requests for a new placement or failed to follow through on these recommendations. (#97-00-013)

In other cases, the young people died violently (as a result of homicide or by their own hand) after being on AWOL status for some period of time. In many of these cases, the private foster care agency was aware of the youth's whereabouts.

- A 13-year old girl was shot to death nearly a year after she went AWOL from care. She had been removed from her parents at the age of two on a neglect petition, returned home, and re-entered care after repeated abuse and neglect (which was reported, investigated, and substantiated many times) over a period of several years. She was placed in another series of foster homes. In her final placement, she had little contact with her social worker, even after the child's biological father died. Six days after the child was informed of her father's death, she went AWOL. Although the documentation is unclear, it appeared that the private agency had contact with the child from time to time after she went AWOL and knew that she was staying with various relatives. The agency, however, did little to support the child and family members nor did it notify ACS that the child had been found. At the same time, ACS knew that the child was AWOL but did not monitor the private agency's efforts to find her or provide needed services. (#97-99-008)
- In another case, an 18-year old committed suicide while on AWOL status. The private foster care agency had recommended to ACS at least twice (beginning approximately 18 months prior to his death) that he be moved to a more structured setting. The youth had been placed in care because his mother felt she could not control his behavior. While in the group home, he engaged in dangerous behavior, repeatedly ran away, and refused to cooperate with counseling services. ACS, however, failed to respond to the agency's requests or to assess the youth's need for a higher level of care. While in group care, the young man was arrested for attempted robbery. Two days later, he went AWOL. Subsequently, he was detained by the police and sentenced to a correctional facility. He was released from the facility in October 1998. The private foster care agency was aware of his release and his whereabouts. The agency, however, did not provide him with services or ensure his safety and well-being. He committed suicide eight months after being released from jail. (#97-99-022)

Finally, in one case, a staff member facilitated the child's departure — which had immediate tragic consequences.

- A 17-year old girl went AWOL from her residential facility and was killed in a car accident within an hour of leaving the facility. She ran away with a facility staff person with whom she was having a sexual relationship. The director of the facility was aware of the relationship and had handled the situation by directing the staff member not to have any contact with the child and without taking any other action. (#96-00-005)

GENERAL FINDINGS REGARDING THE QUALITY OF CHILD FATALITY INVESTIGATIONS AND CHILD PROTECTION EFFORTS

In addition to specific findings for each of the three groups of children whose fatality review reports were studied, this review sought to identify overarching issues that affected the quality of child fatality investigations and the quality of safety and risk assessments and services to children and families. Although occasionally OCFS determined that ACS had done a good job (see #95-00-053), OCFS identified problems in most instances. The overarching issues relate to (1) the processes used in the course of child fatality investigations that impact the outcomes of these efforts; and (2) the quality of the investigations and the subsequent protective services response.

The Processes Used to Investigate Child Fatalities

With regard to the process of investigating child fatalities, overarching issues related to the role of ACS caseworkers in relation to the role of law enforcement; the role of ACS when there are no surviving children in the home; the quality of documentation; and the timeliness of investigations.

1. The role of ACS in investigating children's deaths was found to vary significantly depending on the initial classification of the child's death. In some cases, the roles of ACS caseworkers and of law enforcement seemed duplicative, while at other times, ACS caseworkers seemed to be expected to function as if they were law enforcement officials.

Expectations of ACS varied depending upon whether a child's death was initially identified as a homicide. When deaths were identified as homicides, ACS social workers were not allowed (nor expected) to interview key collaterals to obtain additional information. Instead, police officers conducted such interviews. As an example, in a case involving the death of a 10-year old from starvation and dehydration which was determined to be a homicide (prolonged nutritional neglect), the assigned detective interviewed the parents and all relevant collateral contacts (#95-00-007). When cases were not initially identified as homicides, however, ACS caseworkers appeared to be expected to conduct "forensic" investigations akin to police investigation in homicides. In a number of the cases that were reviewed, OCFS criticized ACS investigations because the caseworkers did not resolve discrepancies in the time frames provided by various individuals, did not interview neighbors, and did not contact other collaterals for additional information. In none of the cases was it clear that such activities would have contributed to the assessment of safety of the surviving sibling/s in the home. As such, this practice raised questions about the appropriateness of such activities and the use of caseworker time and resources for these efforts.

