



The Public Advocate for the City of New York

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# A Pattern of Preventable Deaths: **2004 Child Fatality Report**

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## **EXECUTIVE SUMMARY**

Last year, 73 children known to the New York City Administration for Children's Services (ACS) died, the statistical equivalent of one child death every five days. This is a significant increase in fatalities since 2002. Child fatalities jumped from 46 in 2002, to 63 in 2003, to 73 in 2004, for an increase of nearly 60 percent over the last two years. This report analyzes the 73 child fatalities known to the child welfare system in 2004, and discusses the growing number of deaths related to infant sleeping position. Such deaths are potentially preventable, yet make up the largest category of deaths of children in the child welfare system.

While some of these deaths involved medically frail children in foster care and were due to natural causes, most were not. Nearly 75 percent of the deaths last year were ruled to be homicides or accidents, or the cause was undetermined. Upon analyzing these tragic deaths, the Public Advocate's Office believes that many were preventable, and calls on ACS and other city agencies to better protect children under the administration's care.

The Public Advocate's Office is particularly concerned with the increase in the number of infant deaths due to improper sleeping position. Last year, improper sleeping position was the top cause of death for children accounting for 23 deaths, nearly double the number in 2003 (12). Improper sleeping position occurs when caregivers place infants in sleeping arrangements other than in a crib, alone, free of loose bedding, toys, or other clutter, and with the child's back against the mattress. Deaths from co-sleeping, a form of improper sleeping position in which an adult or older child sleeps in the same bed as an infant, rose from 5 in 2003 to 15 in 2004. Deaths due to improper sleeping position are, by their nature, preventable.

A review of OCFs reports shows that ACS caseworkers may miss opportunities to educate caregivers on preventing child deaths such as the dangers of improper sleeping position. In one instance detailed below, two children in the same family died due to improper sleeping position several years apart, and there is no documentation to show that the City provided this family with information on the dangers of co-sleeping.

Nearly 70 percent of the families involved in child fatalities in 2004 had prior involvement with ACS. Either the children's caregivers were known to have abused or neglected them in the past or they themselves were abused and neglected when they were children. One-third of these families had multiple past reports of abuse and neglect. One family had as many as 15 reports, spanning 9 years. From the beginning of her tenure as Public Advocate for the City of New York, Betsy Gotbaum has made it a priority to ensure that the Bloomberg administration does everything it can to protect the welfare of New York City's children. To that end, the Public Advocate has repeatedly called on City agencies to do more to protect children whose families are known to have abused and neglected them before.

Last year, for example, Gotbaum successfully called on ACS to share child welfare histories of families living in the City shelter system with the Department of Homeless Services (DHS). She also introduced legislation in the City Council requiring DHS to post signs in shelters that remind DHS staff of their responsibility as "mandated reporters" to report all suspected child abuse and neglect to ACS or the New York State

Central Register of Child Abuse and Neglect (SCR). The legislation also requires DHS to post signs informing clients of the dangers of improper sleeping position for infants. The legislation also requires DHS to train homeless shelter staff to address proper sleeping position with applicable clients. The legislation is now New York City Law.

## **FINDINGS**

### **1. Child Fatalities Increase Nearly 60% in Two Years**

- The number of fatalities of children known to the child welfare system increased by 10 in 2004 to 73 deaths<sup>1</sup>;
- This is a 58% increase in deaths from the 46 reported in 2002;
- This is a 16% increase in deaths from the 63 reported in 2003<sup>2</sup>.

### **2. Most Fatalities Involved Families with a Previous History of Abuse and Neglect**

- 42, or 61%, of deaths involved families who had previous reports of abuse and neglect with ACS and/or SCR<sup>3</sup>.
- 23, or 33%, of reports indicated that the subject's families had multiple reports of abuse and neglect;
- One family had 15 reports of abuse and neglect over a 9 year period;
- 13, or 18%, of deaths occurred in households with caregivers who were known to the child welfare system as abused and neglected children.

