Analysis of Child Fatalities in the New York City Shelter System 2004 - 2006

NOVEMBER 2007

Office of the New York City Public Advocate

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EXECUTIVE SUMMARY

On August 7, 2007, two-month-old London Rogers died while residing in New York City's homeless shelter system with his mother and three-year-old brother. While the death is still under investigation, it appears London may have died of Shaken Baby Syndrome. London's brother reportedly told authorities that their mother shook the baby because she wouldn't stop crying. To make matters worse, it appears that the Administration for Children's Services (ACS) may have had information about the family that possibly could have prevented London's death.

London's mother and family were known to ACS. Most recently, the mother as involved in another suspicious child fatality just one year prior to London's death. Since the death of London Rogers, the investigation into the previous year's fatality has been reopened.

The case of London Rogers, while not currently conclusive, appears to follow many of the same patterns of other suspicious child fatalities within the city's homeless shelter system. London Rogers' death, in combination with the well-documented history of poor communication between ACS and the Department of Homeless Services (DHS) prompted the Public Advocate's Office to launch an investigation into all suspicious child fatalities within the shelter system between 2004 and 2006.

The Public Advocate's Office found that children in the shelter system are dying at an alarming rate. In fact, between 2004 and 2006, 20 children died in a suspicious manner while living with their families in the shelter system. The number of child fatalities grew by more than 300 percent between 2005 and 2006 to 12 fatalities despite declining numbers of both children and families within the shelter system.

A closer look at the families involved in these child fatalities revealed that the vast majority have some sort of past contact with ACS. Sixty percent of the families included at least one parent who was known to ACS in previously substantiated cases of abuse or neglect, or was under investigation by ACS at the time of the fatality. Sixty percent of the families included at least one parent who was known to the system as a maltreated child. Only two of the 20 cases involved families with no previous contact with ACS.

Improper sleeping position and arrangement of infants was a frequent factor in the deaths of children living within the shelter system. Half of the 20 child fatalities involved infants who died while sleeping in unsafe conditions, mainly co-sleeping with an adult in a bed.

Additional Findings:

- *Most children who died within the shelter system were infants.* Between 2004 and 2006, 17 of the 20 children, or 85 percent, who died in the shelter system were one year old or younger, and all were under five years old.
- *Nearly one-fifth of all Manhattan child fatalities occurred in Manhattan homeless shelters*. Between 2004 and 2006, 7 of the 36 (19 percent) children who died in a suspicious manner in Manhattan, died in a Manhattan homeless shelter.

Recommendations:

ACS should create a shelter division of Child Protective Services (CPS)
ACS should create a division of child protective caseworkers to respond to reports of child abuse and neglect within the shelter system and monitor families entering the system with past histories or current cases with the child welfare system.

ACS should assign veteran law enforcement investigators to new CPS shelter division
Since a high profile death of a child in January 2006,[1] ACS has hired 20 veteran law enforcement investigators to aid CPS staff with child welfare investigations. ACS recently announced that it is planning to expand this initiative by increasing the number of veteran law enforcement investigators to 120. ACS should create a pilot program to assign at least one veteran investigative consultant per borough to aid the CPS shelter division recommended above in investigations of abuse and neglect.

ACS should track and report shelter-related child welfare statistics
ACS should track and make publicly available statistics regarding cases of child maltreatment within the homeless shelter system including but not limited to:

- Number of cases of suspected abuse or neglect reported to the New York State Central Register of Child Abuse and Maltreatment (SCR) and ACS;
- Number of cases of suspected abuse or neglect within the shelter system investigated by ACS;
- Number of cases of reported suspected abuse or neglect within the shelter system to which ACS responded within 24 hours of the report;
- Indication rate[2] of cases involving families in the shelter system.

