Investigation of Child Deaths in New York City Shelters

A Report by the Office of the Public advocate of New York City

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Overview

The Public Advocate regularly monitors deaths of children who are under the care of the City's Administration for Children's Services (ACS) to determine whether the fatalities were preventable and to recommend measures that ACS can take to better protect children under its watch.

Recent reports of child fatalities in the City's shelter system, including the May 20, 2004 death of three-month-old Colesvinton Florestal--who was dehydrated and malnourished, had numerous broken bones, and weighed less at death than when he was born-- have prompted the Office of the Public Advocate to investigate the welfare of children living in shelters.

In all, since 2000, 33 children have died while living in, or registered at, a City shelter. These deaths represent a disproportionate share of all child fatalities in New York City . The Public Advocate believes that some of these deaths may have resulted from a lack of coordination between ACS , the primary agency responsible for child welfare, and other City agencies, in this case the Department of Homeless Services (DHS). In *Failed by the System,* her annual report of child fatalities which analyzed deaths in 2002, the Public Advocate found that in 37.5 percent of cases reviewed, coordination around the needs of children was not sufficiently facilitated by ACS and other child-serving agencies.

The 2003 annual report also identified another major cause of child fatalities: ACS 's failure to properly train parents, foster parents, and frontline staff to appropriately care for children, particularly in relation to proper sleeping positions for infants. This failure also occurred in nearly 40 percent of cases. Reports of several recent child fatalities in shelters cite improper sleeping positions as possible causes of death.

The following is an analysis of child fatalities in 2003 that took place in City-run shelters or were shelter related . The review is based on child fatality reports received to date by the Office of the Public Advocate from the New York State Office of Children and Family Services.

FINDINGS

In 2003, 24% percent of cases of child death in which parent abuse or neglect was suspected occurred in City shelters or were shelter related.

- The Public Advocate's office has received 51 reports from 2003 of cases of non-foster child fatalities in New York City in which abuse and/or neglect was suspected.
- Of these, 12 took place in shelters or were shelter related (e.g. families living in apartments obtained through the shelter system).

Children in City shelters are more likely to be the victims of suspected abuse and neglect than children in the general population.

- Roughly 15,000 children are involved in the shelter system, representing less than one percent of all children in NYC; however, fatalities of children in the shelter system represent nearly a quarter of the cases in which abuse and/or neglect was suspected.
- The higher proportion of fatalities in the homeless shelter system can be partially explained by the fact that these families are more likely than the general population to be involved in domestic violence, be jobless, have mental health concerns, and/or have drug use problems--all predictors of child abuse and neglect.

City agencies fail to coordinate their services and share information that might prevent children from dying.

- The Public Advocate is concerned that the supports available through the shelter system and the coordination between that system and the child welfare system are not as strong as they should or could be.
- In the case of Colesvinton Florestal, DHS Commissioner Linda Gibbs admitted that DHS did not even know that Florestal's family had been investigated nine times by ACS for child abuse, a severe example of lack of coordination.
- Lack of coordination has proved problematic in other instances. For example, in 2003, DHS did not inform ACS that a mother and child who were victims of domestic violence had moved out of a City shelter without signing out. They moved back into the home of the abuser where the child died from suspected abuse.

In 2003, five of the twelve shelter-related deaths were possibly caused by or related to sleeping position or sleeping arrangement. To reduce deaths in shelters, the City must immediately ensure that all City and contract agency staff are aware of the proper sleeping position of infants and pass that information along regularly to families.

- In one case, a mother who had spent at least three years in the shelter system was unfamiliar with the dangers of co-sleeping. In another case, the crib in the family shelter didn't even have a mattress.
- In *Failed by the System* , the Public Advocate called on the City to train all child-serving City staff and contract agency staff on the proper sleeping position for infants.

The City may have failed to train shelter staff at all levels on how to fulfill their responsibility to be a "mandated reporter."

- According to the initial accounts of Colesvinton Florestal's death, shelter staff might not have discharged their responsibility as mandated reporters to make a report to the child abuse register regarding allegations of "trouble."

RECOMMENDATIONS

The City must better coordinate services with other City agencies.

In response to these concerns, the Public Advocate has repeatedly called on the City–and all the agencies involved in caring for children, such as the Administration for Children's Service and the Department for Homeless Services–to better coordinate their services to make sure children are protected to the greatest extent possible. Since 2002, the Office has asked the City to take increased steps to prevent abuse and neglect and made numerous related recommendations.

The City must train staff who work with children regarding proper infant sleeping positions.

The Public Advocate introduced legislation to be voted on by the City Council that would require the Department of Homeless Services to create and post signs and other materials related to the proper infant sleeping position and arrangement. The legislation also calls for shelter staff to receive additional training in this area.

The City must train shelter staff at all levels on how to fulfill their responsibility to be a "mandated reporter."

The City must train mandated reporters–including shelter, hospital, day care, and school staff -in their responsibilities. Because they are in contact with a very high-risk population, it is essential that shelter staff be aware of how to act on this responsibility. In addition, the above legislation calls for the Department of Homeless Services to create and post signs and other materials related to the reporting of child abuse and neglect.