INVESTIGATIVE REPORT:
TOO MANY VULNERABLE CHILDREN ARE DYING

An investigation into child fatalities in New York City’s child welfare system
Introduction

After receiving an alarming number of reports from the Office of Children and Family Services (OCFS), the State body charged with overseeing the Administration for Children’s Services (ACS), regarding child fatalities, the Public Advocate’s Office began an investigation into the causes and circumstances surrounding these deaths. The investigation, which examined each of the 123 cases between August 2014 and September 2015, concluded that lack of oversight, lack of supervision and training, and lack of support for children in foster care led to numerous potentially preventable deaths during the highlighted 13 month period. This report outlines eight cases that exemplify the severity of ACS' negligence and systemic problems.

All the names used in this report are pseudonyms.
Executive Summary

The Public Advocate’s Office received an alarming number of reports of child fatalities that occurred while the children had active child protective or preventive services cases with the Administration for Children’s Services (ACS), or following previous contact with the child welfare system that should have given rise to preventive services. The reports were generated by the Office of Children and Family Services (OCFS), the State body charged with overseeing ACS.

The Administration for Children’s Services (ACS) is responsible for investigating all allegations concerning the abuse or neglect of children in New York City. Where allegations are founded but the removal of the child from the home is not deemed necessary, ACS opens a protective or preventive case for the child and is charged with providing support for the family to maintain a safe home environment. Services can include case management, medical care, housekeeping, counseling, support groups, and help accessing benefits. If the supportive services are not successful, the child is moved to a safe alternative home. ACS is failing its basic responsibility to adequately investigate allegations of abuse and neglect, and to provide the services necessary to keep at-risk children safe. As a result, children are dying in circumstances that may have been preventable.

A survey of OCFS reports concerning the deaths of children with ACS involvement reveals that in the 13 month period between August 2014 and September 2015 there were eight deaths that appear to involve some form of institutional neglect or mismanagement.
Allen | 2 years old | Date of death: Sept 6, 2015

On September 6, 2015, Allen, a medically fragile two-year-old died of cardiac arrest. Nine months earlier, ACS received a report that Allen was not receiving adequate care. The child had gone into cardiac arrest for between 10 and 30 minutes, was found soiled in a home while under the care of a visiting nurse, and was brain damaged as a result of the incident. A preventive services case was opened with the ACS contract agency. Although ACS investigated the allegation of neglect, the agency failed to thoroughly investigate the incident to determine necessary facts including why the child’s tracheotomy tube was blocked with mucous, what steps were taken when the child’s blood pressure dropped, and the on-site nurse’s regular responsibilities. Allen remained hospitalized for the next seven months before being discharged to his mother. He died one month after returning home when, once again, his tracheotomy tube filled with mucous.

Brianna | 6 months old | Date of death: July 3, 2015

On July 3, 2015, a six-month-old baby girl, Brianna, died after being taken to Montefiore Children’s Hospital. Brianna’s mother had left her alone with her grandmother. She returned home at 2:45 AM, after Brianna’s grandmother texted Brianna’s mother that Brianna was not feeling well. When she awoke at 8:00 AM, Brianna had a blank stare and difficulty breathing, but her mother did not call EMS for another hour. Montefiore said that the cause of death was an intracranial hemorrhage, the type of injury seen with “shaken baby syndrome.” The Medical Examiner had not confirmed the cause of death as of December 2015.

Just two months before the infant died, ACS had closed an investigation into the neglect of the infant’s three siblings, ages six through 10, who were all frequently absent from school and failing their classes. ACS closed the case, finding that while out of the country, the mother had left the children with a relative who was not ensuring the children’s school attendance. Because the neglect was deemed to be that relative’s fault, the case of neglect was closed, even though the mother had not left the country until after the report was registered. OCFS reviewed this case and found ACS'
investigation into the neglect of the deceased child’s siblings to be faulty. OCFS found that the school staff had sufficiently alleged neglect. The case should not have been closed.

