Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-090

Prepared by: New York City Regional Office

Issue Date: Jan 22, 2020

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: 6 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 05/31/2019
Initial Date OCFS Notified: 07/23/2019

Presenting Information

The narrative of the report alleged on the night of 5/30/19, while in the parent substitute's (PS) home, the PS changed the six-month-old SC' diaper and he put the SC to bed in her crib. The SC was in the care of the BM and the PS at the time. At an unspecified time in the morning of 5/31/19, the BM and the PS went to check on the SC. The SC was found lying face down in her crib deceased. The exact cause of death was unknown. The BM either called 911 or brought the SC to the hospital. Further details were unknown. The BM had been diagnosed with a clinical health condition and it was recommended she go for treatment and she refused. Due to the BM's clinical health condition, she was unable to care for her eight and four-year-old female children. The BF did not have the capacity to provide adequate care to these other children. The BF was aggressive toward the BM and the two children were afraid of him. The children had not been injured.

Executive Summary

On 5/31/19, the SC was found deceased in her crib by her BM. According to the case documentation, the SC had a medical condition since age seven weeks and a history of hospitalizations. She was prescribed medication and being medically monitored by a specialist. The ME determined the SC's cause and manner of death were undetermined.

The case documentation also reflected at about 7:00AM on 5/31/19, the PS changed the SC's diaper and did not notice any issues for the SC. The PS then placed the SC down on her back to sleep in the crib. At 7:40AM, the BM checked the SC and found her face down and cold in the crib. The BM immediately awoke the PS who called 911 and was directed over the phone to perform CPR on the SC. EMS responded to the home, continued CPR and transported the SC to the hospital where the ER Dr. pronounced her DOA at 8:10AM.

At the time of the fatality, the BM was diagnosed with a clinical health condition and was receiving services. The BF and the BM had the SC in common. The BF resided at a different address and was not involved with the family. The PS was the biological father of the two SS. He had caretaking responsibilities for the three children.

On 7/23/19, ACS received the report and commenced the CPS fatality investigation. It was unknown why the SCR was not notified by EMS, the hospital or LE on the day the SC died.

During the investigation, ACS obtained statements from the family and other collaterals. The BM and maternal family members revealed the SC had a medical condition; however, she did not fall sick prior to her passing. LE reported the SC's death was already investigated and the SC's death was not deemed criminal. There was no arrest made. The ME and the hospital staff did not report any concerns of abuse or neglect to the SC. The PS did not make himself available to ACS for an interview and his whereabouts were unknown. The PS had a warrant of arrest for assaulting the BM. The BF declined to speak to ACS regarding the SC.

Additionally, ACS conducted home visits and assessed the two SS to be safe in the care of the BM. Throughout the investigation, ACS offered the BM PPRS services, but she refused any services from ACS. She received services through her service providers and there were no reported concerns regarding the BM or the two SS. The BM ensured that the older SS received counseling services at school.

On 11/14/19, ACS unsubstantiated the allegations of the report. According to ACS, there was no credible evidence found

to substantiate the allegations against the against the BM and the PS. The ME determined the SC's cause and manner of death were undetermined. Also, the ME did not find any trauma to the SC and LE did not deem the SC's death criminal.

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?** Yes
- **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?** 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? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The 30 Day Safety Assessment was not completed in a timely manner.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30 Day Safety Assessment was not completed in a timely manner. It was completed on 8/28/19; which was four days late.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/31/2019 **Time of Death:** 08:10 AM

County where fatality incident occurred:	New York
Was 911 or local emergency number called?	Yes
Time of Call:	07:52 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
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	Deceased Child	Alleged Victim	Female	6 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other - Parent Substitute	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	26 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	26 Year(s)

LDSS Response

On 7/23/19, LE reported the case was already investigated and there was no criminality found and no arrest was made.

Later that same day, ACS visited the BF. He declined to be interviewed by ACS and also declined ACS' offer of counseling. He said his probation officer was assisting him with counseling services. He denied the BM and the two SS resided with him.

ACS then attempted visits to the BM's home without success. The BM's neighbors did not report concerns for the family.

On 7/24/19, the BM contacted ACS and stated she was "out with her daughters" and not in one place all the time because it was the summer. The BM did not provide information about her whereabouts.

On 7/24/19, the BM's service provider reported that on 7/22/19, the BM came in for an intake appointment. She appeared distressed but did not appear to be a risk to harm herself or others. She was given a follow-up appointment to see a clinician on 7/23/19. On 7/23/19, the BM was present with the two SS and the BF. The service provider reported based on the information the BM provided, 911 was contacted as a safety measure.

On 7/24/19, the BM reported physical assault by the PS on 7/18/19. She reported the incident to LE and there was a warrant for the PS' arrest. Following the DV incident with the PS, the BM and the SS moved into the MGM's home. The BM disclosed she received clinical health services at the hospital where her children received pediatric care. She blamed the hospital for the SC's death. She stated that on 5/29/19, the SC was seen at the hospital for her 6-month well child visit and was vaccinated. The BM linked the SC's death to her being vaccinated. The SC was treated for a cold at the hospital six days prior her passing. The MGM and the MA described the BM as a caring and good mother. They did not report any issues with the BM.