### **3. Improper Sleeping Position is Number One Killer of Children**

- In 23, or nearly 33%, of cases, improper sleeping position was the suspected cause;
- All victims were less than 1 year old.

### **4. Co-Sleeping Deaths Tripled in 2004**

- 15 children died of co-sleeping, up from 5 in 2003;
- Co-sleeping was the most common form of improper sleeping position death;
- 75% of co-sleeping deaths occurred in families with histories of abuse and neglect<sup>4</sup>

### **5. Caregivers of Improper Sleeping Position Victims Were Over Three Times More Likely to Have Been Maltreated Children**

- 8, or 35%, of improper sleeping position deaths occurred in households where a caregiver who was known to the child welfare system as an abused and neglected child;
- Only 10% of all children who died for other reasons had caregivers who were known to ACS as maltreated children.

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<sup>1</sup> 76 fatality reports were issued by OCFS for 2004; 5 reports concerned children who either were found alive or did not exist; 2 reports issued contained the deaths of 2 children each; 73 fatalities total.

<sup>2</sup> 64 fatality reports were issued by OCFS for 2003; 2 reports concerned children who either were found alive or did not exist (no fatality occurred); 1 report concerned the deaths of 2 children; 63 fatalities total.

<sup>3</sup> 69 of 73 deaths reported contained information on whether or not the deceased child's family was the subject of previous abuse and neglect reports.

<sup>4</sup> 11 households had past SCR reports or were known to the system as maltreated children themselves; 8 had past SCR reports; 7 caregivers were known to the child welfare system as maltreated children (3 unique).

## **6. Most Child Deaths Were of Children Under Five Years Old**

- 84% of the deaths in 2004 were of children under 5 years old;
- 64% of all the deaths were of children 1 year old or younger.

## **7. Most Child Fatalities Citywide Are Not Reviewed**

- There are over 1,000 child fatalities each year in New York City;
- New York City does not have a comprehensive child fatality review team to review all child deaths. The City only reviews deaths of children known to ACS or cases in which abuse or neglect is suspected;
- Last year, only 7% of all child fatalities were reviewed.

## **RECOMMENDATIONS**

The Bloomberg Administration should take the following actions to reduce the number of child deaths in New York City:

- Secure funding for ACS's *Take Good Care of Your Baby* sleeping position campaign beyond the first year;
- Create protocol to target families at greatest risk of harming their children through improper sleeping position and provide these families with information on proper sleeping position for infants and the dangers of co-sleeping. Information should be communicated in a face-to-face setting to ensure effectiveness;
- Monitor households from which children have been removed to ensure that other children who are born or enter into the household are safe;
- Establish a NYC Child Fatality Review Team to review all child fatalities as called for by Intro 480 which Public Advocate Betsy Gotbaum joined Councilmember Christine Quinn to introduce into the New York City Council in October of 2004;
- Require HHC hospitals to provide more information to families regarding proper sleeping position and preventable child death and injuries;
- Offer parents preventive services such as parenting classes and counseling to parents who are known by the child welfare system to have been abused and neglected children;
- Provide information on proper sleeping positions to pregnant and parenting teenagers in foster care. This information could be included as part of already established sex education and health classes at foster care agencies;
- Track annual citywide co-sleeping and improper sleeping position deaths in the Department of Health and Mental Hygiene (DOHMH)'s Vital Statistics report.

## **INTRODUCTION**

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 the custody of ACS or ACS contract agencies, or whose death was reported to have been caused by suspected neglect or abuse. This report is an analysis of OCFS fatality reports for deaths occurring in calendar year 2004.

For the purposes of the Public Advocate's report, a child is considered "known" to ACS if at the time of death:

- ACS was investigating an allegation against a family member;
- A family-member was receiving foster care or preventive services;
- A family member had been the subject of a past report of child maltreatment filed with the State Central Registry (SCR), the statewide database of abuse and neglect.

