Failed by the System:

A Review of Preventable Child Fatalities in the Child Welfare System

Issued by the Office of the Public Advocate for the City of New York
Public Advocate Betsy Gotbaum

January 2004

EXECUTIVE SUMMARY

New York City has a responsibility to serve its most vulnerable citizens, especially its children. This report examines deficiencies in the child welfare system through the prism of the most extreme form of failure – the preventable death of a child. The Public Advocate finds that more than one in three children who die during or after an investigation by the Administration for Children's Services (ACS) die due to causes that could have been prevented. Of the 46 children who died in 2002, and whose families had a prior or ongoing case with the City, 16 (or 35 percent) died for reasons that could have been prevented[1]. No child should die due to deficient casework, bad decision-making, ineffective services, poor coordination between agencies, or any other preventable factor.

This report provides a summary and analysis of each of the sixteen preventable deaths and identifies the actions taken by the Administration for Children's Services (ACS) and other child-serving City agencies--and the failures to act--that may have contributed to the death of those children.

Findings Include:

- In half the cases reviewed, ACS failed to properly investigate prior reports of abuse or neglect, assess the safety of homes and foster homes, or identify dangerous adults in homes;
- In half of the cases reviewed, appropriate services were not offered, not provided, or not properly monitored. This service failure is directly attributable to deficient investigations;
- In 37.5 percent of cases, ACS failed to properly train parents, foster parents, and frontline staff to properly care for children. This failure led to children sleeping in improper positions or not having their medical needs appropriately addressed;
- Also in 37.5 percent of cases, coordination, particularly around the medical needs of children, was not sufficiently provided by ACS and other child-serving agencies;
- Four of the five foster children reviewed in this report were placed in families that were either unsafe, overcrowded, or not adequately trained;
- Young children continue to be the most vulnerable, and infants are particularly at-risk; and
- Among older children, foster children are most vulnerable.

Recommendations and Conclusion:

The Office of the Public Advocate recommends that the Administration for Children's Services make the following improvements:

- Improve investigation of allegations of abuse or neglect, particularly in cases with multiple reports;
- Make more appropriate and consistent decisions to avert risk and place children in appropriate homes;
- Strengthen oversight of foster boarding homes;
- Hire medical professionals and ensure they are used appropriately on ACS Clinical Consultation Teams to improve coordination around medical issues;

[1] In a similar review last year, the Public Advocate found that about 40 percent of 52 ACS child deaths were preventable. The reduction from 2001 to 2002 was a mere 5 percent.

- Improve parent and foster parent training to better manage children's medical conditions;
- Ensure the proper sleeping position of infants encountered by all child-serving agencies;
- Include cases in which no report of abuse or neglect is made regarding the death of a child in the annual review by ACS's Accountability Review Panel; and
- Institute a dual track approach that improves preventive efforts by engaging families in low-risk cases and reserving an adversarial approach for those high-risk cases unresponsive to services.

INTRODUCTION

New York City has a responsibility to serve its most vulnerable citizens, especially its children. This report examines deficiencies in the child welfare system through the prism of the most extreme form of failure – the preventable death of a child. The Public Advocate finds that nearly one in three children who die during or after an investigation by the Administration for Children's Services (ACS), die due to causes that could have been prevented. Of the 46 children who died in 2002, and whose families had a prior or ongoing case with the City, 16 (or 35 percent) died for reasons that could have been prevented. No child should die due to deficient casework, bad decision-making, ineffective services, poor coordination between agencies, or any other preventable factor.

This report provides a summary and analysis of each of the sixteen preventable deaths and identifies the actions taken by the Administration for Children's Services (ACS) and other child-serving City agencies--and the failures to act--that may have contributed to the death of those children.

This report does not call for children to be removed from the home and placed in foster care when that solution is not the most appropriate choice. Unnecessary placement in foster care also represents a failure of the system. Rather, the Public Advocate calls on ACS to make the current system work better by making sure that families are provided with effective services and that consistent and appropriate decisions are made regarding the safety and welfare of all children introduced into the system.

METHODOLOGY

The New York State Office of Children and Family Services (OCFS), in accordance with state law, prepares a fatality report for each child who dies while in custody of ACS (and ACS contracted agencies), or whose death was reported as having been caused by suspected neglect or abuse. Of the 78[2] New York City child fatalities reported by OCFS for the year 2002, 46 of the children who died were from families known to ACS. A family is considered "known" if it meets the following criteria:

a.) an adult in the family had been the subject of a report of child maltreatment in the State Central Register (SCR), the statewide database of abuse and neglect, before the fatality occurred;
b.) ACS was investigating an allegation against an adult in the family when the fatality occurred; or
c.) a family-member was receiving foster care or preventive services when the fatality occurred.[3]

Each OCFS review examines ACS case records and the actions and decisions of its caseworkers and supervisors in order to assess their compliance with the law and with regulations and to determine if the actions taken were appropriate and fair. OCFS also reviews other relevant documents, including contract agency case records, the autopsy report, medical records, and prior reports of suspected neglect or abuse. In nearly all cases, a determination is made about the quality of the casework and investigation. In many cases, OCFS requires ACS to develop a corrective plan.

[2] This number does not reflect the three reports that were determined to be false (i.e. no child was found to have died).
[3] ACS, *Accountability Review Panel Report 2000 and 2001*
[4] The Accountability Review Panel is an independent oversight body consisting of child welfare experts from outside city government.

ACS works with an Accountability Review Panel[4] that reviews fatalities in order to identify ways to improve. This panel, however, does not review cases in which no report of neglect or abuse was made in relation to the fatality itself. While many of these cases involve children with terminal illnesses or severe health problems, some involve homicide or suicide. The Public Advocate is calling on the Panel to include these cases in its annual review because they often reveal worthwhile information about risk factors and casework practice. For this reason, we include such cases in this report.

For this report, the Office of the Public Advocate reviewed the 46 fatality reports of incidents occurring in 2002 that involved children known to the system and determined that 16 of the 46 deaths could have been avoided. Findings were based on the conclusions of OCFS and on the casework experience of the Child Welfare Project, which is a joint program with Office of the Public Advocate and provides impartial advocacy for individuals and families involved in the child welfare system.

