NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-018 **Prepared by: New York City Regional Office**

Issue Date: 8/25/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 02/25/2015
Initial Date OCFS Notified: 02/25/2015

Presenting Information

The narrative of the SCR report alleged on 2/25/15, the SC was being cared for by the MA while the BM was at work. At 10:00A.M., the MA claimed the SC was acting out and she struck him with a belt on his buttocks then put him in his bedroom. At 12:30 P.M., she checked on the SC and found him unresponsive. At approximately 1:20P.M., when the MA's paramour returned home, the MA was holding the SC on her lap in the living room on the sofa. The paramour called 911 and EMS responded to the home minutes later. EMS performed CPR on the SC but was unable to revive him. The SC had multiple bruises and lacerations on his back and a small welt on his left nipple on his chest.

Executive Summary

This four-year-old male child died on 2/25/15 after he was beaten with a belt by his MA. According to the Medical Examiner, the cause of death was multiple blunt impact trauma and the manner of death was homicide.

ACS' documentation revealed the parents had an open DV/custody case in Kings County Family Court at the time of the fatality. On 3/24/15, Kings County Family Court dismissed the cross custody petition filed by the parents because they failed to appear in court. The BM had legal custody of the SC while the BF resided elsewhere. The MA and the paramour resided with the BM and they provided assistance with the care and supervision of the SC. There were no other children residing in the home and the family had no prior history with child welfare.

On 2/25/15, ACS initiated the CPS investigation and contacted the responding PO and detective. The PO confirmed the multiple bruises and marks on the SC's body and stated the MA told EMS technicians that she struck the SC with a belt earlier that day. The detective stated the investigation was ongoing pending the findings on the final autopsy report. No arrests were made, but the MA and her paramour were being questioned regarding the incident. The Specialist was not allowed to interview the family at the time. The MA was arrested after providing her statement to the police.

On 2/26/15, the BM provided an account of the incident; based on the information learned from relatives. She described a close relationship with the MA and did not have any doubt the MA would have been a good caretaker for the SC. She stated she had never seen marks or bruises on the SC left by the MA or anyone else. The BM did not describe her son as a sickly child but stated he suffered from a breathing condition which was usually triggered if he had a cold. She stated the SC had medication to utilize as needed.

The Specialist then contacted maternal family members, the SC's school and his primary Dr. and there were no concerns by anyone for the SC or about the quality of care he received. They described the SC as a happy child.

Later that same day, the detective reported the ME had ruled the SC's death a homicide by multiple blunt impact injuries; and on 2/27/15, the DA confirmed the MA had been formally charged with the SC's death.

On 3/12/15, the Specialist contacted the BF. He reported being actively involved with his son from birth until he left the home on 1/17/15. He denied any DV incidents in the home. He also denied the BM used corporal punishment to

discipline the SC. He declined ACS' offer of bereavement counseling services and stated he received support from his family.

On 3/20/15, the Specialist contacted the ME for additional information regarding the fatality. The ME stated there was no new information and that the case was signed out as a homicide.

On 3/20/15 and 3/30/15, the Specialist made casework contacts with the BM and she had not engaged in services. She stated she was not ready for services at the time and reported being in the care of supportive family members.

On 4/29/15, ACS substantiated the allegations of the report against the MA. ACS based the decision on the autopsy report in which the ME ruled the SC's death a homicide by multiple blunt impact injuries. Also, the MA had admitted that she disciplined the SC using a belt resulting in multiple injuries. The MA's action caused the SC's death. ACS should have added and substantiated the allegation LMC of the SC by the MA, as the MA did not seek medical attention for the SC when she found him unresponsive.

The MA's criminal case regarding the SC's death remained active in Kings County Criminal Court and she remained incarcerated. Although the detective did not allow the Specialist to interview the MA on 2/25/15, ACS did not make further efforts to interview the MA after she was incarcerated despite ACS' procedures for obtaining information from incarcerated subjects.

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?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** No,sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
There were no safety factors present at the time of investigation determination.

Was the decision to close the case appropriate? Yes

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:
There were no other surviving children in the household. ACS provided the parents with information for bereavement counseling services but had not engaged in services. They continued to receive support from family members. ACS involvement in the family was no longer necessary.

Required Actions Related to the Fatality

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

Issue:	Face-to-Face Interview (Subject/Family)
Summary:	Although the assigned detective did not allow the Specialist to interview the MA on 2/25/15, ACS did not make further efforts to interview the MA after her incarceration.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	The Administration for Children's Services must submit a corrective action plan within 45 days that identifies what action it has, or will take to address the citation 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.
Issue:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	At 12:30 P.M., the MA checked on the SC and found him unresponsive. She did not seek medical assistance for the SC at the time. ACS had information to support the addition of the allegation LMC of the SC by the MA; however, this was not done.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	The Administration for Children's Services must submit a corrective action plan within 45 days that identifies what action it has, or will take to address the citation 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: 02/25/2015 **Time of Death:** 01:44 PM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 01:25 PM
Did EMS to 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

2
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Other Adult	No Role	Male	26 Year(s)