Each report examines the circumstances of the fatality by reviewing ACS case documentation, autopsy reports, police reports, medical records, information on prior abuse and neglect, and other pertinent information when available. Many reports make recommendations on how ACS can better protect the lives of children. Each report is released by OCFS approximately 6 months after the child fatality occurs.

The reports produced by OCFS are the most comprehensive individual child fatality reports in New York City. It is important to note that these reports only review a fraction of all the child fatalities that occur in the city each year. Most child fatalities occur in families that are not known to the child welfare system. For the majority of child fatalities there is no independent team to comprehensively review the circumstances and make recommendations to prevent future loss of life.

## **OVERVIEW OF CHILD FATALITIES IN 2004**

In 2004, deaths of children known to the child welfare system rose by 16% over the previous year and 58% over the last two years for a total of 73 in all. While some of these deaths involved medically frail children in foster care and were due to natural causes, most were not. Nearly 75 percent of the deaths last year were ruled to be homicides or accidents, or the cause was undetermined. Upon analyzing these tragic deaths, the Public Advocate's Office believes that many were preventable and that ACS must do more to protect New York's most vulnerable population by addressing trends in child fatalities statistics.

Many of the deaths that took place in 2004 follow the same pattern that the Office of the Public Advocate identified in previous fatality reports. Last year, after discovering lapses by ACS, Public Advocate Gotbaum called on ACS to make investigations of abuse and neglect cases more thorough to better protect children whose families are known to have

maltreated them in the past<sup>5</sup>. Yet chronic child abusers slipped through the cracks and harmed children in even greater numbers in 2004.

#### **Child Fatalities by Borough<sup>6</sup>:**

- 26, or 35%, occurred in Brooklyn;
- 15, or 21%, occurred in Manhattan (including 1 on Roosevelt Island);
- 12, or 16%, occurred in the Bronx;
- 11, or 15%, occurred in Queens;
- 3, or 4%, occurred on Staten Island.

#### **Child Fatalities by Age and Gender:**

- 2004 fatality reports involve children ranging from newborn to 20 years old<sup>7</sup>;
- 47, or 64%, of the deaths were of children under 1 year old;
- 61, or 84%, of the deaths were of children 5 years old or younger;
- 64% of the children were male, 36% female.

#### **Manner of Death:**

##### *Deaths of Undetermined Intent*

- 22, or 30%, of the deaths were of undetermined intent;
- Improper sleeping position of infants was the most frequent cause of deaths of undetermined intent (18 deaths<sup>8</sup>);
- All victims of improper sleeping position were less than 1 year old.

##### *Deaths from Natural Causes*

- 18, or 25%, of the deaths were from natural causes;
- Complications resulting from premature birth and improper sleeping position were the most frequent natural causes of death (4 deaths each);
- All 4 victims of complications resulting from premature birth were less than 1 ½ years old;
- All 4 victims of complications resulting from improper sleeping position were less than 1 year old.

##### *Deaths from Homicides*

- 16, or 22%, of the deaths were homicides;
- Fatal Child Abuse Syndrome (beating) was the most frequent cause of homicide (7 deaths);
- All 7 victims of Fatal Child Abuse Syndrome were 3 years old or less.

##### *Deaths from Accidents*

- 14, or 19%, of the deaths were accidental;
- Drowning was the most frequent type of accidental death (5 deaths);
- All 5 victims of drowning were 3 year old or younger.

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<sup>5</sup> Gotbaum, B. *Failed by the System: A Review of Child Fatalities in the Child Welfare System*. Office of the Public Advocate for the City of New York. Jan. 2004

<sup>6</sup> 5 reports did not indicate borough or county; 1 death occurred upstate.

<sup>7</sup> ACS can care for individuals until 21 years of age.

<sup>8</sup> Of the 23 improper sleeping position deaths, 4 were ruled to be the result of natural causes, 1 accidental.