The cases were judged on the following criteria:

- Service Breakdown
- Investigation Failure
- Medical Coordination Breakdown
- Inappropriate Foster Home
- Unsafe Home
- Improper Parent Training in Sleeping Position of Infant
- Improper Parent Training in Medical Care
- Poor Coordination of Services
- Dangerous Adult in the Home
- Unreported Incident

INDIVIDUAL CASE FINDINGS

Case # 95-03-001[5]

Fact Pattern: On December 31, 2002, a seven-month-old foster child was killed by his foster mother's adult brother, who resided in the foster home. The brother, a convicted murderer, hit the child's head against a stove in an effort to quiet the child's crying. The foster child had been removed from home two months earlier because of allegations that the birth parents had snapped the child's femur. According to the OCFS report, the contract agency that assumed the planning responsibilities for the family failed to perform a complete background check on all persons living in the foster home and failed to identify the foster mother's brother as a convicted murderer.

Analysis: Although the brother was not living with the foster mother at the time of the expedited home study, the contract agency records indicate that the agency became aware of him three weeks prior to the fatality when the birth father of the child expressed reservations about the brother's presence in the foster home. ACS and its contract agency's decision to allow a foster child to reside in the home of a convicted murder can be directly linked to the child's violent demise.

Fatality determined to be avoidable because of:

√ **Dangerous Adult in Home:** Failure of ACS and/or contract agency to properly investigate all adults in home

√ **Inappropriate Foster Home:** Placement with inappropriate foster family

Case # 95-02-046

Fact Pattern: On August 25, 2002, a twelve year old girl committed suicide by overdosing on her brother's medication. The family was well known to ACS through eleven SCR reports concerning the girl's family, nine of which were unfounded, two of which were indicated.[6] Allegations in the reports included sexual abuse of the now deceased child by the mother's half-brother, lack of supervision, educational neglect, medical neglect, nutritional neglect, and excessive corporal punishment. ACS indicated only the sexual abuse case and the report subsequent to the child's suicide. OCFS, however, determined that, on the basis of the reports of the ACS Specialist[7], there was evidence to have substantiated at least one of the other allegations.

Analysis: According to the OCFS report, "ACS serviced the family for eight years, during which time the family had multiple SCR reports with very consistent allegations regarding the quality of care being provided to the children by the mother. Given the children's and mother's clinical issues and the ongoing educational issues and the condition of the home, ACS should have assumed a greater role, as case managers, in assessing the effectiveness of the services being provided and coordinating the efforts of the

[5] Each fatality reported on by OCFS is identified with case number. No names are used throughout the reports. This report uses the same identifiers.

[6] A note on terminology: 'Reports' to the State Central Register list 'allegations' (i.e. specific charges) against particular 'subjects' (parents, foster parents, or other adults living in the child's home.) After ACS completes an investigation into a report, the allegations are found to be 'substantiated' or 'unsubstantiated,' and the report is either 'indicated' – in the case of substantiated allegations – or 'unfounded' – in the case of unsubstantiated allegations.

[7] The ACS Specialist is the child protective professional responsible for investigating the fatality and deciding what services the family needs and what steps are necessary to ensure the safety of the surviving children.

two preventive agencies involved with the family." This criticism by the state agency shows a persistent failure on the part of ACS to investigate and ensure the appropriate provision of services to this family as well as an inability to address family dynamics as a whole rather that addressing reports in isolation.

Fatality determined to be avoidable because of:

√ **Investigation Failure:** ACS failure to properly investigate multiple SCR reports and/or view them as a whole

√ **Service Breakdown:** ACS failure to monitor effectiveness of services provided

Case # 95-02-011

Fact Pattern: On February 23, 2002, a four-year-old child died of complications resulting from burns she had sustained three weeks earlier. The Medical Examiner's autopsy report stated she had second and third degree scald burns over approximately 80 percent of her body. She suffered these burns at the hands of her mother who was later indicted for murder in the second degree, criminally negligent homicide, and endangering the welfare of a minor. The family had been known to ACS and the SCR since 1996 and was the subject of six reports prior to the scalding report and the subsequent fatality report. Two of these prior reports were substantiated; the other four were unfounded. Of the four unfounded reports, OCFS determined that two of the investigations were incomplete because they did not include documentation of interviews with the father. Although never substantiated, the three most recent reports included allegations of lacerations, bruises, and/or welts against both the mother and father. The last report, 15 months prior to the scalding episode, included allegations of inadequate guardianship. While ACS substantiated this allegation and indicated the case, the report was closed. The stated reason was 'no services required.'

Analysis: Based on the consistent allegations detailed in the OCFS report and that report's determination that several allegations were incompletely investigated, and on the failure to provide services after a substantiated allegation of inadequate guardianship, this office believes that ACS failed, given ample opportunity, to provide preventive services or an intervention that might have had success in securing the safety of the child.

Fatality determined to be avoidable because of:

√ **Investigation Failure:** ACS failure to properly investigate multiple SCR reports and/or view them as a whole

√ **Service Breakdown:** ACS failure to provide appropriate services

Case # 95-02-005

Fact Pattern: On February 5, 2003, a two-month old girl weighing 10 lbs. was pronounced dead on arrival at Jacobi Hospital. While the cause of death was undetermined, the Medical Examiner believed it could be a combination of factors including nutritional neglect, dehydration, and medication. The Medical Examiner did not exclude the possibility of asphyxiation as a contributing factor. The child had been staying in a family shelter with her mother who had been, nine years earlier, the subject of three reports in relation to another child. Two were unsubstantiated. The third report, which alleged

Malnutrition and Failure to Thrive, was substantiated. Following this third indicated report, the child was removed and placed in foster care. In 2001, the child was freed for adoption.

Analysis: The Department of Homeless Services (DHS) should have performed an SCR and criminal background check on the mother during intake. The shelter was required by law[7] to report the nutritional neglect of the now deceased infant if it was observed by shelter staff. If either of these actions had been taken, the mother would have been reintroduced to the ACS system and her previous report would have identified the family as requiring preventive services or some other intervention to provide for the safety of the child.

