Child Fatality Report

Report Identification Number: NY-17-069

Prepared by: New York City Regional Office

Issue Date: Dec 19, 2017

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 07/10/2017
Initial Date OCFS Notified: 07/10/2017

Presenting Information

On 7/10/17, the SCR registered multiple reports regarding the death of the three and two-year-old subject children (SC), alleging DOA/FATL and IG. The BM and the PS were the subjects of the reports.

The reports alleged at about 8:00 P.M. on 7/9/17, the BM put the two children to bed. At 9:00 P.M., the PS checked the children and noticed that they did not look right and alerted the BM. The BM checked on the children and found the two-year-old SC unresponsive. The older SC was wheezing, and barely breathing. The parents gave the older SC an asthma treatment. The BM called 911 and began to administer CPR. The children were transported to the hospital and arrived at the ER in cardiac arrest. Medical staff made unsuccessful efforts to revive both children. The younger SC was pronounced deceased at 2:10 A.M. The older SC was pronounced dead at 2:13 A.M. Prior to her death, the two-year-old SC did not have any known health concerns; however, the older SC had a pre-existing medical condition.

Executive Summary

These two subject children (SC) died on 7/10/17 while in the care of their BM and the PS. At the time of writing this report, the final autopsy regarding the children's deaths had not been completed; however, the ME's preliminary findings determined that the children's causes of death were due to blunt force trauma to their torsos and the manner of death for both children was homicide.

According to ACS documentation, the BM spent the day with the children going to a local pool with other family members and there were no noted concerns for the children. The family arrived home at about 7:00 P.M. At approximately 8:00 P.M., the BM put the children to sleep in their separate toddler beds. At about 8:45 P.M., the PS arrived at the home. The BM checked on the children and they were fine. The BM watched a movie with the PS until 11:45 P.M. when she left the PS alone in the living room and then went to bed. At about 1:15 A.M., the PS awakened the BM and told her the children were "not looking good." The BM rushed into the bedroom and found both children lying on their backs and unresponsive. The PS gave the older child a nebulizer treatment. The BM called 911 and in the process performed CPR on the two-year-old child. EMS responded to the home, took over CPR and then transported the children to the hospital. The children arrived at the ER in cardiac arrest. The hospital staff attempted to revive both children but were unsuccessful. The younger SC was pronounced deceased at 2:10 A.M. The older SC was pronounced deceased at 2:13 A.M.

There were no surviving children in the home. The BF did not reside in the home but was involved with his children. Also, the PS did not reside with the BM; he was visiting the home at the time of the incident. The PS had two teenage sons who resided out of state with their respective BMs.

On 7/10/17, ACS received the report and initiated the CPS investigation that same day. The Specialist contacted the family and relevant collaterals to obtain information regarding the fatality. The statements provided by the family to ACS, LE and the hospital staff were consistent throughout the investigation. LE did not make any arrests pending the final autopsy.

During the investigation, the BM disclosed having a history of clinical health issues and she was not receiving treatment. Following the death of her children, she expressed suicidal ideation and was admitted for an evaluation. Throughout the investigation, the BM had frequent hospitalizations due to her clinical health condition. ACS offered the children's BF

bereavement counseling; however, it was unknown if he used the referral. Additionally, ACS made diligent efforts to assess the PS' two sons. The fifteen-year-old child was deemed safe in the care of his BM. ACS was unable to assess the sixteen-year-old child. The LDSS where the child resided did not assign the case.

On 9/9/17, ACS substantiated the allegations of the report against the BM and the PS. ACS based its decision on the ME's report which determined that the children's causes of death were due to blunt force trauma to their torsos. The manner of death for both children was homicide. The BM and the PS were the only people in the home at the time of the incident.

The LE's criminal investigation regarding the fatalities remains active.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS kept the case open for services; however, there is no documentation since 9/18/17 to reflect whether the family received services.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/10/2017 **Time of Death:** 02:10 AM

Time of fatal incident, if different than time of death: 01:15 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 01:21 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 2
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Other - Parent Substitute	Alleged Perpetrator	Male	31 Year(s)

LDSS Response

On 7/10/17, ACS contacted the medical and LE staff, as well as the family regarding the incident. The hospital staff did not report any signs of trauma to the children and stated the children's cause of death was unknown until an autopsy was completed. LE staff reported the statements provided by the family regarding the incident were consistent and that the PS was being questioned, but not arrested. EMS reported an inoperable carbon monoxide detector in the home.