*Other Deaths*

- 1 death was a suicide;
- 1 was a result of neglect;
- 1 report did not indicate manner of death.

**2004 Child Fatalities: Top Five Causes**

1. Improper Sleeping Position (23)
2. Fatal Child Abuse – Homicide (7)
3. Drowning (5)
4. Complications of Prematurity (4)
5. Fatal Gun Shot – Homicide (3)

**2003 Child Fatalities: Top Five Causes**

1. Improper Sleeping Position (12)
2. Fatal Child Abuse– Homicide (8)
3. Abandoned Baby – Homicide (6)
4. Respiratory Infection (7)
5. Drowning (5)

**Most Fatalities Involved Families with Previous Histories of Abuse and Neglect**

Nearly 70 percent of families involved in a child fatality last year had previous contact with ACS before the death. The majority of deaths occurred in families involved in past reports of abuse and neglect. Some occurred in families in which the caregivers were known to ACS as abused and neglected children themselves. Nearly one out of five children involved in child fatalities had at least one caregiver who was previously known to ACS as a maltreated child.

Many of these families were well-known to ACS. One-third of the deaths occurred in families involved in multiple reports, including several with more than ten reports. One family had 15 past reports of abuse and neglect issued to SCR.

ACS must do more to identify and track unsafe conditions in households known for past abuse and neglect, especially those that are repeat offenders. ACS must also monitor households in which children have been removed to ensure that other children who enter the household are safe.

**Improper Sleeping Position: Number One Killer of Children in 2004**

In 2004, the most frequent cause of preventable death among children was caregivers placing infants in improper sleeping positions. Improper sleeping position was suspected in at least 23, or nearly one-third, of all deaths in New York City that were known to the child welfare system. Improper sleeping position was also the top cause of death in 2003 but the number of cases nearly doubled in 2004 from 12 in 2003.

The medical community knows that the best and safest 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<sup>10</sup>.

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<sup>10</sup> National MCH Center for Child Death Review. *Preventing Child Death*. 8/16/05

Most victims of improper sleeping position are young infants, age newborn to 6 months. Babies less than 6 months old have difficulty moving themselves out of dangerous positions because their neck muscles are not fully developed. Of the 23 improper sleeping position deaths last year, 21 involved infants less than 6 months old, and all 23 involved infants less than 1 year old.

Most improper sleeping position deaths occur while an infant is sleeping in a bed with an adult or older child (co-sleeping), in an adult bed alone, surrounded by loose bedding and/or toys, or lying on his or her stomach.

Informing parents about the dangers of improper sleeping position is the first line of defense against these preventable deaths. Campaigns to teach parents about proper sleeping position for infants are not new to New York City. In 1994, the City started a public education campaign, endorsed by the American Academy of Pediatrics, called “Back to Sleep” to address the high numbers of Sudden Infant Death Syndrome (SIDS) deaths citywide<sup>11</sup>.

SIDS deaths in New York City declined immediately and have continued to decline ever since. In 1990, there were 135 SIDS deaths in the city. Over a 13 year period, SIDS deaths were reduced by 81 percent to 25 in 2003<sup>12</sup>. *Back to Sleep* informs parents that infants should be placed in a crib on their backs with either a taut blanket or full-length pajamas for warmth and that a crib should be clear of toys or other foreign objects.

ACS launched another education campaign in April of this year to inform parents about the dangers of improper sleeping position including co-sleeping. The \$1.5 million *Take Good Care of Your Baby* campaign can now be seen throughout the city on billboards, subways, and buses. Like *Back to Sleep*, the new campaign reminds parents that the best place for infants to sleep is alone in a crib with their back to the mattress.

Last year, Public Advocate Gotbaum’s fatality report called for ACS to develop and implement a public education campaign to inform the public about positive parenting, preventing child injury and death, and proper sleeping position for infants. The new *Take Good Care of Your Baby* campaign is a step in the right direction for ACS, but the campaign is only financed in the budget for one year. The City should take a lesson from its SIDS campaign and fund *Take Good Care of Your Baby* as a long-term project.