Fatality determined to be avoidable because of:

√ **Poor Coordination of Services:** Possible lack of coordination between city agencies

√ **Unreported Incident:** Shelter failure to identify and/or report neglect

Case # 95-02-031

Fact Pattern: On June 26, 2002, a four-year-old died of an untreated head injury that he sustained 11 days earlier when he fell in the bathtub. The family had a prior history with the child welfare system, with six reports since 1998. Four of the reports were indicated. Several contained allegations of inadequate guardianship (three times); lacerations, bruises, and welts; and lack of medical care (twice). According to the OCFS report, "ACS indicated three reports over a one-year period against the parents for lack of medical care, lacerations, bruises, welts, and inadequate guardianship, yet failed to intervene to protect the children in the home or provide the family with any services." Just five months prior to the fatality, ACS substantiated allegations that the parents knew the child's sister had been sexually abused and that, knowing this, they did not seek to provide her with medical attention or take any steps to protect her. The case was indicated and designated as open for voluntary services.

Analysis: According to the OCFS fatality report, "Given the parents failure to report the prior incident, ACS should have implemented an intervention to keep the child safe. In addition, there is no documentation that the family was engaged in services following the indication." This case marks a serious failure on the part of ACS: while cognizant – as evidenced by the indicated reports – of the problems within the home, they took no steps to intervene to ensure the safety of the children in that home.

Fatality determined to be avoidable because of:

√ **Investigation Failure:** ACS failure to properly investigate multiple SCR reports and/or view them as a whole

√ **Service Breakdown:** ACS failure to provide services following indication

[7] Some professionals who work with children and families are required by law to report instances and suspicions of child abuse and neglect. These 'mandated reporters' include doctors, nurses, social services workers, teachers, and shelter operators, among others.

Case # 97-02-021

Fact Pattern: On July 1, 2002, a six-week-old infant was discovered dead in his foster mother's bed. While the cause of death was undetermined, it was suspected to be asphyxiation as a result of the child being placed on his stomach and choking on recently consumed formula. One hour prior to the mother's discovery of the deceased child, who was bluish and had formula leaking out of his mouth and nose, the social worker contracted by the foster agency witnessed the child sleeping on his stomach.

Analysis: The American Academy of Pediatrics has recommended since 1992 that children sleep on their backs. OCFS strongly recommends to ACS and its contract agencies that they teach foster parents and staff the importance of putting an infant to sleep on its back. The social worker, who should have been trained by the contract agency regarding this recommendation, had the opportunity to correct the situation an hour before the fatality.

Fatality determined to be avoidable because of:

√ **Improper Parent Training on Sleeping Position of Infant:** Foster care agency failure to properly train and/or monitor staff regarding the proper sleeping position of infants

Case # 95-02-018

Fact Pattern: On April 15, 2002, a three-year-old fell six stories to his death. It is unclear whether the child unlocked and opened the terrace door, as the mother claims, or if the door had been left open. The child lived with his mother, his 14-year-old sibling, and his 16-year-old, mentally-impaired sibling. The family was known to the child welfare system from six earlier reports, two of which were indicated. Both of the indicated cases, one from 1996 and one from 1999, alleged domestic violence by the father against the mother. Despite the first indication, the children were judged safe in the home, and the case was closed without services. According to OCFS, "ACS failed to appropriately address and assess the domestic violence issues involved in the report. […] In addition, the home was not assessed for future risk of harm to the children." After the second indication, the case was closed because the family refused service and the mother refused to take legal action. The four unfounded reports all involved the 16-year-old sibling who is said to have a mental age of four to five years old. Three of the reports accused the mother of lack of supervision and inadequate guardianship.

Analysis: According to the OCFS fatality report, "NYCRO's [New York City Regional Office of OCFS] review of the unfounded reports revealed that ACS failed to appropriately investigate the four unfounded SCR reports dated 10/9/98, 5/28/98, 3/16/99, and 5/14/99. Throughout the investigations, ACS failed to interview collateral sources, failed to conduct appropriate investigations, and failed to make appropriate safety assessments for the surviving siblings." Despite the mother's reported inability to provide adequate supervision for her children, the family received no services between the last unfounded report and the child's death. Had the reports been appropriately investigated, they may have been indicated and resulted in services or interventions necessary to ensure the safety of the children, including the now-deceased toddler.

Fatality determined to be avoidable because of:

√ **Investigation Failure:** ACS failure to properly investigate multiple SCR reports and/or view them as a whole

√ **Service Breakdown:** ACS failure to provide appropriate services

√ **Unsafe Home:** ACS failure to make appropriate risk assessment

Case # 97-02-010

Fact Pattern: On February 22, 2002, a month-and-a-half-old foster child was found dead in her playpen, the manner and cause of her death undetermined. The child had been removed from her mother's care because the child was found to have traces of cocaine in her system at birth. The child, who had been experiencing nasal congestion in the care of the foster mother, was treated by the foster mother with a suction device given to her during a hospital visit. Prior to the discovery of the child's death, the foster mother cleared the child's nasal passages with the device and placed the infant in the playpen on her stomach – a position advised against by OCFS, as noted in case 97-02-021.

Analysis: As noted above, OCFS strongly recommends that ACS and its contract agencies provide training to all foster parents and staff concerning the correct sleeping position for infants. The foster mother, while certified to take care of children five to eleven years of age, was not certified to take care of infants. Nor was the foster parent trained to care for infants that need special care because they were born with traces of cocaine in their system. Furthermore, the agency did not provide OCFS with medical documentation to confirm whether or not the child received a mandated medical exam during the first two to four weeks of age. While the cause of death was undetermined, it is clear that the training and certification of the foster mother were insufficient and that oversight of the foster home and the medical care of the infant by the contract agency were lacking.