The BM did not report any concerns for the children prior to the incident. She stated the children were asthmatic but did not have any recent episodes; the children did not have any other medical issues. She stated the three-year-old SC had mild autism. The BM and the MGM reported concerns for the PS' method of disciplining the children. The BM said she and the PS had an argument on the night of the incident about the BM being too lenient with the children. The PS had disciplined the children in the past and left bruises on both children. The BM told the PS that he was not to discipline her children anymore and she reported he never did it again. Also, on the night of the incident, the PS smoked marijuana and drank a beer in the home.

LE barred ACS from interviewing the PS due to the ongoing criminal investigation; however, the LE staff stated that the BM and the PS provided similar accounts of the incident. The PS reportedly provided childcare to the children but denied he harmed them.

On 7/11/17, the ME reported that preliminary findings revealed blunt impact injuries on both children. ACS documented the ME ruled the children's deaths homicides. The ME did not provide additional information regarding the children's injuries. Consequently, the LE opened a homicide investigation into the children's deaths.

On 7/12/17, ACS assessed the PS' fifteen-year-old son at his BM's home and did not document any concerns for the child. The child reported a good relationship with his father and denied the PS physically disciplined him. The child's BM did not report any concerns about the PS as a parent.

Also on 7/12/17, ACS received the children's medical records. The records revealed the children were often seen by their doctor due to asthma related issues and were prescribed medication.

On 7/13/17, the children's BF reported he was involved with his children. He visited with his children on 6/19/17 and observed that his older son had a mark on the left side of his eye. The BM told the BF the child fell off his bike. The BF disclosed the BM had prior incidents of hallucinations when he resided in the home but the children were always well cared for and were never abused. ACS offered the BF bereavement counseling. It was unknown if he used the referral.

On 8/3/17, the DC provider reported the children were always well cared for and were never sick. There were no reported concerns for the family.

On 8/9/17, ACS made diligent efforts to contact the LDSS where the PS' sixteen-year-old son resided for a courtesy home visit. The LDSS staff stated the case was closed and not assigned.

Between 7/13/17 and 9/8/17, ACS made several casework contacts with the family and relevant collaterals. ACS was unable to interview the PS. He had retained an attorney and was advised not to speak to ACS. The BM did not provide any new information regarding the incident but she continued to state the PS harmed her children, causing their deaths. The BM had frequent hospitalizations since her children died and continued to receive treatment. The ME reported that the final autopsy was pending and there were no updates.

On 9/9/17, ACS substantiated the allegations of the report against the BM and the PS.
LE's investigation regarding the fatalities remains active.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: The investigation adhered to approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042721 - Deceased Child, Female, 2 Yrs	042722 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
042721 - Deceased Child, Female, 2 Yrs	042724 - Other - Parent Substitute, Male, 31 Year(s)	Inadequate Guardianship	Substantiated
042721 - Deceased Child, Female, 2 Yrs	042722 - Mother, Female, 31 Year(s)	DOA / Fatality	Substantiated
042721 - Deceased Child, Female, 2 Yrs	042724 - Other - Parent Substitute, Male, 31 Year(s)	DOA / Fatality	Substantiated
042723 - Deceased Child, Male, 3 Year(s)	042722 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
042723 - Deceased Child, Male, 3 Year(s)	042724 - Other - Parent Substitute, Male, 31 Year(s)	DOA / Fatality	Substantiated
042723 - Deceased Child, Male, 3 Year(s)	042722 - Mother, Female, 31 Year(s)	DOA / Fatality	Substantiated
042723 - Deceased Child, Male, 3 Year(s)	042724 - Other - Parent Substitute, Male, 31 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving siblings.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No

Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

The family did not have any CPS history prior to the fatality.

Known CPS History Outside of NYS

The family did not have any known CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No