ACS and DHS should collaborate to create a risk-based assessment tool for families staying in the shelter system
ACS and DHS should create a risk-based assessment tool for families within the shelter system and assign preventive services as necessary. The tool should take into consideration past substantiated cases, unsubstantiated cases, and open cases of abuse or neglect, correlated with other risk factors such as:

- Past child fatalities reported to the SCR, with special attention paid to those households in which a previous child has died due to improper sleeping position or arrangement;
- Parents, caregivers or household members who were known to the child welfare system as maltreated children;
- Families with a documented history of unsafe sleeping conditions for infants;
- Families with a documented history of alcohol and substance abuse;
- Parents with a documented history of relationships involving abusive companions coupled with a non-parental adult residing with the family;
- Persistent homelessness;
- Households with children under one year of age.

[1] The death of seven-year-old Nixzmary Brown.
[2] The Indication Rate as measured by ACS' Monthly Update. A case becomes "indicated" when there is credible evidence to suggest a child has experienced child abuse or neglect.

DHS should inform parents residing within the shelter system of the dangers of improper sleeping position
DHS should distribute literature on the dangers of co-sleeping and the importance of proper sleeping position to the parents in the shelter. DHS should distribute this literature at intake.

INTRODUCTION

On August 7, 2007, two-month-old London Rogers died while residing in the city's homeless shelter system with his mother and three-year-old brother. According to news accounts, Tasha Rogers, the child's mother, told authorities she awoke to find that London was not breathing and shook the child in an attempt to resuscitate her. Authorities became suspicious of her story after her three-year-old child told authorities that his mother shook the baby because she would not stop crying. It was also revealed that the mother was known to the Administration for Children's Services (ACS), most recently from the death of another baby the year before. The previous death was ruled to be Sudden Infant Death Syndrome but the case was reopened due to London Rogers' death.

The death of London Rogers, in combination with her mother's history with the child welfare system prompted the Public Advocate's Office to investigate all suspicious child fatalities in the city's shelter system between 2004 and 2006. The following is a report based on this investigation. The purpose of the investigation is not to lay blame on any one agency but to strengthen the system in order to prevent child fatalities.

BACKGROUND

The New York State Office of Children and Family Services (OCFS), in accordance with state law, prepares an individual fatality report for each child who dies while in the custody or under the supervision of ACS or ACS contract agencies, or whose death was reported to have been caused by suspected neglect or abuse.[3]

For each fatality report, the state examines the circumstances of the fatality by reviewing ACS and/or contract agency case documentation, autopsy and police reports, medical records, information on prior abuse and neglect cases, and any other pertinent information available. Each state-issued fatality report contains sections describing the sources of information and documentation used to review the death, the cause and circumstances of the death, the child welfare service history of the child and/or family, and any child-welfare-related services provided to or actions taken involving the child and/or family.

The Public Advocate's Office closely monitors child fatalities in order to make policy recommendations with the goal of decreasing the number of future child fatalities.

In 2004, the Public Advocate's Office released a report that found that a disproportionate number of children who died of suspected child abuse and neglect belonged to families residing in New York City's shelter system at the time of death. The report also revealed

[3] Social Services Law §422.

that improper sleeping position or arrangement (such as co-sleeping with an adult in an adult bed) was a frequent cause of the deaths which occurred in the shelter system.

In response, Public Advocate Gotbaum introduced legislation in the New York City Council requiring:

1. The posting of signage in homeless shelters to remind shelter staff that they are mandated by law to report suspected child abuse and neglect to the State Central Register of Child Abuse and Maltreatment (SCR);
2. Training of homeless shelter staff on their responsibility as mandated reporters;
3. The posting of signage warning shelter residents of the dangers posed to infants by improper sleeping position and arrangements.

The Public Advocate's bill was passed by the City Council and was signed into law by Mayor Bloomberg in March 2005.[4]

OVERVIEW OF SHELTER FATALITIES

Between 2004 and 2006, 20 children died while residing in the New York City shelter system.

Shelter Fatalities by Borough

Of the 20 shelter fatalities:

- 6, or 30 percent, occurred in the Bronx;
- 2, or 10 percent, occurred in Brooklyn;
- 7, or 35 percent, occurred in Manhattan;
- 5, or 25 percent, occurred in Queens;
- Zero occurred on Staten Island.