### **Caregivers of Improper Sleeping Position Victims Much More Likely to Have Been Maltreated as Children**

The Public Advocate’s analysis of child fatalities revealed that victims of improper sleeping position are over three times more likely to have caregivers who were abused and neglected when they were children than other types of child fatalities. In fact, 35% of all families involved in improper sleeping position deaths last year had at least one caregiver who was known to ACS as a maltreated child.

To begin to address this problem, ACS should provide information on improper sleeping position to teenagers in foster care. Most foster care youth are removed from their

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<sup>11</sup> ACS Press Release. Dec. 17, 2002.

<sup>12</sup> Department of Health and Mental Health. Vital Statistics. 1990-2004.

biological parents due to maltreatment. According to the Public Advocate's May 2005 report "Children Raising Children: City Fails to Adequately Assist Pregnant and Parenting Youth in Foster Care," 1 in every 6 young women in foster care is either pregnant or parenting. ACS must provide comprehensive information on the dangers of improper sleeping position to pregnant and parenting teenagers in foster care and those soon to age out of foster care. ACS should also consider providing improper sleeping position information to all teenagers in foster care as part of sex education and health classes.

ACS should also identify those families with caregivers who were maltreated children and have or are expecting babies. Once identified, these families should be educated on proper sleeping position.

### **Most Improper Sleeping Position Deaths Were Caused by Co-sleeping; Number Triple That of Last Year**

The large majority of improper sleeping position deaths resulted from co-sleeping, a form of improper sleeping position in which an adult or older child sleeps with an infant in an adult bed. In fact, 1 in every 5 deaths last year documented by OCFS was caused by co-sleeping for a total of 15 deaths in all, compared to 5 such deaths last year. Most of these deaths occurred when the child's sleeping partner rolled over and smothered him or her, but in some cases the child suffocated when he/she became wedged between the bed, the co-sleeper, and the wall.

Some advocates argue co-sleeping creates a bonding effect between infant and caregiver and encourages breast-feeding, but the risk of death negates any potential benefit. Co-sleeping puts young children less than 1 year old at risk of serious injury or death. Furthermore, these deaths are fully preventable if the practice is avoided.

Victims of co-sleeping are much more likely to have caregivers with past histories of abuse and neglect than other types of child fatalities. Seventy-five percent of co-sleeping cases last year involved families with prior SCR reports.

### **Co-Sleeping Death Profiles**

The Public Advocate's Office, upon analyzing OCFS fatality reports, identified specific family attributes which appear to heighten the risk of co-sleeping deaths. A more concerted effort must be made by the City to identify and service families with the attributes listed below.

- Previous history of abuse and neglect;
- Caregivers were maltreated as children;
- Substance abuse in household;
- Overcrowding in household;
- Past documentation of improper sleeping position practices.

ACS should identify families with young infants that have been known to the child welfare system in the past and possess attributes that put them at-risk for improper sleeping position. Once identified, these families should be given one-on-one counseling about the dangers of co-sleeping and the importance of proper sleeping position for infants.

The following are three examples of deaths due to co-sleeping. The profiles identify the warning signs that existed before the death occurred.

**Case Number 95-04-030**

*Fact Pattern:* On May 30, 2004, a 4-month-old infant boy died while co-sleeping with his father and older sister in a Bronx three-bedroom apartment. The family in question was well-known to ACS. The mother was known to ACS as an abused and neglected child herself. Furthermore, the now-deceased infants' parents had 10 SCR reports of abuse and neglect of their 6 children dating back to 1996. Allegations in the reports included inadequate guardianship, medical neglect, burns, fractures, scalding, lacerations, and welts. The 5 older siblings had been removed from the home and placed in foster care following substantiated findings of abuse and neglect. The parents had another child after the 5 other children had been removed from the household. At the time of the death, the 5 children in foster care were home with their parents on an unsupervised weekend visit.

