NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-056 **Prepared by: New York City Regional Office**

Issue Date: 12/9/2016

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	

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	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-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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 7 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 06/09/2016
Initial Date OCFS Notified: 06/10/2016

Presenting Information

According to the narrative of the report, at approximately 6:00 P.M. on 6/9/16, the SC was having difficulty breathing because of a breathing condition. The BM and the parent substitute (PS) were home and instead of calling 911 they proceeded to take the SC downstairs to ask a passerby in a car to take them to the hospital. By the time the SC arrived at the hospital he was deceased. The SC had medication that should have been administered; however, there was no indication that either the BM or the PS gave the SC medication. The SC was very underweight and his twin sister was underweight as a result of not being fed by the BM and the PS. The report also alleged both children had a history of having dirty clothes and having unclean bodies.

Executive Summary

This seven-year-old male SC died on 6/9/16 . According to ACS' investigation, at approximately 6:30 P.M. on 6/9/16, the SC had difficulty breathing. The BM gave the SC a nebulizer treatment and the SC returned to his bedroom. At about 7:30 .PM., the BM checked the SC and found him unresponsive in his bed; lying down on his back with his lips black. The BM yelled to the parent substitute (PS) to call 911. While the PS was speaking to the 911 operator, the BM picked up the SC and ran from the home. The BM flagged down a passerby who transported her and the SC to the hospital. The SC arrived at the hospital in cardiac arrest. The attending Dr. attempted resuscitative efforts on the SC and at 8:30 P.M., the Dr. pronounced him dead. According to the ME, the SC's cause of death was acute asthma attack. The manner of death was natural.

The SC was survived by his twin sister and fifteen-year-old sister. The birth parents had the twin children in common; however, the BF did not reside in the home. He visited with his children through an informal arrangement. The BM's boyfriend, who was the PS resided in the home.

ACS initiated the investigation within the mandated time frame. The ACS Specialist obtained information from the hospital, NYPD personnel and the ME which deemed the SC's death non-suspicious. The accounts of the SC's death provided by the BM and information from relevant collateral sources were consistent throughout the investigation. ACS and the NYPD assessed the surviving children to be safe in the BM's care.

During the course of the investigation there was a DV incident between the BM and the PS. The BM contacted the NYPD. The PS was arrested and the Bronx Criminal Court granted the BM and the children a full stay away Order of Protection (OOP) against the PS.

On 7/6/16, ACS held a family team meeting (FTM) with the BM. The FTM formulated a service plan for the family which included referral for bereavement counseling and clinical health services.

On 8/10/16, ACS unsubstantiated the allegations of the report against the BM and the PS. ACS based its decision on the information obtained from the family and other relevant collaterals during the course of the investigation. Consequently, ACS closed the CPS investigation but kept the case open for services.

On 9/28/16, there was a DV incident between the BM and the fifteen-year-old surviving child. Consequently, on 9/30/16, ACS registered a subsequent report alleging DOA/ Fatality and IG of the SC, and B/S, EM/NG, IG, LMC, LS and SA of the fifteen-year-old surviving child. The BM was listed as the subject of the report.

On 11/29/16, ACS completed the investigation of the 9/30/16 report and substantiated the allegations EM/NG, ExCP and L/B/W of the fifteen-year-old child by the BM.

Also, ACS substantiated the allegations EM/NG and IG of the child by the BM and the PS. The family continued to receive PPRS services. Additionally, the BM and the child were in receipt of individual therapy.

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? N/A

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 case remained open for services.

Required Actions Related to the Fatality

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

Issue:	Failure to Offer Services
Summary:	ACS failed to offer the BF services. The BF was also impacted by his son's death and should have been offered bereavement counseling services to deal with his loss.
Legal Reference:	SSL 424(10); NYCRR 428.6

Action:	The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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:	Overall Completeness and Adequacy of Investigation
Summary:	ACS failed to obtain any information regarding the fifteen-year-old surviving child's biological father; his whereabouts and or involvement with his daughter/family.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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: 06/09/2016 **Time of Death:** 08:20 PM

Time of fatal incident, if different than time of death: 07:30 PM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: 07:59 PM
Did EMS to respond to the scene? No
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: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Other	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)
Other Household 1	Father	No Role	Male	41 Year(s)

LDSS Response

On 6/10/16, the ACS Specialist initiated the investigation and contacted the hospital staff, the NYPD detective and the ME. The detective stated the ME deemed the SC's death non-suspicious and that there would be no arrest. Consequently, the NYPD was closing the criminal investigation.

Later that same day, the Specialist interviewed the family at the case address. The family provided an account of the events leading up to the SC's death which was consistent with the information that was already known. The BM stated she did not wait for the ambulance to arrive because she wanted to save her son. She reported that on 6/6/16, the SC was hospitalized due to his chronic breathing condition. The SC was prescribed medication and discharged on 6/8/16. The BM also stated the SC was autistic and non-verbal. The Specialist observed the surviving children and they appeared to be in good health. The BM was receptive to the Specialist's offer of bereavement services.

On 6/14/16, the Specialist visited the family at the case address. The family did not provide any new information about the incident. The PS denied child care responsibilities in the home. The Specialist observed the surviving children to be safe in the home.