Shelter Fatalities by Age and Gender

The 20 shelter fatalities ranged in age from newborn to 5 years old. Of these 20 children:

- **17, or 85 percent, were 1 year old or younger**;
- 3, or 15 percent, were 1 to 5 years old;
- None were older than 5 years old.

Manner of Shelter Deaths

Deaths from Homicide

Of the 20 shelter fatalities:

- 7, or 35 percent, were ruled to have been homicides;
- Beating or fatal child abuse was the most frequent cause of death in the cases of homicide (4).

Deaths of Undetermined Intent

Of the 20 shelter fatalities:

[4] Local Law 26-2005.

- 7, or 35 percent, died in a manner in which the intent could not be determined;
- All 7 deaths are suspected to have been caused by improper sleeping position of infants (co-sleeping or positional asphyxia).[5]

Deaths from Accidents

Of the 20 shelter deaths:

- 2, or 10 percent, died due to accidental causes.

Deaths from Natural Causes

Of the 20 shelter fatalities:

- 4, or 20 percent, were ruled by the Medical Examiner to have been the result of natural causes.
- One of the natural deaths was believed to be exacerbated by the presence of improper sleeping position.

DISCUSSION OF SHELTER FATALITIES

Child Fatalities in City Shelters Increase in 2006

Of the 20 shelter fatalities that occurred between 2004 and 2006, 12 occurred in 2006. This represents a 140 percent increase from 2004 to 2006 and a 300 percent increase from 2005 to 2006. (See Table 1).

Table 1

Child Fatalities in the Shelter System

Year	Fatalities in Shelter System[6]	Fatalities Involving Children of Families with Previous Contact with ACS[7]	Fatalities Involving Children of Families with Previous Contact that led to Substantiated Cases[8]
2004	5	3	3
2005	3	1	1
2006	12	9	8
Total	***20***	***13***	***12***

[5] This report uses the term "improper sleeping position" to describe deaths of infants from both co-sleeping and positional asphyxia.

[6] Includes all deaths of children for which the state, pursuant to state law, reviewed and issued a fatality report. This includes the deaths of children who died in a suspicious manner, of children in families that had open child protective or preventive service cases, and of children who were residing in foster care at the time of their death.

[7] Includes deaths of children in families that had previous child welfare cases with ACS (founded or unfounded), previous reports to SCR, or previous preventive service cases. This category is a subset of the category defined in footnote 6.

[8] Includes the deaths of children in families with previous substantiated cases of abuse or neglect, open child protective cases that were not a result of the fatality, or open preventive service cases. This category is a subset of the categories defined in footnotes 6 and 7.

The number of child fatalities in the city's shelter system rose dramatically between 2004 and 2006 despite the fact that the numbers of both families and children in the system decreased. In fact, the average daily number of families in the shelter system decreased by more than twelve percent between 2004 and 2006; the number of children decreased by nearly 20 percent during the same period. (See Table 2).

Table 2[9]

New York City's Average Daily Census Shelter Population		
Year	Pop. of Families[10]	Pop. of Children
2004	8,131	15,705
2005	7,302	13,534
2006	7,117	12,597

The Majority of Families Involved in Shelter Fatalities had Previous Involvement with the Child Welfare System

Most of the families of children who died in the shelter system between 2004 and 2006 were previously known to ACS through past reports of child abuse or neglect. In fact, of the 20 fatalities that occurred in the shelter system, 13 (65 percent) involved families that had previous reports of child abuse or neglect. Furthermore, of the 13 families who had previous reports of child abuse or neglect, 12 had substantiated cases, representing 60 percent of all child fatalities in the shelter system between 2004 and 2006. The percentage of child fatalities involving families with a history of child abuse or neglect was considerably higher within the shelter system than for all non-shelter child fatalities between 2004 and 2006. (See Table 3).