**Charles | 16 years old | Date of death: April 17, 2015**

A sixteen-year-old boy, Charles, was shot and killed in a possible gang-related incident on April 17, 2015 in a NYCHA courtyard in Brooklyn. Just a few weeks before his death, ACS was notified that Charles had not attended school since September 2014. The mother was not responsive to the school’s attempts to engage her and made no efforts to encourage her son to attend school. Between May 2004 and January 2012, there were 10 reports about this family made to the Statewide Central Register of Child Abuse and Maltreatment, eight of which were deemed founded. Between February 2012 and May 2013, the family received court ordered services after ACS filed a case to terminate parental rights in family court. During that time, the mother informed the case planner that she was unable to manage the child’s behavior. Court ordered services ended in May 2013 and the case was transferred to a preventive services agency, Catholic Charities. They closed the case on December 2, 2014, though the deceased child had not attended school for several months.

**Darryl | Two months old | Date of death: Feb 22, 2015**

On February 22, 2015, a two month-old Bronx infant, Darryl, died of unknown causes. At the time of death, Darryl had a broken femur likely from blunt force trauma and a broken rib. One account says that Darryl died after being dropped on his head and another describes him dying in his sleep. Medical records indicate that the mother brought Darryl to the emergency room on January 13, 2015 for a “head bump,” but left before Darryl was seen by a physician. ACS failed to follow-up about the injury despite the mother having an active case with the agency because the child was born with marijuana in his blood.
**Eric | Ten years old | Date of death: Nov 26, 2014**

On November 26, 2014, a ten year-old boy in the Bronx, Eric, died because of peritonitis resulting from a burst appendix. Peritonitis is a slow infection resulting from the contents of a burst appendix slowly leaking into the abdominal cavity. According to the autopsy report, the death could have been avoided if timely medical attention was sought. In that same report, it was observed that the appendix did not rupture on the day of Eric’s death; it ruptured many hours or even several days earlier.

Eric had been experiencing abdominal pain since May 2014. He visited an emergency room on October 23, 2014 with his mother, and was given medication, a prescription, and told to return if the pain got worse. The prescription for medication was never filled. On November 24, 2014 he was sent home from school with an instruction from the school nurse that the family seek medical attention if his symptoms did not alleviate. Either ACS or one of its contract agencies visited the home that day. A report notes that the child was ill, the mother was out of town, and the house was in deplorable condition without electricity or food.

Eric’s symptoms worsened on November 25, 2014. On November 26, 2014 his adult half sibling witnessed his eyes rolling back in his head as he passed out. The sibling called an ambulance. Eric died shortly thereafter.

Eric and his siblings had been in foster care, but were released to their mother in 2008. In 2012, there was a report that Eric was suffering physical abuse. ACS deemed the report to be unfounded. In light of the child’s death, and evidence of abuse found on his body at the time of death, OCFS concluded that ACS’s investigation into that charge of abuse was inadequate. ACS later substantiated an allegation of inadequate guardianship and educational neglect in May 2014.

**Gerald | Three years old | Nov 15, 2014**

On November 15, 2014, a three year-old child in kinship foster care, Gerald, died after being forcibly squeezed two days earlier. The squeezing resulted in massive internal injuries. Gerald had been placed with his paternal grandmother and her boyfriend following an October 3, 2013 child safety conference. Gerald’s lawyer expressed concerns about the placement, noting that the grandmother had a history of reported neglect. The abuse and neglect report history on the paternal grandmother’s
boyfriend revealed a history of domestic disputes and a previous sustained allegation that he drank and did cocaine in the presence of his daughter to the point of impairment on a regular and ongoing basis. Despite this history, caseworkers placed Gerald in the home on October 6th, and observed that the child was “doing well.” The paternal grandmother’s boyfriend was arrested for manslaughter in connection with the death.