Fatality determined to be avoidable because of:

√ **Inappropriate Foster Home:** Placement with inappropriate foster family

√ **Improper Parent Training on Sleeping Position of Infant:** Foster care agency failure to properly train and/or monitor foster care families regarding the proper sleeping position of infants

√ **Medical Coordination Breakdown:** Problems with coordinating medical services

Case # 95-02-023

Fact Pattern: On May 16, 2002, a 10-month-old child died in his sleep. While the cause and manner of his death were undetermined, he did not have his sleep apnea monitor on at the time of death, as was required. Six months prior to the fatality, the family was the subject of an SCR report alleging that the mother did not use the sleep apnea monitor. The visiting nurse stated that, after seeing the child was not on the monitor, the machine was checked at the hospital and was discovered never to have been turned on. During the investigation of the prior SCR report, the child was in the hospital. Two weeks prior to the child's discharge from the hospital, the allegations of inadequate guardianship and lack of medical care were unsubstantiated.

Analysis: Based on NYCRO's review of the case, the state revealed that ACS did not conduct a thorough and complete investigation. According to the report, "ACS completed the investigated [sic] without the child being discharged from the hospital. The child was discharged from the hospital on 2/19/02; therefore ACS did not have sufficient information to determine if the child would be unsafe or at risk under the mother's care." Based on the fact that the now-deceased child was not on the apnea monitor, this office believes that either the parents were still not trained properly to use the machine or they were continuing to act unsafely. In either case, ACS failed to appropriately address the issue of the child's safety upon his discharge from the hospital and his return to the family.

Fatality determined to be avoidable because of:

√ **Medical Coordination Breakdown:** Problems with coordinating medical services

√ **Unsafe Home:** ACS failure to make appropriate risk assessment

√ **Improper Parent Training in Medical Care:** Failure to provide training to care for medical condition

Case # 95-02-001

Fact Pattern: On January 9, 2002, a three-month-old child died of asphyxiation as the result of co-sleeping with her mother. At the time, the child lived with the mother and the mother's friend. The mother's friend was known to the child welfare system because her children were removed from the home when it was found to be unsafe due to the presence of guns and drugs. The mother was known to the system through an SCR report alleging that she tested positive for marijuana upon delivery of the child. Three days after the birth of the child, an ACS Specialist made a visit to the mother's home and observed that the mother did not have a crib or bassinet or other essentials for the child.

The child's environment was deemed unsafe, but because the mother agreed to comply with services, ACS chose not to intervene. The Specialist obtained the needed items for the child, and the mother agreed to comply with a drug treatment program and preventive services. Two months later, the home was deemed safe despite the fact the mother tested positive for drugs in November and December. This safety decision was based on the mother's cooperation and the child's positive development. OCFS determined that this safety assessment was made incorrectly. "ACS should have based its safety decision on the mother's failure to plan for the child and the impact of her drug use on her ability to care for the child. ACS should also have based its safety decision on the functioning of the friend's home, as they had already determined the home to be unsafe for two of the friend's children."

Analysis: While the initial safety assessment may have been incorrect, it is not unreasonable to believe that the child was safe while the mother was making progress; many parents are able to care for their children and home successfully while receiving treatment and services; however, it is clear from the mother's positive drug tests that she was not progressing adequately enough to void what should have been a determination that the home was unsafe. Additionally, the Specialist had made arrangements to have a crib provided to the mother, and the mother was participating in parenting classes, yet the child was still co-sleeping with the mother. It is unclear from the case documentation whether the mother received instruction on appropriate sleeping arrangements for an infant.

Fatality determined to be avoidable because of:

√ **Dangerous Adult in Home**: Failure of ACS and/or contract agency to properly investigate all adults in home

√ **Improper Parent Training on Sleeping Position of Infant:** Failure to properly train mother in appropriate sleeping position for infants

√ **Unsafe Home:** ACS failure to make appropriate risk assessment

√ **Poor Coordination of Services:** Possible lack of coordination between contract agencies

Case # 97-02-005

Fact Pattern: On January 4, 2002, a 16-year-old foster child died from complications resulting from a kidney condition, diagnosed in August 2001. After four visits to the hospital for the condition between August 21 and October 23, 2001, she was referred to a nephrology clinic. Until November 2, 2001, there was no indication in the case notes that either the child or foster mother were informed of the diagnosis, plan of treatment, or the need for training. The child continued to experience complications and was hospitalized three more times; the last time was the day before her death. On January 3, she was admitted with chest pains and shortness of breath. She was discharged the same day with a diagnosis of bronchitis, inflammation of the lungs, and anxiety. The next morning the child woke up unable to breath. The kidney disease caused a loss of large amounts of protein from the blood into the urine. This in turn caused a clotting disorder and led to a clot in the lungs. Despite a prior diagnosis of her condition and a well-documented treatment plan, the blood clot was improperly diagnosed as bronchitis the day before her death.

Analysis: According to OCFS, "Although the agency provided the foster child with medical services, due to the severe nature of her condition, closer monitoring and coordination by the agency with the foster parent, child, and medical providers relative to her treatment was warranted." The report went on to conclude, "The agency must develop a system to increase its monitoring of seriously ill foster children that provides closer consultation between the foster family, foster child, the agency's medical clinic, medical consultants, and hospitals, in order to communicate and coordinate vital information such as medical history, diagnostic evaluations, treatment plans, and follow-up care in accordance with [OCFS regulations]."

Fatality determined to be avoidable because of:

√ **Medical Coordination Breakdown:** Problems with coordinating medical services

√ **Improper Parent Training in Medical Care:** Failure to provide training to care for medical condition

Case # 97-02-001:[8]

[8] This case is not counted by ACS when measuring the number of fatalities of children known to the system. ACS's Accountability Panel only reviews deaths of children known to the system that are associated with child abuse or neglect where a call was made to the state hotline. In the past, the Child Welfare Project and the Office of the Public Advocate have recommended that ACS's Panel review all child fatalities so that we can learn more about preventable measures and other risk factors.

Fact Pattern: On January 29, 2002, a 16-year-old foster child died from gunshot wounds received 12 days earlier during a robbery attempt perpetrated by the child. The child and an acquaintance were attempting to rob a deliveryman when, during the struggle, the deliveryman's licensed gun was fired and killed the foster child. The child had been voluntarily placed in foster care by the mother because of lying, stealing, and truancy. Because of the foster child's particular needs, he had been placed in a therapeutic foster boarding home, where he was to receive more intensive services than a typical placement.

