Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-18-074

Prepared by: New York City Regional Office

Issue Date: Jan 17, 2019

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: 1 day(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 07/18/2018
Initial Date OCFS Notified: 07/18/2018

Presenting Information

The 7/18/18 SCR report alleged the SM gave birth to the SC at 35-weeks gestation in her hotel room in July 2018. The SM notified a family member via text message to get the SC and take the SC to the hospital. The family member did not receive the message until 7/18/18. The SC was found unresponsive in the hotel room on 7/18/18. The SM was in the room and she did not seek immediate medical assistance. As a result, the SC died.

Executive Summary

This one-day-old female SC died on 7/18/18. NYCRO had not yet received the autopsy report at the time this fatality report was issued.

The allegations of the 7/18/18 SCR report were DOA/Fatality, IG, and LMC of the SC by the SM. The SCR registered a subsequent report concerning allegations of IF/C/S, IG, and PD/AM of the SC by the SM. ACS conducted the investigations of the two SCR reports simultaneously.

ACS interviewed the SM regarding the circumstances that led to the SC's death. The SM denied she had labor pains when she went to the bathroom and saw the SC was delivered in the toilet. The SM said she cleaned the SC with the hotel towels, cut the cord, and wrapped the SC in towels. She stated she placed the SC on her chest, where the SC slept for hours. According to the SM, the PGM had agreed to pick up the SC; however, the PGM visited the BF in prison. The SM acknowledged she did not call for medical attention. ACS found the SM did not have a crib or other provisions for the SC, as the SM had no intention of being the SC's primary caretaker. The ACS findings reflected the SC had a 7-year-old surviving half-sibling who was in the legal custody and care of her PGF. The SM did not have contact with the half-sibling for more than one year prior to the date of the SC's death.

The SM resided alone in a hotel room which she rented for two months. The SM utilized family resources to support herself. The SM stated she used prescribed medication during her pregnancy with SC. There were no surviving children in the SM's household; therefore, there were no child safety concerns or risk issues noted. ACS assessed the safety and well-being of the half-sibling who was in the custody of her PGF. The BF was incarcerated at the time of the fatality.

ACS reviewed the SM's CPS and criminal history. ACS interviewed relevant collaterals and gathered pertinent information about the SC's death. The SM had a history of mental health related issues and substance abuse. ACS explained the allegations of the report to the SM and provided the required notifications.

During the investigation, ACS made additional attempts to locate and engage the SM to no avail. On 10/10/18, the SM contacted ACS and declined offered services; she decided to seek services privately. The SM refused to reveal her whereabouts.

On 12/31/18, ACS substantiated the allegations of PD/AM, LMC, and IG of the SC by the SM on the basis the SM failed to seek medical attention after she gave birth to the infant. ACS added that the first responders observed the infant was covered in a blanket and was blue. There was drug paraphernalia in the room.

ACS unsubstantiated the allegations of DOA/Fatality and IF/C/S on the basis of no credible evidence. The ME's report

was pending results of additional tests. ACS had interviewed LE who stated there were no criminal charges due to the pending autopsy results.

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?** Unable to determine - insufficient documentation.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
ACS case record did not include adequate information to determine whether ACS appropriately determined the report.

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:
N/A

Required Actions Related to the Fatality

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

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	ACS did not approve the 30-Day Fatality Report document within the required timeframe.
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.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS did not enter progress notes contemporaneously. Some events occurred on 7/26/18, 8/2/18, 8/10/18, 8/21/18, 8/27/18 and 9/12/18 but were not entered until 11/21/18.
Legal Reference:	18 NYCRR 428.5

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

Incident Information

Date of Death: 07/18/2018 **Time of Death:** 08:17 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 07:42 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: in utero

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was:

- ☒ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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	1 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)

LDSS Response

On 7/18/18, hospital staff informed ACS that the SC arrived at the hospital at 8:11 PM and was pronounced dead at 8:17

PM. The SM said the SC was born alive and cried; she cut the umbilical cord, cleaned, and fed the SC twice. Upon giving birth, she sent messages to the PGM over the course of several hours, before threatening to harm herself. The SM was unable to provide a timeline regarding when she observed the SC was unresponsive. The SM admitted to use of suboxone and heroin. The documentation did not reflect the time the SM last used drugs.

An attending physician confirmed the SC arrived in the ER at 8:11 PM. The physician was unable to determine whether the SC was born alive. It was determined the SC was deceased for several hours. The SC was premature and there were no injuries observed. Regarding the SM's medical condition, another attending physician stated the SM was unsure of the timeline of events and expressed suicidal ideation. The SM was referred for psychiatric and medical evaluations. ACS learned that the visible marks on the SM's arms were indicative of her intravenous drug use.