Table 3

Child Fatalities 2004 - 2006 Families with Past History of Abuse Shelter -vs- Non-Shelter Fatalities					
	Total	# with Previous Reports of Abuse or Neglect	% with Previous Reports of Abuse or Neglect	# with Previous Substantiated Cases	% with Previous Substantiated Cases
Shelter Fatalities	20	13	65%	12	60%
Non-Shelter Fatalities	194	82	42%	63	32%

[9] New York City Department of Homeless Services, *Average Daily Census*, www.nyc.gov/html/dhs/downloads/pdf/histdata.pdf. Both the families and children average daily census statistic were calculated by the Office of the Public Advocate by averaging the average daily census for family services for the months January 2006 – December 2006, www.nyc.gov/html/dhs/html/about/car.shtml.

[10] Only includes families with children and does not include adult families.

Not only did the majority of families involved in child fatalities in the shelter system between 2004 and 2006 have a documented history of abuse or neglect, the majority also had at least one parent who was known to the child welfare system as a maltreated child. Of all the families that were involved in child fatalities in the shelter system between 2004 and 2006, 12 (60 percent) had at least one parent who was known to the child welfare system as an abused or neglected child. In fact, the percentage of fatalities involving families with at least one parent who was known to the child welfare system as a maltreated child was far higher within the shelter system than for all non-shelter child fatalities between 2004 and 2006. (See Table 4).

Table 4

Child Fatalities 2004 - 2006
Parents Who Were Maltreated Children
Shelter –VS- Non-Shelter Fatalities

	Total	# with Parents who were Maltreated Children	% with Parents who were Maltreated Children
Shelter Fatalities	20	12	60%
Non-Shelter Fatalities	194	39	20%

It is important to note that only two of the 20 fatalities that occurred within the shelter system involved families that had no previous contact with the child welfare system. Eighteen of the 20 fatalities involved families that had either a history of abuse or neglect through past substantiated cases or at least one parent who was known to the child welfare system as a maltreated child. Furthermore, of the seven children whose deaths were ruled homicides, only one came from a family with no past history with the child welfare system.

Improper Sleeping Position and Arrangement of Infants was the Most Frequent Factor in Child Fatalities within the Shelter System

The proper sleeping position for an infant is in a crib, alone, without loose bedding, toys, or other clutter, with the child's back against the mattress. When infants are not placed in such an environment, they are at risk of serious injury or death due to overlay or positional asphyxia. Overlay or rollover refers to incidents in which an adult or older child is sleeping in the same bed with an infant and rolls on top of the infant accidentally. This can cause severe brain damage or death by suffocation. Positional asphyxia occurs when an infant cannot move out of an unsafe sleeping position, such as lying on his or her stomach, and suffocates.[11]

Half of all children (10) who died in city shelters between 2004 and 2006 died while sleeping in unsafe, improper sleeping positions or arrangements. Co-sleeping, a form of improper sleeping position in which an infant sleeps with an adult in a bed, was a contributing factor in six of the deaths. Five of the six co-sleeping deaths were caused when the adult rolled over and suffocated the child. One of the six co-sleeping deaths

[11] *Preventing Child Death,* National MCH Center for Child Death Review, August 2005.

occurred when the parent was co-sleeping with the child and pushed the child off the bed into a bucket of vomit while sleeping. The child drowned.

Two of the fatalities occurred because the child suffocated in a crib due to improper sleeping position. In one case, the child was placed to sleep on her stomach and suffocated against the crib mattress. In another case, the child was placed to sleep on his side and rolled over onto his stomach, once again suffocating against the crib's mattress.

The two other deaths include a child who died of Sudden Infant Death Syndrome while sleeping overnight in a car seat and another child who died while sleeping face down in a crib with a pacifier in his mouth.[12]

Nearly One-fifth of All Child Fatalities in Manhattan Occurred in Homeless Shelters

Between 2004 and 2006, nearly one out of every five suspicious child fatalities in Manhattan occurred in shelters—the highest proportion of all New York City boroughs (see Table 5).

Table 5

Child Fatalities 2004 - 2006			
Shelter Deaths by Borough			
	Total Child Fatalities	Fatalities in Shelter System	% in Shelter System
Manhattan	36	7	19%
Queens	33	5	15%
Bronx	49	6	12%
Brooklyn	80	2	3%
Staten Island	13	0	0%
Other[13]	3	0	0%

Children who died in the city shelter system were younger on average than children who died in non-shelter settings.

