



Report Identification Number: NY-17-019

Prepared by: New York City Regional Office

Issue Date: Aug 14, 2017

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

- A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- The death of a child for whom child protective services has an open case.
- The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

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

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



Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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



Case Information

Report Type: Child Deceased
Age: 11 year(s)

Jurisdiction: Kings
Gender: Female

Date of Death: 02/18/2017
Initial Date OCFS Notified: 02/18/2017

Presenting Information

On 2/18/17, the SCR registered three reports alleging DOA/Fatality and Inadequate Guardianship of the eleven-year-old subject child by the stepfather (SF).

The reports alleged that at 8:28 A.M. on 2/18/17, the SF found the SC in the bathroom sitting on the toilet unconscious and unresponsive. The SF called 911 and the 911 operator advised him to administer CPR on the SC until EMS arrived at the home. EMS and the police responded to the home and transported the SC via ambulance to the hospital. The SC could not be revived and was pronounced dead shortly after arriving at the ER. The SC did not have any preexisting medical condition. The SF was the sole caregiver of the SC at the time of the incident.

Executive Summary

At approximately 8:30 A.M. on 2/18/17, the SF found the eleven-year-old female SC unconscious in the bathroom. The SF attempted to wake the SC up, and when he touched her she was cold. The SF then called 911 and he was instructed to administer CPR to the SC while EMS was on their way. EMS arrived to the home minutes later, transported the SC to the hospital, and continued resuscitation efforts unsuccessfully. At 9:05 A.M., the hospital staff pronounced the SC dead. Per the ME, the SC's cause of death was Pilocytic Astrocytoma with Obstructive Hydrocephalus. The manner of death was natural. There were no other children in the home.

The BM was at work at the time of the incident. The BF resided at a different address but he was involved with his daughter.

On 2/18/17, ACS received the report and initiated the CPS investigation by contacting the family and relevant collaterals. The information obtained from the collaterals regarding the fatality did not reveal any suspicion of foul play. Also, the statements provided by the family to ACS, LE and hospital staff were consistent. The LE did not make any arrests and no charges were pending.

On 7/13/17, ACS unsubstantiated the allegations of the report against the SF. There were no surviving siblings or other minor children in the home. ACS closed the case and referred the family for community based services.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- Was sufficient information gathered to make the decision recorded on the:

- Safety assessment due at the time of determination? Yes

Determination:

- Was sufficient information gathered to make determination(s) for all Yes, sufficient information was



allegations as well as any others identified in the course of the investigation?

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?

Yes

Was there sufficient documentation of supervisory consultation?

Yes, the case record has detail of the consultation.

Explain:

Throughout the CPS investigation, the level of casework activity was commensurate with the case circumstances. There were detailed documentation of supervisory involvements during the investigation.

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: 02/18/2017

Time of Death: 09:05 AM

County where fatality incident occurred:

Kings

Was 911 or local emergency number called?

Yes

Time of Call:

08:28 AM

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: In the bathroom

Did child have supervision at time of incident leading to death? Yes

How long before incident was the child last seen by caretaker? 5 Hours

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

Adults: 0



Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	11 Year(s)
Deceased Child's Household	Mother	No Role	Female	50 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	55 Year(s)
Other Household 1	Father	No Role	Male	51 Year(s)
Other Household 2	Adult Sibling	No Role	Male	26 Year(s)

LDSS Response

On 2/18/17, the Specialist contacted the medical and LE staff. The medical and LE staff did not report any signs of trauma or injuries to the SC.

On 2/19/17, the SC's BF stated that he last saw his daughter on 1/16/17. He did not report anything unusual regarding the SC's appearance or behavior. Also, he did not report any concerns about the BM's ability to care for their daughter. The BF described the SF as a "good guy" and did not believe the SF would harm his daughter. He stated his daughter was well cared for by her caretakers.

On 2/21/17, EMS reported the SC was in cardiac arrest at the time of arrival to the scene. EMS did not suspect any foul play regarding the fatality.

Also on 2/21/17, the parents provided a consistent timeline of events that transpired prior to the SC's death. They reported the SC did not exhibit any unusual behavior that would cause them to worry. The BM stated she was at work at the time of the incident. The SF reported he and the SC came home from a church program at about 2:30 A.M. The SC was awake, alert and coherent. She changed into her pajamas and then went to bed. The SF also went to sleep. At about 8:30 A.M., the SF noticed that the SC was not in her bed and started looking for her. The SF found the SC on the toilet bowl, slumped to the side with her head on the vanity. The SF went over to the SC and tried to wake her, and when he touched her she was cold. He then contacted 911 and the 911 operator instructed him to administer CPR to the SC. EMS came to the home about minutes later, took over the CPR and then transported the SC to the hospital. The family did not report any underlying medical conditions for the SC.

The family's neighbor did not report any concerns for the family. The neighbor described the family as very nice and that the SF was a gentleman.

Later that same day, the assigned detective stated the statements obtained from the parents were consistent and that the ME reported there were no physical or sexual signs of trauma to the SC.

On 2/22/17, the SC's pediatrician reported that the SC did not have any significant past medical history or current medical issues other than the SC's high cholesterol that was being managed with dietary changes. The pediatrician did not report any concerns regarding the SC's care.

On 2/28/17, the SC's school did not report any behavioral issues for the SC. The school staff described the SC as a lovely child. There were no concerns about the care she received from her caretakers.

Between 3/6/17 and 6/6/17, the Specialist made multiple casework contacts with the family, and other collaterals. There was no new information regarding the fatality investigation.



On 6/9/17, ACS received the results of the autopsy report on the SC. The SC's cause of death was Pilocytic Astrocytoma with Obstructive Hydrocephalus. The manner of death was natural.

On 7/13/17, ACS unsubstantiated the allegations DOA/FATL and IG against the SF. The autopsy report indicated the SC died of natural causes. The parents declined ACS' offer of services; stating they would seek support from their church and family. ACS closed the case and referred the family for community based services.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039401 - Deceased Child, Female, 11 Yrs	039403 - Stepfather, Male, 55 Year(s)	Inadequate Guardianship	Unsubstantiated
039401 - Deceased Child, Female, 11 Yrs	039403 - Stepfather, Male, 55 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Needed but not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No

Explain:

The parents declined services; stating they would seek support from their church and 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 in NYS within three years prior to the fatality.

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

The family did not have any prior CPS history.

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

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.

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