**Case Number 95-04-054**

*Fact Pattern:* On September 10, 2004, a 10-month-old female child died while co-sleeping in the same bed with her father on a couch. The father had been drinking alcohol and smoking marijuana. The father and infant slept on the family couch. The father subsequently passed out and rolled over the infant, causing her to suffocate. The Medical Examiner's Office ruled that the intent of the father's actions could not be determined. The family was previously known to the child welfare system. The father was known to ACS as a maltreated child. Furthermore, the family had been the subject of two reports. The father had been cited in a in an SCR report for co-sleeping with a then 1-month-old infant causing its death. This report found maltreatment was due to inadequate guardianship stemming from domestic violence in the household.

**Case Number 95-04-037**

*Fact Pattern:* On July 12, 2004, a 2-month-old male infant died while co-sleeping with his mother and older sibling in a bunk bed. The infant resided with his parents in an overcrowded 2-bedroom apartment in Queens along with 11 other people from 3 different families, including a pregnant woman. The family was the subject of two SCR reports for inadequate guardianship and

lack of medical care in 1999 and 2000. Furthermore, the family had an active case with ACS' Preventative Services Unit from June 2002 through October 2003. Documentation indicated that ACS caseworkers had witnessed both over-crowding and improper sleeping position prior to the death.

### **City Wide Fatalities**

In 2003, the last year for which statistics are available from DOHMH, well over 1,000<sup>13</sup> children died. Some of these children were known to the child welfare system, most were not. Deaths of children who are not known to the child welfare system or those that do not appear to be caused by child abuse and neglect are not reviewed.

Most states and counties in the United States have teams of experts known as Child Fatality Review Teams that review each child fatality and make recommendations based on their findings. The review teams' recommendations are used to create policies intended to save lives by preventing similar future deaths. Child Fatality Review Teams around the country have been responsible for creating safe crib/safe baby programs and fire safety programs, increasing driver training for teenagers, and requiring carbon monoxide detectors and window guards.

Currently, New York City does not have such a review team. A Child Fatality Review Team should be created to review all deaths in the city, to determine whether problems such as improper sleeping position are even more widespread than available data indicates, and to make recommendations to prevent further tragedies.

There is currently legislation before the city council that would create a Child Fatality Review Team for New York City. Intro 480/2004 establishes a multi-disciplinary, multi-agency advisory team to review all child fatalities in the city and make recommendations with the goal of decreasing the number of preventable child deaths. Public Advocate Gotbaum joined Councilmember Christine Quinn in October of 2004 to introduce this legislation into the New York City Council.

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<sup>13</sup> Department of Health and Mental Hygiene. *Vital Statistics*. 2003

## RECOMMENDATIONS

The Bloomberg Administration should take the following actions to reduce the number of child deaths in New York City:

- Secure funding for ACS's *Take Good Care of Your Baby* sleeping position campaign beyond the first year;
- Create protocol to target families at greatest risk of harming their children through improper sleeping position and provide these families with information on proper sleeping position for infants and the dangers of co-sleeping. Information should be communicated in a face-to-face setting to ensure effectiveness;
- Monitor households from which children have been removed to ensure that other children who are born or enter into the household are safe;
- Establish a NYC Child Fatality Review Team to review all child fatalities as called for by Intro 480 which Public Advocate Betsy Gotbaum joined Councilmember Christine Quinn to introduce into the New York City Council in October of 2004;
- Require HHC hospitals to provide more information to families regarding proper sleeping position and preventable child death and injuries;
- Offer parents preventive services such as parenting classes and counseling to parents who are known by the child welfare system to have been abused and neglected children;
- Provide information on proper sleeping positions to pregnant and parenting teenagers in foster care. This information could be included as part of already established sex education and health classes at foster care agencies;
- Track annual citywide co-sleeping and improper sleeping position deaths in the Department of Health and Mental Hygiene (DOHMH)'s Vital Statistics report.