Of the 20 children who died in city shelters between 2004 and 2006, 17 (85 percent) were one year old or younger. Sixty-one percent of children who died in non-shelter settings during the same period were one year old or younger.[14]

[12] The latter fatality was ruled to have been caused by a preexisting medical condition, but documentation of improper sleeping position led the Public Advocate's Office to suspect that sleeping position may have been a contributing factor.

[13] Child Fatalities which occurred outside of the city.

[14] It is important to note that this disproportion could be attributed to the possibility that the percentage of young children residing in the shelter system is greater than in the general population in New York City. Because data on the ages of children residing within the shelter system is not publicly available, this theory could not be ruled out. ACS and DHS should collect data to determine the reason for the disproportion.

RECOMMENDATIONS

ACS should create a shelter division of Child Protective Services (CPS)
ACS should create a division of child protective caseworkers to respond to reports of child abuse and neglect within the shelter system and monitor families entering the system with past histories or current cases with the child welfare system.

ACS should assign veteran law enforcement investigators to new CPS shelter division
Since a high profile death of a child in January 2006,[15] ACS has hired 20 veteran law enforcement investigators to aid CPS staff with child welfare investigations. ACS recently announced that it is planning to expand this initiative by increasing the number of veteran law enforcement investigators to 120. ACS should create a pilot program to assign at least one veteran investigative consultant per borough to aid the CPS shelter division recommended above in investigations of abuse and neglect.

ACS should track and report shelter-related child welfare statistics
ACS should track and make publicly available statistics regarding cases of child maltreatment within the homeless shelter system including but not limited to:

- Number of cases of suspected abuse or neglect reported to the New York State Central Register of Child Abuse and Maltreatment (SCR) and ACS;
- Number of cases of suspected abuse or neglect within the shelter system investigated by ACS;
- Number of cases of reported suspected abuse or neglect within the shelter system to which ACS responded within 24 hours of the report;
- Indication rate[16] of cases involving families in the shelter system.

ACS and DHS should collaborate to create a risk-based assessment tool for families staying in the shelter system
ACS and DHS should create a risk-based assessment tool for families within the shelter system and assign preventive services as necessary. The tool should take into consideration past substantiated cases, unsubstantiated cases, and open cases of abuse or neglect, correlated with other risk factors such as:

- Past child fatalities reported to the SCR, with special attention paid to those households in which a previous child has died due to improper sleeping position or arrangement;
- Parents, caregivers or household members who were known to the child welfare system as maltreated children;
- Families with a documented history of unsafe sleeping conditions for infants;
- Families with a documented history of alcohol and substance abuse;
- Parents with a documented history of relationships involving abusive companions coupled with a non-parental adult residing with the family;
- Persistent homelessness;
- Households with children under one year of age.

[15] The death of seven-year-old Nixzmary Brown.
[16] The Indication Rate as measured by ACS' Monthly Update. A case becomes "indicated" when there is credible evidence to suggest a child has experienced child abuse or neglect.

DHS should inform parents residing within the shelter system of the dangers of improper sleeping position
DHS should distribute literature on the dangers of co-sleeping and the importance of proper sleeping position to the parents in the shelter. DHS should distribute this literature at intake.

Appendix I

SELECTED CHILD FATALITY PROFILES

Case Number 95-06-005

Fact Pattern: On January 30, 2006, a four-year-old male child died of injuries suffered inside a shelter in the Bronx, allegedly at the hands of his mother's boyfriend. At the time of his death, he resided in a one-bedroom scatter site shelter[17] with his mother, four sisters—ages nine, six, two, and fifteen months—and the mother's boyfriend.

On January 27, 2006, the child was under the supervision of the mother's boyfriend in the shelter. The child was playing when he knocked over a 32-inch television which fell on him. The unconscious child was then placed into bed by his mother's boyfriend. When the child woke up, the boyfriend, angry about the television, beat the child's head against the wall. The child started to vomit blood and was bleeding from the ear as a result of the beating. He vomited again the following day. The family did not seek medical attention until January 29, 2006, two days after the initial incident. The child died a day later from blunt force trauma injuries suffered at the hands of the boyfriend. The death was ruled a homicide by the Medical Examiner.