2. It was not clear what role ACS should play in investigating the deaths of children whose biological families were not previously known to ACS and there were no surviving children in the home.

It may be assumed that a primary role of ACS is to ensure the safety of surviving siblings when a child in the family dies and the case is reported to ACS. If the primary role of ACS is to ensure the safety of surviving siblings, it is not clear what role ACS should be expected to play when there are no siblings or other children in the home. Nonetheless, in a number of cases, ACS devoted considerable resources to investigating the circumstances of children's deaths in these situations. As an example, one case involved the death of a 5-month old from perinatal asphyxia associated with a degenerative disease of the brain. The child lived only with his mother and maternal grandmother. ACS conducted extensive interviews with the hospital staff, the mother, maternal grandmother, a neighbor of the father (whose whereabouts were not known), and a maternal uncle. ACS eventually determined that there was no evidence to substantiate any allegations of maltreatment by the mother (#95-00-13). As another example, a case involved a 2-year, 11-month old child with no siblings who died from an accidental fall from a roof top. ACS conducted extensive and multiple interviews with the hospital staff, the parents, and neighbors. ACS was not able to ascertain how the child gained access to the roof on her own, finally substantiated the report allegations regarding lack of supervision, and referred the parents to counseling sessions (#95-99-011).

3. OCFS, in reviewing child fatality investigations, often found documentation problems of such a magnitude that it could not assess the situation as fully as its mandate requires.

One of the most common OCFS findings in the child fatality review reports was that ACS failed to adequately document its decision-making process, making it difficult to evaluate the appropriateness and quality of safety and risk assessments and service provision. The documentation that was provided in these reports indicated that in the course of investigating children's deaths, caseworkers typically did not explain adequately why each decision was made – specifically, they did not make clear how the decision was in the best interest of the child. In many cases, it was not clear how the questions asked and information obtained informed the safety and risk assessment nor how decision making and interventions were related to the assessment (#95-01-025; #95-01-028). Other documentation problems were cited by OCFS. These problems included the reporting of inaccurate information (#95-99-045, #95-00-018); failure to document why the allegations of child maltreatment were unsubstantiated (#95-99-046; #95-00-037; #95-01-019) or were substantiated (#95-00-025; #95-99-002); such poorly organized documentation that it was not possible to determine the sequence of events or the basis for crucial decisions (#95-99-047); failure to explain why the case remained open with no services provided or any investigative activity taking place (#95-00-003 — more than two months; #95-00-030 — six weeks); and failure to document that ACS contacted and interviewed family members of the deceased child (#95-01-004).

4. *The required steps in child fatality investigations frequently were not completed in a timely way.*

In some cases, OCFS' sole criticism of the child fatality investigation was that ACS had failed to make determinations on reports within the mandated 60-day time frame (#95-00-049; #95-01-013). In many other cases, however, untimeliness (whether in completing the required safety assessments for the 24 or 30 day Fatality Summary Reports or in completing the determination within 60 days) was one of many areas which OCFS cited as needing corrective action (#95-99-032; #95-99-046; #95-01-001). In some instances, ACS's untimeliness was the result of the caseworkers' inability to obtain the necessary information in a timely manner (#95-00-030: District Attorney awaiting autopsy report prior to deciding whether to bring criminal charges against father; #95-99-056: awaiting Medical Examiner's report). In the other cases, the reason for the delay was not clear (#95-99-008; #95-99-041; #95-00-003).

The Quality of Fatality Investigations and Subsequent Protective Services

With regard to the quality of the investigations and the subsequent protective service response, overarching issues related to the practice of almost routinely removing surviving siblings from their parents' custody; inadequately articulated rationales for decisions made and actions taken; inattention to critical practice elements in assessing child safety; and limited reliance on medical expertise.