Analysis: According to OCFS, "Due to his special needs the deceased child was placed in a therapeutic foster boarding home to receive additional services and supports so he could remain in the community. The provision of services to the deceased child were [sic] not significantly greater than those received in a regular foster boarding home. The services provided were not to the extent of their approved TFBH program proposal." This finding in the OCFS report suggests to the Office of the Public Advocate a failure on the part of the contract agency to provide needed services that may have corrected the behaviors that led to the child's demise.

Fatality determined to be avoidable because of:

√ **Service Breakdown:** Failure to ensure that agency was providing services for which it was contracted

√ **Inappropriate Foster Home:** Placement with inappropriate foster family

97-02-011[9]

Fact Pattern: On July 3, 2002, a 16-year-old foster child was stabbed to death by another foster child while the now-deceased child was AWOL from her foster boarding home. Despite the fact that the foster home was only licensed for four children, had been recommended to reduce to three, and had been originally cleared for only two, the deceased child was one of five foster children ranging in age from seven to 19 years that resided in the home. The child had been in foster care since 1993 and had a long history of truancy, going AWOL, and inappropriate sexual behavior. She had not attended many of the service plan conferences although she was invited to all of them. She was receiving casework counseling, independent living, tutoring, clinical evaluations, and psychotherapy (which she had stopped attending).

Analysis: Because only one bedroom was available to board all five children – some of whom were older and needed more privacy – it is reasonable to conclude that the overcrowded conditions were partially responsible for the deceased child's AWOL episodes.

Fatality determined to be avoidable because of:

√ **Inappropriate Foster Home:** Placement with inappropriate foster family

Case # 95-02-054

Fact Pattern: On December 11, 2002, a twenty-three-month-old child died of injuries resulting from a kick in the stomach by his mother's paramour[10]. The mother was the subject of two prior SCR reports; one was unfounded while the other, which alleged inadequate guardianship, was substantiated in 1998.

[9] This fatality is also not counted by ACS as known to the system for the same reasons as case 97-02-001 above.
[10] "Paramour" is the term used by ACS.

Prior to the child's death, the sibling of the child was removed from the home and placed with a cousin. This followed an ACS Specialist finding the child with a severe rash over much of her body in an apartment described as "filthy and foul smelling, with roaches crawling all over the walls and ceiling." After the mother completed parenting skills classes and received preventive services from a contract agency, the child was discharged to her mother's care in August of 2000 after which there was no ACS involvement with the family. It is unclear from the OCFS report why ACS involvement with the family ended even though the child had just been discharged into the mother's care. There is no evidence in the record to indicate that ACS or its contract agency made any effort to monitor the home after the reunification, either through voluntary or mandated home visits.

Analysis: That this family did not continue to receive preventive services, particularly considering that the surviving sibling was returned to the mother at the beginning of the mother's third trimester with the deceased child, was ill-advised and constitutes a failure on the part of ACS to provide necessary services. A trial discharge with a significant level of services might have been more appropriate.

Fatality determined to be avoidable because of:

√ **Service Breakdown:** Reunification without necessary ongoing services.

Case # 95-02-019

Fact Pattern: On April 18, 2002, a 21-day-old infant died in a manner and by a cause that was undetermined. The Medical Examiner did not, however, rule out Sudden Infant Death Syndrome (SIDS). Living with the infant were his mother, six-year-old sibling, and 19-year-old maternal aunt. The family had a long history with ACS and the SCR with a total of 14 reports: 11 on the mother as a maltreated child and three on her as the subject. In all 14, the surviving sibling was listed as a maltreated child. All 14 reports were unfounded. The reports – dating back to 1996 – alleged lack of supervision and drug abuse by the maternal grandfather, the mother, and her siblings. Many of the reports included allegations of educational neglect. For example, one alleged that the mother (who was then 16) and her sister (then 13) were not going to school and were having 'beer parties.' OCFS found it "unclear from the case documentation why all of the report allegations were unsubstantiated" despite the many factors that indicated that there were problems in the home, including: the fact that the family underwent family preservation services and preventive services; that the surviving sibling was, at one point, removed by court order because of unsanitary conditions in the home; and that, subsequent to the Article 10 Neglect Petition filed by ACS, the court's disposition was Court Ordered Supervision. Allegations of intergenerational drug abuse continued, and the family continued to receive intensive services (although the case record does not clearly document that ACS was appropriately monitoring their delivery, according to the OCFS report).

Analysis: Despite the fact that, according to OCFS, it was "clear from ACS documentation that the allegations contained in the various reports were under-investigated and that the determinations for these reports were not consistent," ACS closed the family's case on 10/12/00. While the family had no further reports until the infant's death, had the family continued to receive the services that seemed warranted, the child's living situation may have been improved, possibly producing a different outcome.

Fatality determined to be avoidable because of:

√ **Investigation Failure:** ACS failure to properly investigate multiple SCR reports and/or view them as a whole

√ **Service Breakdown:** Failure to investigate prior reports probably led to failure to ensure the effective provision of preventive services

Case # 95-02-040

Fact Pattern: On August 18, 2002, an 11-month-old child died of complications resulting from an intestinal condition that prevented her body from absorbing nutrients. The deceased child lived with her 14-year-old mother, her maternal grandmother, and three male cousins. The family was known to ACS and the SCR through two unfounded reports. The child was hospitalized for its intestinal condition from 10/2/2001 to 5/31/2002 and again from 6/16/02 to 7/17/02. In the month between the child's second release from the hospital and her death, she was receiving services from a visiting nurse, a social worker, and, to address suspected developmental delays, various therapists – physical, occupational, and speech.

Analysis: Despite receiving home visits from all of these professionals, the knowledge of the visiting nurse and the physician of the child's ongoing diarrhea and weight-loss (according to the grandmother), and the long hospitalization for the same condition, the child's condition was not properly addressed by those involved. Based on the findings in the OCFS report, it appears that the family was not trained properly to respond by readmitting the child to the hospital if they saw signs of its condition worsening, and the professionals involved in the child's case were not responsive to the child's worsening condition. While the child's death was not specifically a failing on the part of ACS, the healthcare and early intervention agencies contracted by other city departments had ample opportunity to ensure the child was readmitted to the hospital.