On 7/26/19, ACS visited the BF. He refused to speak with ACS regarding the SC's death. He stated he had not established paternity for the SC and denied contact with the BM and stated he not was not involved with the family. The BF disclosed that he was on probation and mandated to services.

On 7/29/19, ACS requested two dressers and two twin beds for the two SS.

On 7/30/19, the responding LE did not provide any explanation why ACS was not contacted on the day the SC passed away. LE stated upon the ER Dr.'s initial assessment, there were no external marks or bruises on the SC. LE did not report any concerns for the parents.

On 7/31/19, the hospital staff reported the BM received clinical health services since she was a teenager and saw a clinician for medication management. The staff did not report any concerns for the BM. The staff had observed the BM to be appropriate with her children.

Also on 7/31/19, ACS held a child safety conference (CSC) and the CSC decided there was no need for family court intervention for the family. The BM was referred for bereavement services.

Between 8/8/19 and 11/11/19, ACS made home visits to the family and contacted pertinent collaterals. The two SS remained safe in the care of the BM. Their medicals were current, and their Dr. did not report any concerns of abuse for them. Also, they were doing well in school. The BM reported she was in school to obtain her GED. She refused services from ACS but continued to receive therapy through her service provider. The whereabouts of the PS remained unknown. He had not made himself available to ACS; however, the BM had changed the locks to her home as a safety measure. The BM was receiving additional support from Safe Horizons and The Family Justice Center.

On 9/17/19, the ME reported the autopsy had been finalized. The SC's cause and manner of death were undetermined. The ME stated SC had a little ear infection, but it was not life threatening.

On 11/14/19, ACS UNSUB all the allegations of the report.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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)? Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050893 - Deceased Child, Female, 6 Mons	050895 - Other - Parent Substitute, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
050893 - Deceased Child, Female, 6 Mons	050895 - Other - Parent Substitute, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
050893 - Deceased Child, Female, 6 Mons	050894 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
050893 - Deceased Child, Female, 6 Mons	050894 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
050897 - Sibling, Female, 4 Year(s)	050894 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
050898 - Sibling, Female, 8 Year(s)	050894 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☒	☐	☐	☐

Additional information:

The PS did not make himself available for an interview and his whereabouts were unknown.

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 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?	☒	☐	☐	☐
Explain: The 30 Day Safety Assessment was not completed in a timely manner. It was completed on 8/28/19; which was four days late.				

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The BM declined services from ACS.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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? Yes

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/22/2018	Sibling, Female, 7 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 7 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 7 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
On 10/22/18, the bio-parents (BPs) left the then seven and the three-year-old children alone in the shelter hallway, so they could argue and chase after staff. The BF was banging on doors. The BPs' behavior was irrational and aggressive.

Report Determination: Unfounded **Date of Determination:** 12/24/2018

Basis for Determination:
On 12/24/18, ACS unsubstantiated the allegations IG and LS of the family's two children by the BPs. The BM denied leaving the children unsupervised in the hallway to argue with BF and chase shelter staff. The BM and the children denied any issues of DV.

OCFS Review Results:
Based on the case documentation, AC conducted the investigation appropriately.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/09/2018	Sibling, Female, 3 Years	Father, Male, 29 Years	Other	Unsubstantiated	No
	Sibling, Female, 7 Years	Father, Male, 29 Years	Other	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 23 Years	Other	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 23 Years	Other	Unsubstantiated	

Report Summary:
On 3/9/18, Family Court ordered ACS to conduct a Court Ordered Investigation with the allegation OTH/COI of the then three and seven-year-old children by the bio-parents (BPs). The report was due back in court on 4/23/18.

Report Determination: Unfounded **Date of Determination:** 04/26/2018

Basis for Determination:
On 4/26/18, ACS unsubstantiated the allegation OTH/COI of the children by the BPs. There were concerns of DV by the BF in the presence of the children. During the investigation, ACS did not find any credible evidence to support that the children were impacted by DV. The children's basic needs for food, clothing, shelter, sleeping arrangements and supervision were met in the care of their BM. The BF failed to make himself available to ACS.

OCFS Review Results:
The investigation was appropriate.

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

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

The PS had one unfounded report dated 12/10/15. The case records revealed the PS abused alcohol and K-2 to the point of impairment daily. This mixture was known to cause psychotic episodes and irrational behavior. The BM was disabled and it was unknown if she was able to protect the children.

On 2/3/16, ACS unsubstantiated the allegation IG of the two children by the PS due to lack of credible evidence to support the allegation. The BM confirmed the PS used prescription pills and K-2; however, she denied it was done in the presence of the children who did not reside with the PS at the time. The BM reported she was no longer in a relationship with the PS. The BM and the children resided with a friend at the time and the PS' whereabouts were unknown. The BM was meeting the children's basic needs. She declined referral for community based resource.

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