1. *ACS appeared, as a general practice, to almost automatically remove siblings from parents' homes while children's deaths were being investigated.*

The review of the cases in the first two groups of families – those not previously known to ACS and those previously known – strongly indicated that the general practice of ACS is to remove children from the parental home during the child fatality investigation, irrespective of the risk assessment (in most instances, children were placed with relatives). It appeared that children were automatically assumed to be at risk without a consideration of whether the removal of the child from the parents' care would be psychologically more harmful than the risks associated with the child's remaining in the home. Although this practice seemed more clearly justified in homicide cases (particularly when the identity of the perpetrator was unclear), the rationale for this practice was far from clear when the child died of natural causes or the risks were not the same for an older sibling (for example, in a case of an older child or teen when the younger sibling drowned when left unattended while the parent talked on the phone or answered the door). In a number of cases in the first two groups of families, children were removed from their parents for months pending the report of the Medical Examiner that subsequently confirmed what had been indicated in the beginning stages of the investigation — that the child most likely died of natural causes. Given the research on the impact of bereavement on surviving siblings (Riches, 2002), this practice raises important issues regarding the impact of almost routinely separating children from their parents following the death of a sibling.

2. *The rationales for the decisions made in the course of child fatality investigations typically were not clearly articulated or, if stated, did not clearly support the decisions made or the actions taken.*

Numerous OCFS child fatality reviews concluded that the rationale for safety decisions was not given, or if a rationale was stated, it did not relate to case decisions. Likewise, it was frequently concluded that the risk assessment was not related to subsequent planning and service delivery. The lack of clear articulation and documentation of the rationales for case decisions related to safety and risk is not unique to New York City but, instead, is an issue with which the child welfare field as a whole is grappling (see Grayson & McNulty, 1999; Holder & Salovitz, 2001). Nonetheless, there appeared to be significant problems associated with New York City's practices related to the articulation of the rationale for safety and risk decisions and planning and services consistent with the stated rationale.

3. *Many of the child safety assessments did not comply with State regulation requirements regarding the specific practice elements that must be addressed.*

New York State Regulations (Sections 428.1 – 428.3) require that child safety assessments include specific practice elements, such as: involvement of the child and family in case planning; a discussion of strengths and/or protective factors that are present in the family; an assessment that includes the consideration of the relationship among the assessed factors related to safety and risk and case planning; and preservation and stabilization of the family, unless the child is in immediate danger. It did not appear that these elements were addressed in many of the cases in which ACS had been previously involved nor in the investigations in which the safety of surviving siblings was at issue. In particular, there was only limited evidence that the interaction of risk factors was assessed; that any consideration was given to family strengths and/or protective factors; or that children or families were involved in the decision process (although in some cases, family involvement was implied in the identification of family members as potential placement resources for surviving siblings while the investigation was being conducted).

4. *The child fatality investigations indicated that ACS had limited access to medical information or medical expertise.*

Considerable variation was found in the extent to which medical information was gathered in the course of child fatality investigations. In many cases, the information on the child's medical status and prior health care was quite limited. It did not appear that medical expertise was readily available to ACS and as a consequence, ACS often lacked guidance concerning the type of medical information that should be gathered or how to interpret the available medical information. There was a clear lack of coordination and communication among ACS, hospital emergency rooms, clinics, and the Medical Examiner's Office. In several cases, health care providers (including children's regular physicians) did not respond to ACS' requests for information in the course of the fatality investigation.

RECOMMENDATIONS

The following recommendations address concerns in three key areas: the need to improve the quality of child fatality investigations; the need to improve the quality of child protective services and minimize risks of serious harm to children; and the need to improve the health status and health care of children in foster care. Most of these recommendations can be implemented without the need for additional resources.

To improve the quality of child fatality investigations:

1. Establish an independent local Child Fatality Review Team for New York City.

For a number of years, New York City has not had a local Child Fatality Review Team as permitted by New York State law. Prior to 1997, the Human Resources Administration (when child welfare services were provided by that agency) operated a Fatality Review Panel. Since 1997, ACS has had in its place an Accountability Review Panel that is administered by ACS (New York City Administration for Children's Services, 2002). Although this Panel issues periodic reviews, it does not serve as a local, independent review team that reviews individual child fatalities. In the case of both the Fatality Review Panel and the Accountability Review Panel, there are questions about the independence of the process, a crucial element to a meaningful review of child fatalities.