Fatality determined to be avoidable because of:

√ **Medical Coordination Breakdown:** Problems with coordinating medical services

√ **Improper Parent Training in Medical Care:** Failure to provide training to care for medical condition

FINDINGS

- **Investigation by ACS Workers and Contract Agency Workers Was Deficient in Half of the Cases.** One of the primary functions of ACS is to investigate allegations of abuse and neglect and determine whether children are safe or unsafe in their homes. Foster care agencies are charged with investigating potential foster boarding homes and all adults who reside in them. In eight of the cases examined in the preceding section (50%), poor investigation of incidents and individuals contributed to the circumstances of the fatality.

    - **ACS Fails to Properly Investigate Previous Reports of Abuse and Neglect.** In six of the 16 (38 percent) cases reviewed, ACS workers did not appropriately investigate allegations of abuse or neglect. Family members in these cases were the subjects of a total of 43 reports of abuse or neglect prior to the fatalities – an average of 7.1 reports per family. Most of these reports were found not to have merit based on ACS investigations. While it is impossible to say how many of these reports, if properly investigated, would have been found to have merit, it is clear from the consistent nature of the allegations that these families deserved closer scrutiny by ACS. According to ACS guidelines, a managerial review is required in cases with four or more reports of abuse or neglect. The outcomes of these reviews – if indeed they took place – did not lead to the discovery of the inadequate investigations, nor did they lead to the appropriate level of involvement through services, supervision, or other intervention.

    - **ACS Fails to Properly Investigate the Safety of the Home.** In three of the 16 cases (19 percent), ACS failed to make the appropriate safety assessment that would have led to the removal of the child prior to the fatality. One of these improper safety assessments was the direct consequence of an improper investigation. The other two were the result of poor judgment on the part of the caseworkers.

    - **ACS Fails to Properly Investigate All Adults in the Home.** In two cases (13 percent), adults were not properly investigated. One of these was a convicted murderer who was residing with a foster mother. According to the case records, the foster agency was made aware of this adult three weeks prior to the fatality, yet the agency did not conduct an investigation. The other case was one in which the mother lived with her female friend. The fact that this friend's own children were in foster care because of the presence of guns and drugs in the apartment should have informed the safety decision.

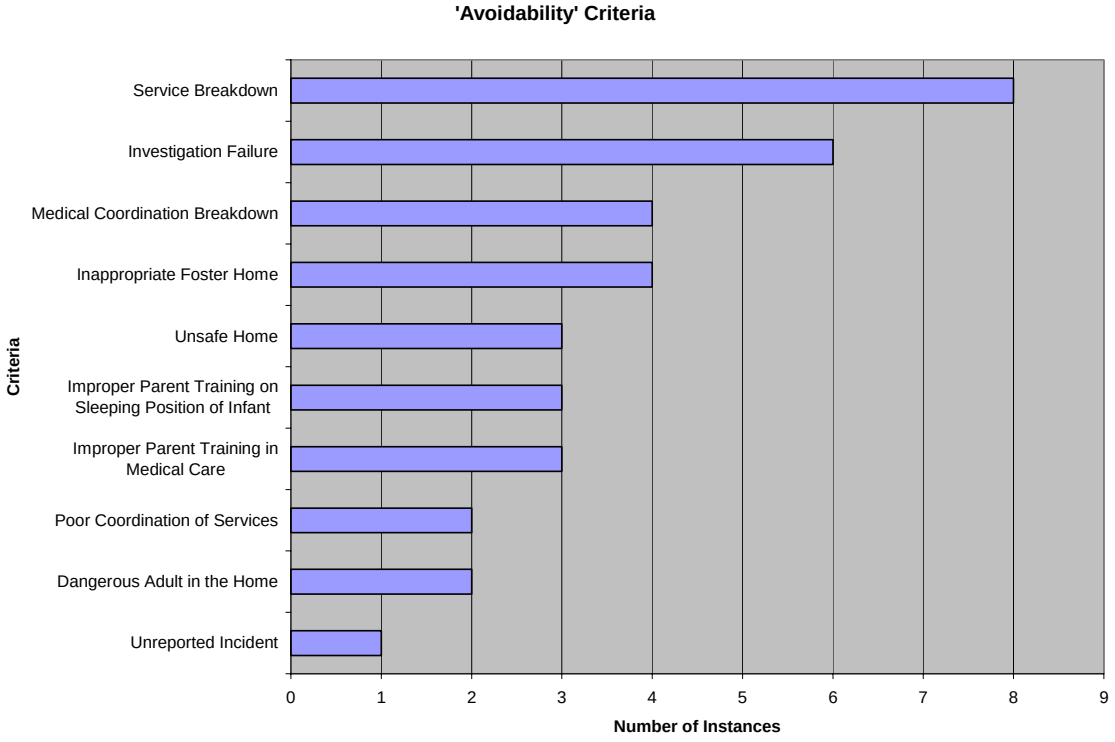
- **ACS Fails to Provide Appropriate Services.** In eight of the 16 cases reviewed (50 percent), ACS or its contract agencies failed to provide necessary and appropriate services. This was sometimes the result of cases in which investigations were not completed properly and therefore did not connect to services. There were some even more disturbing cases in which the reports of abuse or neglect were found to have merit, yet no services were provided, either because the subject was unwilling or because the caseworker found that none were necessary. An example of this type of failure is the case of the scalded four-year-old, in which allegations of inadequate guardianship had been substantiated only 15 months earlier, yet the case was closed with no services provided. In some cases, the failure to provide appropriate services was the result of poor monitoring of service outcomes and ineffective management of complex cases. In one case, a particularly troubled child was not receiving the services that the special 'therapeutic' foster home was contracted to provide.

- **ACS Fails to Properly Train Parents, Foster Parents, and Frontline Staff.** This type of failure was noted in six of the cases reviewed (37.5 percent). In three, the lack of training led to the improper sleeping position of the deceased child. In three, it led to improper care of serious medical conditions by parents or foster parents.

