Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-083

Prepared by: New York City Regional Office

Issue Date: Jan 08, 2018

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

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Still Born
Age: Unknown
Jurisdiction: New York
Gender: Male
Date of Death: Unknown
Initial Date OCFS Notified: 08/31/2017

Presenting Information

The 8/31/17 SCR report alleged that on 8/30/17, the SM who was homeless, gave birth to the SC at about 8:00 PM on the steps of an industrial building. After giving birth, the SM fell asleep with the SC in her arms and the umbilical cord wrapped around the SC's neck, still attached. When the SM woke up, the SC was not moving. A bystander found the SM and the SC on the steps of the industrial building and called 911. The SM appeared to be dazed and calm. Emergency medical technicians responded and pronounced the SC dead on 8/31/17 at 7:25 AM. The SM allegedly had other CH who had an unknown role.

Executive Summary

On 8/31/17, the SCR received information regarding the death of a newborn infant (SC). The ACS case record reflected that the ME conducted an autopsy and determined this was a stillborn fetus and not a live birth. As of 1/8/18, NYCRO had not yet received the ME report.

The allegations of the 8/31/17 SCR report were DOA/Fatality and IG of the SC by the SM.

According to LE, the SM and SC were found in a public location near the front entrance of a building. A bystander had observed the SM and SC, and the bystander provided details of his observations. Prior to the SC's birth, the SM slept in the public location for about a one-month period. The bystander observed the SM on 8/31/17 at the time the SM told him she gave birth to the SC on 8/30/17 between 8:00 PM and 10:00 PM. The bystander observed the SC was wrapped in a sheet, the SC did not move and seemed lifeless.

LE said the SM did not seem to be under the influence of drugs/alcohol. The SM provided more than one name and three different dates of birth. SM told LE that she gave birth between 8:00 PM and 10:00 PM on 8/30/17, and was tired and fell asleep. LE said it seemed the SM gave birth to a male fetus with an umbilical cord around the neck. The SM arrived at the hospital and where she admitted she had used an assumed name. She did not provide her family members' information. The SM provided an address which LE proceeded to visit, and confirmed the address did not exist. The ACS case record did not reflect whether ACS made diligent efforts to interview the attending physician at the hospital.

On 9/1/17, ACS contacted EMS and verified a 911 call was received on 8/31/17 at 7:17 AM. When EMS arrived, the SM gave the SC to EMS and told them the SC was not moving. The SC was pronounced dead at the scene at 7:25 AM. SM stated she gave birth on 8/30/17 at 8:00 PM. SM did not receive pre-natal care. Per the SM, the SC was alive and then she fell asleep. When she awoke, the SC was not moving. EMS observed the SC was nude, the umbilical cord was wrapped around the neck, and there was no material covering the body. EMS observed the SM seemed dazed and was possibly under the influence of an illicit drug. SM denied she had a clinical health issue. The SM informed EMS she was not homeless, but refused to provide an address.

On 9/1/17, the ME confirmed the SC was stillborn and there was no observable internal or physical trauma to the SC. On 9/1/17, ACS contacted hospital staff who said the SM was positive for cocaine and cannabis. There was no social planning for the SM.

ACS opened a service case on 12/8/17 to monitor the case circumstances and assess the SM's needs although there were no surviving siblings or other children in the household. ACS closed the service case on 12/12/17 as the SM's whereabouts

remained unknown. ACS did not enter any Family Service Progress Notes.

On 12/8/17, ACS obtained a legal consultation from Family Court Legal Service (FCLS). According to FCLS, there was no legal basis to file a petition.

On 12/27/17, ACS Unsub the allegations of IG and DOA/Fatality of the SC by the SM. ACS based the determination on findings of the autopsy that listed the cause of death as intrauterine fetal demise with cocaine present. There was no determination regarding the manner of death as the SC was stillborn. The SM was homeless, her whereabouts were unknown and she did not have surviving CHN.

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 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? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
NA

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The documentation did not reflect whether ACS made diligent efforts to interview the attending physician at the hospital.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

On 8/31/17, ACS interviewed the Assistant District Attorney (ADA). ACS learned that the SM was known by different aliases. It seemed the SM was previously arrested and was known by a different name. The ADA established that the SM recently delivered the SC. The SC's was medically examined and deemed stillborn.

On 8/31/17, the ACS Specialist interviewed the SM at the hospital. ACS verified details of the SM's identity. The SM acknowledged she used an assumed name. The SM did not provide clear details about her residence, pre-natal care, identity of the BF, family and friends. She denied she was in receipt of TANF. She was unaware whether she had arrived at the hospital by ambulance. She denied she misused drugs. The SM denied she had another CH.

On 8/31/17, ACS interviewed the bystander who had observed the SM outside of his work location. On the morning of 8/31/17, the SM had informed the bystander that during the night of 8/30/17, she (the SM) gave birth to the SC. The bystander observed the SC wrapped in a white cloth and noted that the body seemed lifeless. ACS learned that LE was contacted to obtain assistance for the SM.

ACS found that the ADA did not have contact information for the SM. On 9/20/17, LE said the case was closed pending the results of final autopsy report. LE did not have a new address for the SM.

On 9/21/17, ACS met with the medical records representative at the hospital. ACS learned that the hospital was unable to provide ACS with the medical records regarding the SM.

On 10/12/17, ACS documentation reflected that the SM’s whereabouts were unknown.

On 12/8/17, ACS interviewed the ADA who said the case would be closed with DA's office as the cause of death was listed as intrauterine fetal demise.

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042808 - Deceased Child, Male, 1 Days	042809 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
042808 - Deceased Child, Male, 1 Days	042809 - Mother, Female, 22 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:

The documentation did not reflect the SM provided information about her family relatives. ACS did not make diligent effort to interview the attending physician. LE went to address the SM provided but found the address did not exist.

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? 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS was unable to locate the SM after making contact with her in the hospital.

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:
ACS documentation reflected that there were no surviving siblings or other CHN in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The documentation reflected that other than the initial contact with the SM on 8/31/17, the SM's whereabouts were unknown.

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 SM was not known to the SCR or ACS as a subject.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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