Although OCFS reviews have attempted to identify and address systemic problems and practice and policy issues, a state-level review of individual child fatalities cannot bring the same vitality to prevention and child protection efforts as can a local effort. When agencies and professionals are brought together at the community level, there is a greatly enriched capacity to strengthen prevention and intervention efforts on behalf of children and families. At the same time, it is far more likely that local, independent review efforts can be translated into action. A fully independent, adequately staffed Child Fatality Review Team is needed in New York City to improve the City's response to at-risk families; identify preventable social and family circumstances that contribute to child fatalities; identify the causes of children's deaths, whenever possible; share information about advances in the areas of investigation, intervention, and prevention of child deaths; identify problems in practices and recommend solutions; and heighten community awareness through education and prevention strategies. In addition, a local independent Child Fatality Review Team would help ensure that the unique aspects of child protection that arise in an extremely large urban area are appropriately identified and addressed. Of particular importance in light of the findings of this study, an independent Child Fatality Review Team in New York City is needed to promote cooperation and communication among the various agencies involved in investigating child fatalities and mobilizing the services needed by children and families.

2. Re-examine and clarify the role of ACS in investigating child fatalities.

The role of ACS in child fatality cases should be clarified in two key areas: the role of ACS caseworkers in conducting “forensic” investigations in non-homicide cases; and the role of ACS caseworkers in responding to child fatalities when there are no other children in the home. Under current policies, there appears to be considerable duplication in activities because ACS caseworkers are expected to undertake “police” work (without the qualifications to do so) in cases not initially determined to be homicides. In addition, ACS is expending considerable time and effort in investigating child fatalities when there are no other children in the home at risk. ACS should develop guidelines that address the role of ACS caseworkers in the investigation of child fatalities under various circumstances (homicide and non-homicide cases; cases in which there are children in the home and cases in which there are no children in the home). If the role of the ACS caseworker continues to be forensic in nature, training and resources are needed to enable caseworkers to conduct “police-type” investigations.

3. Strengthen the assessment and decision-making processes so that the siblings of children who have died are removed from their parents’ homes only when at imminent risk of harm.

As noted earlier, current practice typically is one of an almost “automatic” removal of siblings from their parents’ homes when a child has died, irrespective of the circumstances or the results of the safety and risk assessment. Family strengths, as well as risk, should be considered in determining whether siblings should be removed from the home while the investigation is in process. These strengths and/or protective factors should be integrated into the decision-making process and case planning when determining whether children are safe; whether they need to be removed from their parents’ home; and if removed, whether they can be reunified with their parents. ACS should develop guidelines regarding the removal of children when a sibling has died to assist caseworkers in determining whether children should be removed or could remain in the home with parents or primary caregivers while the investigation is in progress. These guidelines should address the level of effort (or “due diligence”) that caseworkers should make to obtain the necessary information. The guidelines also should address the development of appropriate interim safety plans for siblings when all necessary information is not available (such as the Medical Examiner’s final report).

4. Assess the appropriateness of investigation timelines in light of the purposes of child fatality investigations.

In many of the cases reviewed, OCFS criticized ACS for failing to meet required time frames. It is not clear under current policy and practice whether the current time frames are realistic, as a general matter, or whether they are appropriate under the circumstances of individual cases. Time frames should be assessed in light of the role that ACS is expected to play (an issue addressed in recommendation # 1 above). If the current time lines are determined to be unrealistic, they should be changed. If the current time frames remain in place, ACS and other parties to the investigation should be provided with the necessary resources to meet the time frames (and then held accountable for meeting those time frames).

There may be legitimate circumstances under which current timelines cannot be met (such as the inability to obtain the Medical Examiner's report within the required time frame). These circumstances should be identified and guidelines should be developed for dealing with such situations. Evaluations of child fatality reviews should focus on the quality of safety and risk assessment, decision-making, and service planning and delivery as opposed to the issue of time (particularly when factors beyond the control of ACS result in time frames not being met).