**Fatima | Nine years old | Date of death: Aug 28, 2014**

On August 28, 2014, a nine year-old girl in Manhattan, Fatima, suffering from sickle cell anemia, died of septic shock because of apparent inadequate medical care. Fatima had been hospitalized in 2011, 2012, and 2013 in connection with her disease. After the 2013 hospitalization, her pediatrician recommended that she be evaluated by a blood specialist every six months. The parents failed to make appointments with the specialist, or to attend follow up visits with the pediatrician.

Three days before she died, on August 25, 2014, Fatima was taken to St. Luke’s Hospital complaining of joint pain. She was discharged, but between August 25, 2014 and August 28, 2014, her condition worsened. Fatima’s mother called EMS at 11:11 p.m. on August 28, 2014 when she found the child unresponsive and covered in vomit. She was pronounced dead on arrival at Harlem Hospital at 11:39 p.m. that night.

After two substantiated claims of abuse and neglect – one in 2009 and one in 2013 – ACS opened a preventive services case to provide necessary services and support to ensure the safety and wellbeing of Fatima and her siblings. The parents were themselves ill, and even though the family had an active preventive services case with ACS, the agency failed to ensure that the now deceased child attended the recommended medical appointments.

Less than four hours before the child was pronounced dead, an ACS child protective worker visited the home, but failed to check on Fatima. She had just begun working with the family and was not aware of Fatima’s medical condition.
Henrietta | Fourteen years old | Aug 4, 2014

On August 4, 2014, a fourteen year-old Staten Island girl, Henrietta, with an active ACS foster care services case, died from complications of a chronic medical condition that had not been adequately treated or monitored. She was rushed to Staten Island Hospital on August 3, 2014 because she wasn’t feeling well. It was clear to doctors that she had not been compliant with her medical regimen. She was transported to New York Presbyterian Hospital for additional treatment. On August 4, 2014, she had two emergency surgeries, and remained on a ventilator in critical condition until approximately 6:55 p.m., when she was pronounced dead.

Henrietta had been placed in foster care in December 2011 after her mother tested positive for crack cocaine and entered a residential rehabilitation program for mentally ill, chemically abusing adults. Henrietta remained in care until June 2014, when she was released to her mother on a trial basis. Henrietta was hospitalized from November 5 to December 5, 2013, and again from March 12 to March 23, 2014.

In response to charges of medical neglect against the foster parent, it was found that the private foster care agency – contracted by ACS – was not informing the foster parent of all the child’s medical appointments. When Henrietta was returned to her mother on a trial basis, her foster care case remained open, meaning it continued to be the foster care agency’s responsibility to ensure Henrietta was taking her medication.
Recommesdations

ACS – and the private agencies it oversees – is not providing adequate care to protect at-risk children from death. The Public Advocate’s Office calls on ACS to:

**Exercise More Rigorous Oversight Over Contract Agencies**

ACS has contracted with private agencies for the provision of case management services, but does not exercise sufficiently rigorous oversight over the quality of the services provided.

**Ensure that Caseworkers are Adequately Trained and Supervised**

Caseworkers must receive additional training, support, and supervision. In several of the cases that ended in fatalities, caseworkers failed to find neglect when it was indicated, discontinued services without cause, and failed to adequately investigate events resulting in injury to vulnerable children.

**Provide Deeper Support to Children Exiting Foster Care**

Two of the children whose deaths are described above had been in foster care and were released to their parents. One was in kinship care. ACS’ failure to provide ongoing support to children and families who have been reunified puts children at risk of being re-abused.

**Ensure that the Health Care Needs of At-Risk Children are Met:**

Several of the fatalities described above involved some form of medical neglect. This demonstrates a troubling pattern of failing to ensure that caregivers are aware of, and in compliance with, the recommendations of health care professionals. Further, there appears to be a lack of attention paid to medical visits that occur, or don’t occur, while a child has an active case with ACS.
Conclusion

ACS is failing its basic responsibility to ensure that children are safe. In a span of thirteen months between August 2014 and September 2015, eight at-risk children under the care of ACS died preventable deaths. By carrying out the recommendations of the Public Advocate’s Office, ACS can vastly improve its child protective and preventive services and provide the care New York City’s children deserve.
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