LDSS Response

On 2/25/15, the Specialist visited the local police precinct and interviewed the detective who established that the MA and her paramour resided with the BM; they provided the bulk of the care and supervision of the SC due to the BM's job and school schedules, and this was the only child in the home. Regarding the incident, the detective stated the paramour reported that at about 8:20 A.M., the SC was wheezing, he was given medication and allowed to stay home from school. At 10:00 A.M., the MA used a belt to discipline the SC because "he would not write his name" and then sent him to his bedroom. At 12:30 P.M., the MA checked the SC and found him unresponsive. She did not seek medical assistance for the SC at the time. At about 1:20 P.M., the paramour, who had left the home at 8:45 A.M., came home and found the SC in the MA's arms. The MA admitted to beating the SC. The paramour called 911. EMS arrived shortly thereafter and administered CPR. EMS pronounced the SC dead at the scene. The Specialist was not allowed to interview the family. Also at the precinct, the PO confirmed the multiple bruises and marks on the SC's body and stated the MA had told EMS that she hit the SC with a belt earlier that day.

On 2/26/15, the Specialist interviewed the BM. The BM did not have a firsthand account of the incident; however, she repeated the information that was told to her. She added that the SC had a breathing condition and she had the medication to treat the condition as needed. The BM stated her son was not afraid of the MA or the paramour, and she did not have any concerns about their parenting. She denied using corporal punishment to discipline her son. ACS provided the BM information regarding bereavement counseling.

The Specialist then contacted maternal family members and the SC's school. They did not report any concerns for the SC or about the quality of care he received. Later that same day, the detective reported that the ME ruled the SC's death a homicide caused by multiple blunt impact injuries.

On 2/27/15, the detective and the DA reported that the MA had been formally charged with Manslaughter in the 1st Degree. The Specialist then contacted the ACS' EMS liaison and the SC's Dr. The liaison provided the same timeline of events regarding EMS' response to the incident as reported by the detective. The Dr. did not report any prior concerns for the SC.

On 3/12/15, the BF stated he had been involved with his son from birth until he left the home on 1/17/15. He denied any DV incidents between him and the BM. He denied the BM used corporal punishment to discipline the SC. He could not provide any information about the care the MA and the paramour gave the SC. He declined ACS' offer of bereavement counseling services.

On 3/20/15, the Specialist contacted the ME for additional information regarding the fatality. The ME stated there was no new information and that the case was signed out as a homicide.

On 3/20/15 and 3/30/15, the Specialist contacted the BM. She had not engaged in services at the time because she was not ready. She remained in the care family members.

On 4/29/15, ACS substantiated the allegations of the report against the MA. ACS based the decision on information from the autopsy report which listed the SC's death a homicide by multiple blunt impact injuries. Also, the MA had admitted that she disciplined the SC using a belt resulting in multiple lacerations, bruises, and welts on his back. During this investigation, ACS did not attempt to interview the MA, the subject of the report. ACS has procedures for interviewing incarcerated subjects. The MA remains incarcerated.

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)?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: There is no OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
019141 - Deceased Child, Male, 4 Yrs	019143 - Aunt/Uncle, Female, 21 Year(s)	DOA / Fatality	Substantiated
019141 - Deceased Child, Male, 4 Yrs	019143 - Aunt/Uncle, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
019141 - Deceased Child, Male, 4 Yrs	019143 - Aunt/Uncle, Female, 21 Year(s)	Lacerations / Bruises / Welts	Substantiated
019141 - Deceased Child, Male, 4 Yrs	019142 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated

019141 - Deceased Child, Male, 4 Yrs	019142 - Mother, Female, 27 Year(s)	Lacerations / Bruises / Welts	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

On 2/25/15, the detective did not allow ACS to interview the MA . ACS did not make further efforts to interview the MA after she was incarcerated although ACS had procedures for obtaining information from incarcerated subjects.

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?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Manslaughter **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
02/25/2015	The MA	Pending	The case remained active in Kings County Criminal
Comments:	On 2/25/15, the MA was arrested without bail. She was charged with Manslaughter in the 1st Degree, four counts of Assault in the 2nd Degree, Criminal Possession of a Weapon in the 4th Degree, one count of Endangering the Welfare of a Child. She remained incarcerated in the correctional facility on Riker's Island. Her next court date is 8/10/15.		

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS provided the BM with information for bereavement counseling services but the BM had not engaged in services. She stated she continued to receive support from family members. Also, the BF declined ACS' offer of services and stated he received support from his family.

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 was no surviving sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
ACS provided the BM with information for bereavement counseling services but the BM had not engaged in services at the time of completing this report. She continued to receive support from family members. Also, the BF declined ACS' offer of services and stated he received support from his family.

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 within three years prior to the fatality.

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

There is no CPS investigative history more than three years prior to the fatality.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/29/2015	There was not a fact finding	Petition Dismissed
Respondent:	None	
Comments:	On 1/29/15, the biological parents filed a cross custody petition in Kings County Family Court for the SC. On 3/24/15, Kings County Family Court dismissed the petition without prejudice (for failure of the petitioners to appear).	

Have any Orders of Protection been issued? Yes	
From: 01/18/2015	**To:** 06/18/2015

Recommended Action(s)

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

Action:	ACS supervision should provide its investigative staff with the procedures for attempting to interview incarcerated subjects of reports or other incarcerated parties that may have relevant information regarding the outcome of a CPS investigation.

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