- **City, Health, and Contract Agencies Fail to Coordinate Services.** Six of the cases reviewed showed that a lack of coordination on the part of the numerous agencies involved in serving children and families was a contributing factor in the fatalities. The lack of adequate coordination of services around a child's medical care was a contributing factor in four (25 percent) of the deaths reviewed. In all four of these cases, the child had previously been admitted to the hospital for a particular condition (or, in one case, made numerous visits to the doctor) and died shortly after release. In all these cases, it is unclear whether the parents, foster parents, and City and contract agency staff were properly aware of the children's particular medical needs and concerns. In two non-medical cases (13 percent), there was a lack of coordination between City and contract agencies.

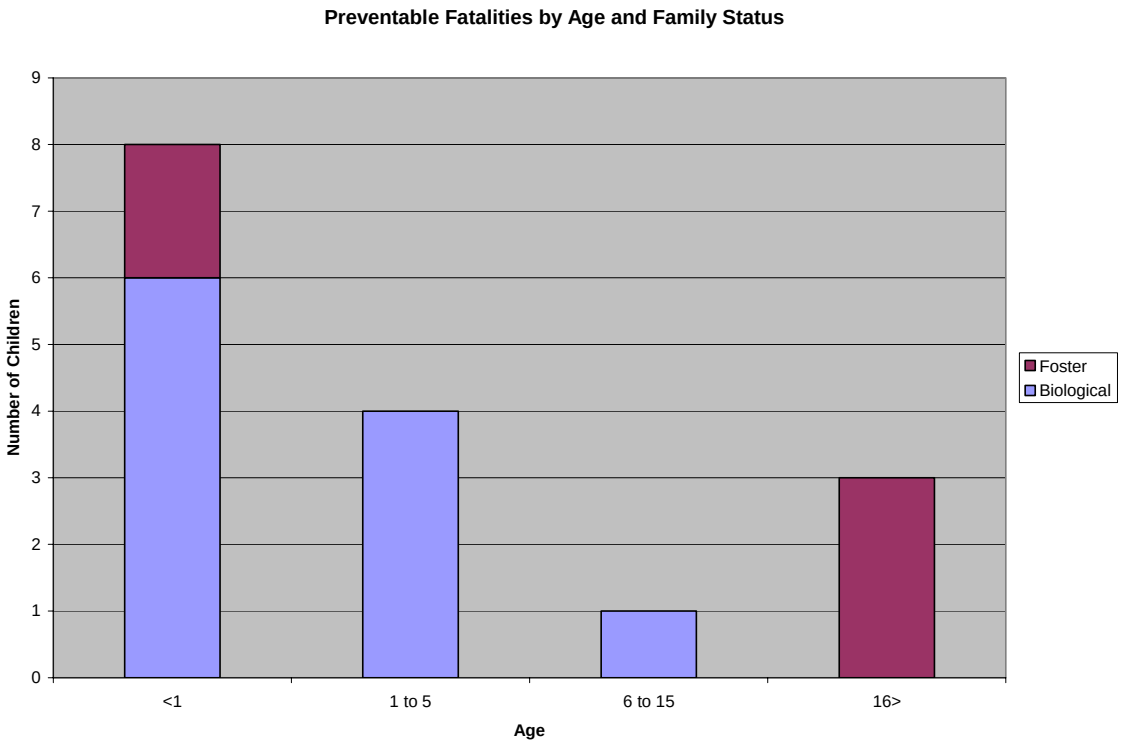
- **ACS Makes Inappropriate Foster Home Placements.** The City takes it upon itself to take the highly disruptive step of removing children from their homes in order to ensure their safety. To take this dramatic step without providing a safe alternative is unconscionable. In four of the five foster care cases reviewed, children were placed in foster homes that were unsuitable, either because they were not properly licensed (as in the case of the foster family that was not trained or licensed to take in infants or children born with cocaine in their systems), they did not provide the appropriate services (as in the case of the therapeutic foster boarding home noted above), they were over capacity (as in the case of the 16-year-old girl living in the same bedroom as four other foster children), or they were merely unsafe as the result of dangerous adults living in the home (as in the case of the convicted murderer who lived with the foster parent).

The findings listed above are summarized in the figure below:



- **Young Children Are Most Vulnerable and Most Likely to Be Involved in an Avoidable Fatality.** Last year's report found that young children were the most vulnerable and most likely to be involved in an avoidable fatality, and infants are particularly at-risk. This report reaffirms that finding. This is most likely the case because it is these young children who cannot advocate for themselves and rely on ACS and the other child-serving agencies to identify risks to their welfare and to address them. Twelve of the 16 (75 percent) reports reviewed here relate to the deaths of children under five; eight of those relate to children under the age of one.

- **Among Older Children, Foster Children Appear to be the Most Vulnerable.** Three of the remaining four fatalities were of children 16 years or older. All three of these were foster children. These findings are summarized in the figure below.


Preventable Fatalities by Age and Family Status
Number of Children
0
1
2
3
4
5
6
7
8
9
<1
1 to 5
6 to 15
16>
Age
Foster
Biological

RECOMMENDATIONS AND CONCLUSION

Based on these findings, the Office of the Public Advocate recommends the following:

Improve Investigation of Allegations of Abuse or Neglect. Special attention needs to be paid to families that are the subject of numerous reports of abuse and neglect. Several of the cases reviewed here exhibited a pattern of unsubstantiated and substantiated allegations – sometimes more than 10 – prior to the fatality. Subsequent OCFS reviews showed that many of these prior investigations were incomplete.

Failure to properly investigate often leads to an ACS failure to connect families with adequate services or make appropriate safety decisions. According to ACS guidelines, cases in which more than four reports have been made to the SCR are designated as 'high priority' and are subject to managerial review. In the cases which the Office of the Public Advocate reviewed, there was no evidence in the OCFS reports of these managerial reviews and, if indeed they did take place, they did not resolve issues of deficient prior investigations. Nor did they adequately address the overall dysfunction of the families involved.

Rather than treating reports of abuse or neglect in isolation, the entire case history, including interacting risks, should be taken into account when making decisions regarding the need for services or other intervention. Often these families were not connected to the services they needed because no single report warranted the intervention; however, a look at the cases in their entirety would have provided a different picture.