5. Fully involve health care providers in child fatality reviews and hold other investigative partners as well as ACS accountable for child safety and the quality of child fatality investigations.

The quality of child fatality reviews would be greatly enhanced through a more extensive involvement of physicians and other health care providers in child fatality reviews. Greater access to medical expertise would permit a more thorough identification of medical issues. At the same time, ACS' investigative partners must be held more accountable for the safety of children in the community.

Medical Examiners should be required to make timely determinations in child fatality cases, with such cases receiving priority attention (particularly when the safety of a surviving sibling is in question). Other investigative partners – including the police and children's health care providers — should be held accountable for providing necessary information in a timely manner and working in conjunction with ACS to ensure that decisions are made in children's best interests.

To improve the quality of child protective services and minimize risks of serious harm to children:

1. Implement within ACS ongoing quality assurance reviews.

Absent systematic ongoing quality assurance reviews of child protective services cases, it will not be possible to effectively monitor practice. ACS should develop an internal quality assurance system to assess its level of practice in child protective services cases and provide, as discussed more fully in the next recommendation, training to address practice deficits.

2. Establish clear practice guidelines and training regarding safety and risk assessment and the provision of services to respond to families' needs.

Based on the findings of this review, it is clear that specific practice guidelines are needed in various aspects of child protective services – but particularly in relation to accurate assessments of risk (including both risk and protective factors), the interaction of risk and protective factors (which can raise or lower risk in individual cases), the involvement of children and families in decision-making and planning, and the mobilization of formal and informal services to address the identified risks. Training should be developed to ensure that ACS staff members have strong skills in each of these areas and other areas identified through the quality assurance review process. Supervision should reinforce training in all areas of practice. The focus should be on the development and strengthening of sound casework practice, not simply on compliance with rules, regulations or documentation requirements.

3. *Institute specific processes to monitor and take action on issues that have been found to be associated with child fatalities.*

Based on the findings of this review, ACS should take the following actions to ensure that factors associated with child fatalities are closely monitored and receive an appropriate response:

- Develop guidelines to ensure a special review of child protective services cases in which there are multiple referrals (for example, a “rule of three” which requires a special review of any family with three reports of child maltreatment within a specified period of time).
- Develop a process for carefully assessing cases involving adolescents on AWOL status. In the case of congregate care facilities with relatively high rates of adolescents on AWOL status, identify any environmental factors that may be associated with adolescents’ decisions to run away. In the case of foster family homes, ensure that foster families receive guidance and support regarding adolescents placed with them who may be apt to run away and provide foster families with assistance to defuse situations that may lead to such outcomes.

To improve the health status and health care of children in foster care:

1. *Develop mechanisms to ensure the access of children in foster care to needed health care services.*

Given the numerous medical issues that were identified in connection with the deaths of children in foster care, specific procedures and structures are needed to ensure that the caregivers of children in foster care understand their health needs and that children receive needed health care services. Specifically, the following should be developed and/or implemented:

- Processes that ensure that ACS obtains all relevant medical information on children upon their entry into foster care;
- Mechanisms, such as a medical passport or other tool, that provide caregivers and children’s health care providers with updated medical information on each child in care (with access to such information available on a 7-day/24-hours-a-day basis);
- Individualized, age appropriate medical case management for each child with regular, periodic reviews of medical issues, anticipatory guidance, medical risk assessments, and appropriate referrals for follow up and specialty care;
- Processes to ensure communication among ACS, the private foster care agency, the child’s primary health care provider, and providers of emergency and specialty health care regarding the child’s medical condition, health care needs, referrals for follow up and specialty care, and the effectiveness of medical treatment that the child is receiving;
- Processes and tools to ensure that foster parents and foster care facilities have children’s medical information (including the child’s medical history, the birth family’s medical history,

current health issues, and conditions for which the child may be at risk); understand the children's medical needs; and are able to obtain anticipatory guidance, primary health care, and specialty medical care for children, as needed; and

- Processes for obtaining information on and following up on children's visits to hospital emergency rooms.