According to LE, the SC was in the ambulance when LE arrived. The SM declined EMS recommendation for medical attention. LE deemed the SM needed intervention; therefore, LE transported the SM to the hospital. The SM had a warrant from Suffolk County; therefore, the SM was arrested and later released.

On 7/19/18, the SM said that prior to the time she gave birth to the SC, she arranged for the PGM to care for the SC upon birth and later said she intended to place the SC for adoption. The SM stated she refused the PGM's request to call 911 due to an active warrant. The SM informed ACS of the half-sibling who lived with her PGF. The SM denied drug and alcohol use. ACS observed the SM frequently nodded off and her moods rapidly shifted between agitation and confusion. ACS observed marks and open sores on the SM's arms.

On 7/19/18, the PGM said she did not observe the SM during the pregnancy. She acknowledged the SM sent a text to her on 7/17/18 at 7:50 PM. The PGM said she did not read the text until 7/18/18 at approximately 12:30 PM. The PGM spoke with the SM at around 5:00 PM and advised her to contact 911. The SM did not contact 911. Shortly afterwards, the SM sent the PGM a text; threatening to harm herself. The PGM called 911 when she arrived at the hotel. The PGM observed the SC had a dark purple color. Along with LE and EMS, the PGM observed syringes throughout the bed. The PGM denied she made a previous agreement with the SM.

On 7/20/18, the hotel staff said the SM paid weekly for the hotel room for approximately 3 months. The staff said the SM appeared pregnant but not under the influence. The SM did not allow hotel staff to clean the room.

According to EMS, at 7:42 PM the 911 call was received regarding a person with suicidal ideation. EMS arrived at the hotel at 7:47 PM. EMS performed CPR on the SC. The SC and SM were transported separately to the hospital. The SM appeared under the influence and was combative with EMS.

On 7/21/18, 8/30/18, 11/14/18, and 12/6/18, ACS visited the PGF's home and observed the half-sibling. The PGF had a final order of custody of the half-sibling. The half-sibling appeared well nourished, well groomed, and free of marks and bruises. The home was appropriate and there were no safety concerns. The half-sibling had no contact with the SM in over a year.

The documentation reflected that the whereabouts of the SM remained unknown.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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 previously 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047055 - Deceased Child, Female, 1 Days	047056 - Mother, Female, 35 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047055 - Deceased Child, Female, 1 Days	047056 - Mother, Female, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
047055 - Deceased Child, Female, 1 Days	047056 - Mother, Female, 35 Year(s)	Lack of Medical Care	Substantiated
047055 - Deceased Child, Female, 1 Days	047056 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
047055 - Deceased Child, Female, 1 Days	047056 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Substantiated

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:
ACS did not enter progress notes contemporaneously. Some events occurred on 7/26/18, 8/2/18, 8/10/18, 8/21/18, 8/27/18 and 9/12/18 but were not entered until 11/21/18.

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:
The SM received mental health referral, health care and substance abuse services while hospitalized after the fatality.

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:
The SM did not have children in her household at the time of the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM was admitted to the hospital for medical care and was subsequently referred for mental health treatment.

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

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

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 an alleged subject in three reports dated 1/28/11, 6/4/11 and 3/26/14.

The allegation of the 1/28/11 report was LS of the half-sibling by the SM. ACS investigated the report. On 3/29/11, ACS substantiated the allegation on the basis the shelter staff observed the half-sibling alone in the room and the SM did not make plans for supervision of the half-sibling.

The allegations of the 6/4/11 SCR report were IG, LS and PD/AM of the half-sibling by the SM. Nassau County DSS

(NCDSS) investigated the report. On 9/13/11, NCDSS unsubstantiated all the allegations on the basis of no credible evidence.

The allegations the 3/26/14 SCR report were IG and PD/AM of the half-sibling by the SM and father of the half-sibling. NCDSS substantiated the allegations on 6/13/14.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

As a result of the 1/28/11 investigation, ACS opened a preventive services case for the family on 4/1/11. The service plan included: case management, child care, and casework counseling. ACS closed the preventive services case on 5/19/11 as the family relocated out of NYC jurisdiction.

As a result of the 3/26/14 investigation, NCDSS opened a preventive service case on 6/17/14 and closed the case on 12/14/15. The family received case management, drug counseling/treatment and parent training services. The case was closed as NCDSS supervision expired on 9/24/15. The half-sibling remained in the care and legal custody of her PGF who provided adequate care to the half-sibling.

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

Criminal Charge: Other - Criminal Possession of Narcotic Drug		**Degree:** NA	
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
06/10/2015	SM	08/08/2015	Probation
Comments:	The SM pled guilty to the charge and was sentenced to probation to expire on 8/7/21.		

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