While the boyfriend was not known to the child welfare system prior to the child's death, the mother was known to ACS. Since 1996, the mother had been investigated by ACS at least nine times in response to nine separate reports of abuse and neglect. ACS concluded the children were abused or neglected in six of the nine reports. In fact, at the time of the child's death, his mother had an open child welfare case stemming from a report made two-and-a-half months earlier. The report included allegations of Educational Neglect; Inadequate Guardianship; Inadequate Food, Clothing, and Shelter; and Lack of Supervision.

After the child's death, OCFS reviewed the fatality and the family's history with ACS. The review found that ACS made at least twelve mistakes in handling both the family's previous reports of abuse or neglect and its investigation into the child fatality itself. Below is a sample of what the state found:

1. The prior history of this family reflects that ACS treated each report as a separate incident as opposed to assessing the family's functioning and the service needs of the family members. There is never an adequate assessment of the service needs of the family and no services were provided. ACS' involvement with this family was report-oriented.

[17] A privately owned building leased by the New York City Department of Homeless Services.

2. There was no consideration by ACS that the repeated allegations in the SCR reports were indicators of the mounting crisis in the family.
3. ACS unfounded two prior reports of abuse or neglect involving the mother. The state review revealed that this decision was incorrect based on the failure of ACS to complete a thorough and complete investigation before rendering the decision.
4. ACS did not make the appropriate collateral contacts[18] during the investigations of three previous reports of abuse and neglect.
5. ACS did not act appropriately on the information obtained during the investigation into a previous report regarding the presence of the boyfriend in the home. Therefore, ACS failed to accurately assess risk and ongoing safety issues and failed to provide services to address the risk and safety issues within the household.
6. ACS failed to interview the boyfriend, who was the subject of the report, in their investigation into the child fatality.
7. ACS failed to interview the mother in their investigation into the child fatality.
8. ACS failed to interview relevant collateral contacts regarding the child fatality such as first responders to the scene and the children's physician.

Case Number 95-06-045

Fact Pattern: On June 24, 2006, a two-month-old male died while co-sleeping with his mother on a futon in a two-bedroom unit in a Tier II homeless shelter. The child resided in the shelter with his mother and four siblings.

According to documentation, the mother fell asleep with the child on the futon. Sometime during the night, the mother rolled over the child in her sleep and smothered him. Documentation indicates that the mother had a crib in the apartment, but it was unassembled. The mother stated that the crib was unassembled because the family intended to move.

The Medical Examiner ruled that the manner of death was undetermined but listed co-sleeping with an adult as a contributing cause.

The mother was known to ACS before the child fatality. Between October 1, 2002 and January 18, 2006, ACS received and investigated seven reports of abuse and neglect against the mother. ACS substantiated two of the reports. The state review, however, notes that ACS inappropriately unsubstantiated the last report of abuse and neglect (January 18, 2006) prior to the child fatality.

In 2002, the now-deceased child's siblings were removed from their mother's care and placed in foster care because of allegations of Inadequate Guardianship and Lack of Supervision. The children were later returned to their mother under the supervision of their maternal grandmother. The family was provided preventive services including parenting skills classes for the mother.

[18] Collateral contacts are contacts with people who are indirectly involved and may have pertinent information about the family or child in an abuse or neglect investigation, such as a doctor, emergency medical technician, teacher, school social worker, neighbor, etc.

After the child's death, OCFS reviewed the fatality and the family's history with ACS. The review found that ACS made at least three mistakes in handling the family's previous reports of abuse or neglect and its investigation into the child fatality itself. Below is a sample of what the state found:

1. Throughout the history of the family's involvement with ACS, supervisors inappropriately unsubstantiated allegations when there was sufficient credible evidence to support an indicated finding.
2. ACS did not complete a thorough investigation of the report's allegation of Inadequate Guardianship during the course of their investigation.
3. The determination of the report was not completed within the required timeframe of 60 days.