Child Fatality Report

Report Identification Number: NY-17-084

Prepared by: New York City Regional Office

Issue Date: Feb 06, 2018

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: 4 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 09/06/2017
Initial Date OCFS Notified: 09/06/2017

Presenting Information

On 9/6/17, the SCR registered a report alleging DOA/Fatality and Inadequate Guardianship of the four-year-old male subject child (SC). There was no explanation for the death of this otherwise healthy SC. The BM and the maternal great aunt (MGA) were listed as the subjects of the report.

The narrative of the report alleged that on 9/6/17, the four-year-old SC was found pale and not breathing while in bed. Emergency medical personnel were called to the home and the SC was pronounced deceased at the case address.

Executive Summary

On 9/6/17, the BM left the SC unsupervised for approximately one and half hours while she took the six-year-old surviving sibling (SS2). A 7-year-old surviving sibling (SS1) also resided in the home. The BM reportedly gave a verbal command to the MGA to supervise the children while she was gone. The BM did not wait or confirm the MGA heard the verbal command. The MGA reportedly had headphones in her ears and did not hear the BM tell her to supervise the children. At approximately 8:30 A.M., the BM returned home and found the SC unresponsive while in bed. EMS personnel responded to the home and were unable to revive the SC. The EMS staff pronounced the SC dead in the home. The ME ruled the SC's cause of death was complication of cerebral dysgenesis/congenial brain malformation. The manner of death was natural.

The parents had the SC in common. The BF did not reside in the home but was involved with the family. The BF of the two SS was reported deceased on 12/28/13.

The case records revealed the SC was born premature and was diagnosed with multiple medical conditions from birth. He was prescribed different medications and received his feedings and medication through a tube. Additionally, he received 24 hour home health aide services. The SS1 also had multiple medical conditions. She was bedridden and nonverbal. She was prescribed various medications and also received home health aide services and used a feeding tube. The SS2 did not have the same medical conditions as her siblings but had a breathing condition which she treated with medication.

On 9/6/17, ACS received the SCR report, visited the family and contacted LE, medical staff, and the service providers who worked with the BM. The parents and the service providers reported the SC was fine prior to his death. The parents reported being trained to care for their special needs children. The medical staff disclosed the SC arrived to the ER DOA. There was no trauma, or bruising to the SC. The LE staff did not suspect any criminality regarding the SC's death.

Following the fatality, ACS accompanied the BM to the hospital to have the SS1 examined. The hospital electively admitted SS1 considering her brother's passing and the BM's emotional state; however, there were no concerns noted about her condition or medical care.

During the investigation, ACS held a child safety conference (CSC) for the family. The outcome of the CSC was to file an Article 10 Neglect Petition against the parents and the MGA, with the release of the two SS to the BM and COS to ensure the SS were not left unattended. The case filing was delayed in Family Court to enable ACS obtain additional information on the investigation. ACS then referred the family for medical PPRS Services. On 10/20/17, the BM signed up for services.

Prior to the fatality, the BM had applied for housing through the New York City Housing Authority and had been on the waiting list for three years. ACS and the PPRS agency assisted the family to relocate to a New City Department of Homeless Services (NYDHS) shelter.

According to ACS documentation, there were concerns the BM did not keep scheduled medical appointments for the SS1 and failed to follow up with her medication. Additionally, the SS2 had excessive lateness and absences which affected her academic performances. The BM was unreceptive to school staff's outreach and missed several scheduled meetings. On 12/5/17, the SCR registered a subsequent report alleging ED/NG and LMC. The BM was the subject of the report.

On 12/22/17, ACS substantiated the allegations IG and LS of the SC and SS1 against the BM and the MGA. ACS unsubstantiated the allegation DOA/FATL. ACS based its decision on the ME's final autopsy report and the information obtained during the investigation. ACS investigation of the 12/5/17 report remain active.

PIP Requirement
The report did not require any performance improvement practice.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** No
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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. On 10/20/17, the BM signed for PPRS services with HeartShare.

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: 09/06/2017 **Time of Death:** 09:27 AM

Time of fatal incident, if different than time of death: 08:30 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:40 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? No - but needed
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	55 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	7 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)

LDSS Response

On 9/6/17, ACS staff contacted the hospital and LE staff and they reported the SC arrived to the ER DOA; however, there were no signs of abuse or trauma to the SC. He appeared to be well taken care of. The LE staff did not suspect any criminality regarding the SC's death.

ACS interviewed the family and the service providers at the case address. The family provided an account of the events

that led to the fatality which corroborated the information that was previously known. The family and the service providers reported that the SC was fine prior to his death. The BF stated the SC's last hospitalization was in 2015 due to a virus infection. He was discharged with medication. Prior to discharge, both parents were trained on how to administer the SC's medication and his overall care. The MGA stated she supervised the children in the BM's absence. She gave the SS1 medication and food but denied providing medical care to the SC. The BM disclosed bedsharing with SS2 in her twin size bed. She also stated that both SS bedshared SS1's bed at times. The ACS staff advised the BM to refrain from allowing the two SS to bedshare and that she should also stop bedsharing with SS2. The BM was receptive to the staff's advice. The two SS were unable to provide details of the incident. The SS1 was non-verbal and being attended to by her service provider. The SS2 only recalled her brother was sleeping in the BM's bed when she left home for school. There were no concerns for either SS at the time.