2. Integrate health care providers more fully into the provision of services for children in foster care.

Research clearly documents the health care needs of children in foster care and the importance of access to preventive, primary and specialty health care (American Academy of Pediatrics, 2002; Georgetown University Center for Child and Human Development, 2001; United States General Accounting Office, 1995). This analysis of child fatalities leads to the same conclusion. Children in foster care in New York City would greatly benefit from a system that ensures that each child has a health care provider who coordinates the child's primary care and refers the child for (and receives all information on) all specialty care that the child needs. Together with the structures and processes outlined in the above recommendation, the assignment of a primary care case manager to each child would help ensure that children's medical needs are identified and documented; are communicated to all relevant parties, including caregivers; and are monitored on an ongoing basis.

CONCLUSION

This report — which focuses on the deaths of 194 children in New York City from 1999 through mid-2001 — analyzes child fatalities for three groups of children and families: (1) children whose families were not known to ACS prior to the children's deaths; (2) children whose families were previously known to ACS at the time of the children's deaths; and (3) children in foster care who at the time of their deaths resided with relatives or non-related foster families or who were placed in a group or residential care settings. The findings specific to each group of children emphasize the key practice issues that must be addressed for each group of children and families.

Children Whose Families Were Not Previously Known to ACS

Of importance with regard to the cases of children whose families were not known to ACS at the time of the children's deaths is the fact that these families often presented a range of risk factors – in fact, in some instances, more risk factors than were found among families previously known to ACS at the time of the children's deaths. This reality makes the inadequacy of safety assessments for this group of families of particular concern because of the elevated risk. Problems with safety assessments were noted in a number of areas. In many cases, it was not clear that safety assessments were done at all. In other cases, the information strongly suggested that safety concerns were identified but were not addressed. In yet other cases, safety assessments were conducted and did not indicate an imminent risk of harm to the surviving siblings of children who died, but the children, nevertheless, were removed from their parents' custody. Safety assessments and subsequent decisions were found to be inconsistent in other ways. In some cases, for exam-

ple, children were determined to be “safe” but were removed from their parents’ custody, and in other cases, children were determined to be “unsafe” but no protective action whatsoever was taken. Also of concern with this group of children and families were two specific practices on the part of ACS: (1) keeping children and parents separated without the legal authority to do so; and (2) caseworkers’ failures to contact the physicians of deceased children to confirm the children’s prior health status and health care.

Children Whose Families Were Previously Known to ACS

With regard to children whose families were previously known to ACS at the time of the children’s deaths, many of the same issues were identified as in the cases involving families not previously known to ACS. Similar problems were noted in the adequacy of safety assessments for surviving siblings; in case decision-making (particularly with regard to “next steps” being inconsistent with safety assessment results); and in the common practice of removing surviving siblings from their parents’ custody without evidence of an imminent risk of harm to these children. Also of note with these families were problems associated with the safety and risk assessments that were made and the interventions that were undertaken when the families were initially referred to ACS on allegations of child maltreatment. Of particular concern was the lack of attention to the interaction of multiple risk factors in these families’ lives that elevated the risk of harm to children and the inattention to patterns of multiple reports of child maltreatment. In many of the cases, domestic violence, a factor that is strongly associated with child maltreatment, was present along with parental substance abuse. In some of the same cases, the families were the subjects of numerous child maltreatment reports before the child died. Finally, monitoring and follow-up services for many families appeared problematic, particularly in situations where the parents were not willing to cooperate with services or comply with the case plans.

Children in Foster Care

Several issues were identified with regard to the deaths of children in foster care. Of concern in several cases was the lack of adequate training for foster parents, including training on CPR and infant sleep positioning and guidance on appropriate responses to emergency situations. In a number of cases, it was clear that foster parents were not informed of children’s serious health conditions or of their need for ongoing medical attention. In some cases, foster parents were not aware that children in their care needed specific medical care and as a result, did not seek appropriate health care services. In other cases, foster parents sought care for children but could not provide treating physicians with information that would have supported a correct diagnosis and treatment plan. Safety considerations emerged as a critical issue in a number of cases. Threats to children’s safety included failures on the part of ACS to respond to dangerous behaviors on the part of children (such as fire setting), inappropriately placing older children with troubling behaviors with foster families whose work schedules required them to be out of the home for extensive periods of time, and failures to monitor the presence of other adults in the foster or kinship home who posed dangers through drug use and/or the possession of firearms. Finally, several disturbing cases involved violent deaths of adolescents who were on AWOL status from their placements. In many cases, the private foster care agencies were on notice that the adolescents were prone to running away, but they did not put a plan in place to prevent these incidents. In some instances, the private foster care agencies were aware of these children’s whereabouts after they left the facilities, but they did not act to protect the children or return them to care.