A similar recommendation appears in the ACS Accountability Review Panel Report. According to that report, "The managers [during case reviews], however, did not always guide staff in conducting thorough case assessments or require them to explore convening Elevated Risk Conferences that included other service providers involved with the family. Instead, staff considered reports in isolation with little evidence of insight into assessing multiple, interacting risks, and why interventions were not effective…"[11]

Additionally, ACS needs to ensure that contracted foster agencies perform investigations of all adults living in foster homes. That a foster child was allowed to live with a convicted murderer is unconscionable, particularly considering the fact that the agency was made aware of concerns about this adult three weeks prior to the fatality.

Improve Consistency and Appropriateness of Decision-Making by ACS and Contract Agencies. ACS has implemented its Common Core Training System, which is a step in the right direction, as are multi-level case reviews; however, these are inputs into the system. Clear outcome measurements need to be developed in order to assess whether training is effective and methods are implemented consistently. Additionally, this system does not ensure consistency and appropriate decision-making among contract agencies.

It should be emphasized that the appropriate response to this report would *not* be to call for more conservative decision-making regarding whether or not to remove a child. In fact, more than a quarter of the fatalities reviewed here were of children in foster care. This indicates that safety is not just a question of removal and placement but rather a result of good decision-making. Consequently, decision-making by

[11] NYC Administration for Children's Services, *Accountability Review Panel Report 2002,* p.25.

ACS and its contract agencies must be made even *more consistent* and *more appropriate*. While the focus of this report has been on the prevention of fatalities, inappropriate removals are also to be avoided because they are devastating to families and lead to poor outcomes for children.

Strengthen Oversight of Foster Boarding Homes. The removal of children from their homes is a harrowing experience that is justified by the necessity of keeping the child safe. This justification falls apart when the foster home that the child is placed into is not appropriate to the child's needs. ACS must ensure that its contracted foster agencies provide safe, licensed, uncrowded foster homes. Greater oversight of foster agencies and the boarding homes they manage is needed.

Strengthen ACS Clinical Consultation Teams to Coordinate on Medical Issues. Children with medical conditions who are in foster care or who are receiving services from ACS need a greater level of service coordination around their medical needs.

Last year, ACS established 12 Clinical Consultation Teams in their Department of Child Protection Field Offices to provide expertise in the areas of mental health, domestic violence, and substance abuse. While ACS intends to add a medical nursing consultant with expertise in child abuse and maltreatment to these teams, a clear set of guidelines should be developed to indicate when these nursing professionals should be consulted.

Currently the use of the consultation teams by case management staff is voluntary and inconsistent. ACS needs to better utilize these teams so that they provide a coordinating role for children with medical issues. This is a crucial step towards better integrating sensitivity to children's medical concerns into the child welfare case practice.

Improve Training of Parents and Foster Parents to Better Manage Children's Medical Conditions. Parents and foster parents need to be fully enabled to properly care for the children in their custody. All organizations contracted by ACS to work with families who have children with medical conditions – chronic or otherwise – should ensure that those families are fully informed about their child's condition and adequately trained to manage the condition. In cases in which medical neglect has been alleged – whether those allegations are substantiated or not – ACS should take the lead in ensuring that information concerning the child's condition has been absorbed by the family and that training of the family has been effective.

Ensure the Proper Sleeping Position of Infants. There is no reason for any infant – particularly a foster infant – to die as the result of being placed on his or her stomach or of co-sleeping with an adult. All frontline staff who come into contact with children and families should be knowledgeable about parenting best practices and should train parents and foster parents in these practices, particularly with regard to the proper sleeping position of infants. Since 1992, the American Academy of Pediatrics has recommended that children sleep on their backs. ACS and its contract agencies should, through face-to-face interactions with parents and foster parents and through other outreach, reiterate this simple message along with a caution against co-sleeping with infants.

Expand Array of Preventive Services to Help More Families Prior to Crisis. Special attention must be paid to immigrant families, young parents, and adolescents. Added prevention services would be a net savings for the City since prevention of abuse and neglect tends to be less expensive for the public than foster care placement. Up-front prevention could include:

- public awareness campaigns targeted specifically to immigrants and youth that emphasize child development and positive parenting;

- expansion of successful home-visiting programs for at-risk families;
- expansion of support services that relieve the pressure of parenting and contribute to family functioning (e.g. child care, counseling, family home care, etc.)

This recommendation is similar to a proposal made in last year's report and is supported by those findings. While this report did not specifically address the issue of the array of preventive services, this recommendation complements the discussion of decision-making because the array of services directly influences the options available to ACS and contract agency decision-makers.

Engage Parents Whenever Possible, To the Greatest Degree Possible. Preventive services are at their most effective when families 'buy in.' ACS should emphasize a 'dual track' in referrals that would stress cooperation with lower risk cases and reduce the adversarial nature of families' interactions with the child welfare system. The unnecessarily adversarial nature of many interactions with the system can reduce the effectiveness of preventive services and impede positive, cost-effective outcomes. Last year, this office recommended this 'dual track' and again, based on the findings of this report, we stress this recommendation. While many of the cases examined here represent the more challenging, high-risk variety, the vast majority of cases with which ACS deals are not. By treating cases appropriately according to risk factors, resources could be allocated more efficiently to improve family functioning when possible and remove unsafe children when necessary.

The state legislature did pass a dual track bill in the 2003 session that was vetoed by Governor Pataki largely due to New York City's objections. ACS does support the dual track concept but insists that legislation should include funding to support training and evaluation. We agree. Meanwhile, ACS must use the resources it does have at its disposal to continue to identify ways of more effectively engaging and partnering with families.

ACS's Accountability Review Panel Should Include Cases in Which No Report of Abuse or Neglect Is Made. This report examined a larger universe of fatalities than ACS's panel by including those fatalities of children known to the child welfare system in which no report of abuse or neglect was filed in relation to the fatality. The focus of ACS on reports of abuse and neglect in relation to the fatality leads that agency to miss valuable opportunities to gain insight into systemic problems, particularly for the foster care population.