On 6/20/16, the children's primary Dr. reported the children's immunizations were current and that the BM was compliant with their medicals care.

On 6/21/16, the staff at the surviving twin sister's school did not report any behavioral concerns for the child. The staff stated the BM had attended scheduled meetings.

On 6/22/16, the BM reported a DV incident between her and the PS and she contacted the NYPD. The PS was arrested and Bronx Criminal Court (BxCC) granted the BM and the children a full stay away OOP against the PS.

On 6/30/16, the DA reported that the PS was arrested regarding a prior case in BxCC for assaulting another woman. He was released from jail and the case was adjourned till 9/14/16.

On 7/6/16, ACS held a family team meeting (FTM) with the BM. During the FTM, the BM disclosed that she and her older daughter were diagnosed with a clinical health condition "in the past" and were prescribed medication. They were not engaged in services at the time of the fatality. The FTM formulated a service plan for the family which included referral for bereavement counseling and clinical health services.

On 7/7/16, the Specialist visited the family and did not report any safety concerns in the home. The children appeared to be

in good health and did not have any visible marks or bruises on their bodies.

On 7/7/16, the ME reported the SC's cause of death was acute asthma attack and the manner of death was natural.

On 7/27/16, the BM accepted and signed to receive PPRS services with Leake and Watts.

On 8/8/16, the assigned detective reported the PS was rearrested for violating the OOP granted by BxCC on 6/24/16. The next court date was on 9/14/16 on the case. The detective stated a new OOP was given to the BM because of the PS' new arrest.

On 8/10/16, ACS unsubstantiated the allegations of the report against the BM and the PS. ACS based its decision on the information obtained from the family and other relevant collaterals during the course of the investigation. Consequently, ACS closed the CPS investigation but kept the case open for services.

On 9/28/16, a DV incident occurred between the BM and the fifteen-year-old surviving child. The child had head and jaw pain and red marks to her left shoulder and thighs. Also, the child was sexually active with her same-age boyfriend. The BM was aware, but did not provide the child with adequate supervision. As a result, the child continued to engage in sexual behaviors. On 9/30/16, ACS registered a subsequent report alleging DOA/ FATL and IG of the SC; and B/S, EM/NG, IG, LMC, LS and SA of the fifteen-year-old child. The BM was the subject of the report. On 11/29/16, ACS substantiated the allegations EM/NG, IG, ExCP and L/B/W of the 9/30/16 report.

Official Manner and Cause of Death

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: There is no OCFS approved CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
031746 - Deceased Child, Male, 7 Yrs	031747 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
031746 - Deceased Child, Male, 7 Yrs	031747 - Mother, Female, 32 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated

031746 - Deceased Child, Male, 7 Yrs	031748 - Other - Parent Substitute, Male, 36 Year(s)	Lack of Medical Care	Unsubstantiated
031746 - Deceased Child, Male, 7 Yrs	031747 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
031746 - Deceased Child, Male, 7 Yrs	031748 - Other - Parent Substitute, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
031746 - Deceased Child, Male, 7 Yrs	031747 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
031746 - Deceased Child, Male, 7 Yrs	031748 - Other - Parent Substitute, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
031746 - Deceased Child, Male, 7 Yrs	031748 - Other - Parent Substitute, Male, 36 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
031752 - Sibling, Female, 7 Year(s)	031748 - Other - Parent Substitute, Male, 36 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
031752 - Sibling, Female, 7 Year(s)	031748 - Other - Parent Substitute, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
031752 - Sibling, Female, 7 Year(s)	031747 - Mother, Female, 32 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
031752 - Sibling, Female, 7 Year(s)	031747 - Mother, Female, 32 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?	☒	☐	☐	☐
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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	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

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 first known to the SCR and ACS in a report registered on 10/21/10. The report alleged IG and PD/AM by the birth parents. According to the report, the parents engaged in a DV incident in the presence of their then ten-year-old daughter and one-year-old twins. The BM destroyed the home furnishings and cut up the BF's clothes. The BF attacked the BM and when the ten-year-old child intervened the BF pushed the child away. The BM called the police and the BF was asked to leave the home. The BM was issued an Order of Protection (OOP) against the BF.

ACS' Brooklyn Field Office (BFO) investigated the report. On 12/14/10, ACS referred the family for PPRS services and on 12/17/10, the BM signed for services through the Puerto Rican Family Institute.

On 12/21/10, ACS found credible evidence to substantiate the allegation of IG against the parents. ACS based its decision on the information obtained from the family and other relevant collaterals during the investigation.

ACS unsubstantiated the allegation PD/AM against the parents. ACS documented the parents took a drug test and the results were negative.

Known CPS History Outside of NYS

The family did not have any known CPS history outside of NYS.

Required Action(s)

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

Preventive Services History

Between 12/17/10 and 1/19/12, the family received PPRS through the Puerto Rican Family Institute. The family received child care services, early intervention services for the twins and DV services for the older child and the BM. The BM also received clinical health services.

During the period, the family had become stable. The children were safe and their basic needs were met. There was no reported DV in the home. The BF continued to comply with the OOP. He was visiting his children and providing financial support. Although the BM did not completely follow through with the provision of clinical health services, she did not show or mention any symptomology to be concerned about. On 1/19/12, PPRS services to the family were closed.

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