Overarching Findings

The review of the child fatalities also permitted an identification of certain overarching themes related to the processes utilized in child fatality investigations and the quality of the investigations and service response. With regard to the process of investigating child fatalities, problems were noted with regard to the role of ACS caseworkers in such investigations – both in terms of their role vis-a-vis law enforcement and their role in cases in which there were no surviving siblings or other children in the home; the quality of the documentation; and the timeliness of the investigations. With regard to the quality of investigations and the subsequent protective service response, problems were noted in the almost automatic practice of removing surviving siblings from parents' custody; the absence of clearly stated rationales for the decisions made and the actions taken in the course of the investigations; the absence of attention to critical practice elements in assessing child safety; and the limited reliance on medical expertise in making determinations regarding the circumstances of children's deaths and the potential risks posed to surviving siblings and other children in the home.

Recommendations

This review establishes the need for specific steps to be taken in three critical areas – (1) to improve the quality of child fatality investigations, (2) to improve the quality of child protective services and minimize the risks of serious harm to children, and (3) to improve the health status and health care of children in foster care. In order to improve the quality of child fatality investigations, a local independent and adequately staffed Child Fatality Review Team should be established in New York City. In addition, careful attention should be given to the role of ACS in investigating child fatalities — particularly in relation to the role of law enforcement and in cases in which there is no other child in the home — and to the appropriateness of current time lines. Given the limited resources available to ACS, staff expertise and time should be targeted to safety and risk assessments as opposed to “forensic” activities. Furthermore, more extensive involvement by health care professionals and greater accountability on the part of investigative partners are needed to ensure a quality investigative process. In order to improve the quality of child protective services, ACS needs to establish an internal quality assurance review of child protective service cases. In addition, guidelines and training are urgently needed regarding safety and risk assessments and service provision in light of identified needs. Specific processes, likewise, are needed to ensure appropriate responses to families with histories of multiple referrals for child maltreatment and appropriate interventions with facilities that have high AWOL rates for adolescents in care. With regard to improving the health status and health care of children in foster care, attention must be given to enhancing children's access to health care services and to ensuring that foster families and other foster care providers have medical information on children in their care. Health care providers must be integrated more fully as service providers for children in foster care.

Need for Improvements to Protect Children

Greater public attention is being given to child fatalities – both because of greater societal awareness and because horrific deaths of children (such as the death of Faheem Williams, the 7-year old in Newark, New Jersey discovered in January 2003) force child welfare professionals and the public to confront the issues that place children at risk of serious harm. By examining close to 200 child deaths, this report provides a blueprint for improving assessments of the safety of children, strengthening the process by which

safety-based decisions are made to protect children and serve their best interests, and improving the quality of child fatality investigations so that as much as possible can be learned to protect children in the future.

The preventable deaths of these children must be recognized as our most significant failure. Action must be taken to end the continuing danger to New York City's children. A primary goal of this report is to provide an understanding of how to better protect children and identify specific ways that ACS can improve its child protection practices. Many of the systemic problems identified and recommendations made in this report have been advanced by other children's organizations and by Children's Rights itself in a report that was released in 1999. Some of the recommendations are within the authority and control of ACS to implement and can be addressed immediately. The implementation of other recommendations are beyond the control of ACS and require strong leadership by the Mayor of the City of New York; leadership that must ensure that ACS has the resources it needs to fully protect children at risk of harm. Acting together and with full accountability to the public, we can make certain that the long-standing problems identified in this report are finally addressed and that we bring to an end the preventable deaths of children.

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