On 9/7/17, ACS accompanied the BM to the hospital to have the SS1 examined. The hospital electively admitted SS1 considering her brother's passing and the BM's emotional state. There were no concerns noted about SS1's condition or medical care.

Later that same day, the BM's probation officer stated the BM was in compliance with the conditions of her probation. The BM's most recent drug test results were negative. The case notes reflected the BM was arrested for drug sale in 2014 and was placed on probation until 9/29/20.

On 9/12/17, ACS held a child safety conference (CSC) for the family. The outcome of the CSC was to file an Article 10 Petition against the parents and the MGA, with the release of the SS to the BM and COS to ensure the SS were not left unattended. The CSC also recommended special medical PPRS Services for the family. On 9/13/17, ACS delayed filing an Article 10 Neglect Petition in Family Court to enable ACS to obtain additional information regarding the investigation.

On 9/18/17, the ME reported that based on preliminary findings, the SC's cause of death was natural.

Between 9/18/17 and 10/30/17, ACS made home visits to see the family. There was no new information regarding the fatality and no safety concerns were observed for the two SS.

On 9/19/17, SS1's school staff reported a positive relationship with the BM. There were no concerns noted regarding the BM's case of SS1. SS1 had good attendance and was never observed with any suspicious injuries.

On 9/26/17, the staff at SS2's school reported concerns about her pattern of excessive lateness and absences which had affected her academic performance. The staff also reported concerns about the BM's uncooperative attitude.

On 10/20/17, the BM signed up for services with HeartShare/St. Vincent's Services

On 11/11/17, the ME reported that the autopsy report was pending neuropathology report.

On 11/15/17, the family relocated to a DHS shelter in Brooklyn.

On 12/5/17, the SCR registered a report alleging ED/NG of SS2 and LMC of SS1. The BM was the subject of the report. ACS adequately addressed the allegations of these reports.

On 12/21/17, the ME ruled the SC's cause of death as complication of cerebral dysgenesis/congenial brain malformation. The manner of death was natural.

On 12/22/17, ACS substantiated the allegations IG and LS of the SC and SS1 against the BM and the MGA. ACS unsubstantiated the allegation DOA/FATL. ACS continues to investigate the 12/5/17 report.

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to approved protocols for joint investigation.

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
042986 - Deceased Child, Male, 4 Yrs	043124 - Aunt/Uncle, Female, 55 Year(s)	Lack of Supervision	Substantiated
042986 - Deceased Child, Male, 4 Yrs	043121 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
042986 - Deceased Child, Male, 4 Yrs	043124 - Aunt/Uncle, Female, 55 Year(s)	DOA / Fatality	Unsubstantiated
042986 - Deceased Child, Male, 4 Yrs	043121 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
042986 - Deceased Child, Male, 4 Yrs	043121 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
042986 - Deceased Child, Male, 4 Yrs	043124 - Aunt/Uncle, Female, 55 Year(s)	Inadequate Guardianship	Substantiated
043302 - Sibling, Female, 7 Year(s)	043121 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
043302 - Sibling, Female, 7 Year(s)	043124 - Aunt/Uncle, Female, 55 Year(s)	Lack of Supervision	Substantiated
043302 - Sibling, Female, 7 Year(s)	043121 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
043302 - Sibling, Female, 7 Year(s)	043124 - Aunt/Uncle, Female, 55 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐

Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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 was previously known to ACS in two reports dated 8/28/11 and 4/27/13. The reports alleged IG, PD/AM, LS, and L/B/W.

Per the 8/28/11 report, the BM used excessive force to discipline SS2 and SS2 leaving them with bruises. Also, she used marijuana while caring for her children and left them home alone on numerous occasions.

The BM admitted to using marijuana to alleviate stress. She took a drug test and the results were positive for marijuana use. ACS determined the BM's drug use could impact her ability to care for her special needs child and substantiated the allegation PD/AM against her. ACS unsubstantiated the allegations IG, LS, and L/B/W against the BM. ACS deemed the children safe with the BM and referred the family to PPRS services.

Per the 4/27/13 report, the maternal great aunt (MGA) was physically violent with the BM in the presence of the BM's children. The BM was seven months pregnant at the time. The MGA called LE into the home and the BM was escorted to the hospital for a medical evaluation.

The MGA denied being physically violent with the BM. The BM also denied the incident and declined to be interviewed. ACS deemed the children safe in the home. The BM continued to receive PPRS services and had been compliant. ACS provided the BM with additional referral for her then three-year-old special needs child. ACS unsubstantiated the allegation IG against the MGA and kept the case open for services which ended.

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