Child Fatality Report

Report Identification Number: NY-18-100

Prepared by: New York City Regional Office

Issue Date: Mar 27, 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: 3 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 10/05/2018
Initial Date OCFS Notified: 10/05/2018

Presenting Information

The narrative of the report alleged on 10/5/18, the BM was asleep on the couch with the three and a half-month-old SC. The BM awoke and noticed the SC was not breathing. She called 911 and started CPR on the SC. The SC was brought to the hospital and pronounced dead. She was last seen alive at 5:00 AM by the BM. The SC's body did not have any visible marks or bruises. She was an otherwise healthy child with no preexisting medical condition.

Executive Summary

On 10/5/18, the three-month-old SC died while co-sleeping on a couch with the BM. ACS documented that on 10/4/18, the SC was in the care of the MGM while the BM was out of the home in the company of her friends. At approximately 2:00AM, the BM returned home and observed the SC, the MGM and an unrelated home member (UHM), the MGM's boyfriend were awake in the room at the time. The BM took the SC from the MGM and brought her into the living room. The MGM and the BM spoke for a few minutes in the living room area. The MGM returned to her room minutes after. The BM later fell asleep on the couch with the SC. The BM positioned the SC on her back with her head resting on the BM's left arm. At 5:00AM, the BM awoke, fed the SC and 10 minutes after the feeding, they both went back to sleep in the same position. At approximately 11:00AM, the BM awoke and noticed the SC was purple, cold and unresponsive. She immediately took the SC in her arms and began tapping her on her back. The BM began screaming and woke the UHM who came into the living room and called 911. The UHM gave the SC CPR as instructed by the 911 operator.

The FDNY responded to the home minutes later, took over CPR, and then transported the SC to the hospital where she was pronounced DOA. According to the ME, the final autopsy was pending toxicology and pathology results; however, preliminary findings ruled out concerns of neglect or maltreatment of the SC.

The SC was survived by a four-year-old male sibling. The family resided with the MGM and two minor MUs. At the time of the fatality, the MGM had legal custody of the SS. The SS had supervised visits with the BM. The SS' BF did not reside with the family but was involved with his son. The SC's BF also resided at a different address.

ACS initiated the CPS investigation within the mandated timeframe and made collateral contacts with LE, the family's service providers, medical providers and investigative consultants. ACS assessed the SS and the two MUs and deemed them to be safe. The three children were forensically interviewed at ACS' Child Advocacy Center and there were no reported concerns. Additionally, the family provided a consistent account of the incident to ACS and LE. Based on the information obtained, there were no findings of abuse or maltreatment to the SC. The criminal investigation was open pending the final autopsy.

During the investigation, ACS held a child safety conference (CSC) regarding the fatality. The CSC recommended that the MGM continued to be the SS' primary caretaker. The CSC also recommended services to the family. The family was receptive to services. ACS provided the family with referrals for community based services.

At the time of writing this report, ACS had not yet determined the CPS fatality investigation. The SS remained in the care and custody of the MGM. There were no reported concerns for the SS and the MUs in the MGM's care. The BM did not have any other children in her custody. She submitted to a drug screening and tested negative for all substances. She also agreed to engage in clinical health and substance abuse services. The family had signed up for services with a community based organization.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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 level of casework activity did not commensurate with the case circumstances. The case documentation did not indicate ACS made casework contact with the BF.

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:	The BF did not reside with the family; however, ACS did not make diligent efforts to locate the BF and interview him about his daughter and the BM.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
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:	Failure to provide safe sleep education/information
Summary:	The case records did not indicate ACS discussed safe sleep practice with the family.
Legal Reference:	13-OCFS-ADM-02

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:	Failure to offer services
Summary:	ACS did not identify service needs for the BF or offer him services.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/05/2018 **Time of Death:** 12:32 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 11:30 AM
Did EMS 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
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	Aunt/Uncle	No Role	Male	11 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	16 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	

Deceased Child's Household	Grandparent	No Role	Female	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

On 10/5/18, ACS contacted LE, the family, service providers and the medical staff. EMS and LE stated when they responded to the scene, they did not observe any marks or bruises on the SC. LE assessed only the family's living room area and did not note any concerns. LE did not suspect any foul play regarding the SC's death pending the final autopsy report.

ACS interviewed the family at the Child Advocacy Center. The family provided a consistent account of the incident which revealed the SC was co-sleeping with the BM on a couch when she was found unresponsive. The family reported that prior to her death, the SC was a healthy child. Her immunizations were current and she was up-to-date with her medical appointments. The BM denied marijuana or alcohol use and denied drinking alcohol on the night of the incident. ACS assessed the SS and the 2 MUs and deemed them safe. The 3 children were forensically interviewed and there were no reported concerns.

On 10/9/18, ACS visited the family. The MGM gave the timeline of events from the day prior to the incident leading up to her returning home to find first responders administering CPR to the SC and transporting her to the hospital. The BM disclosed she resumed consuming alcohol to deal with her daughter's death. The family reported they had signed up for services with a community based organization.

Following the visit to the family, ACS contacted the SS' paternal family. They did not report any concerns about the care the MGM gave to the SS. The family stated they agreed to the MGM having custody of the SS because she took good care of him.

On 10/10/18, ACS provided referral for services to the family. The BM agreed to submit to a drug/alcohol screening. ACS provided the BM transport fares to attend the drug test.

On 10/22/18, ACS received the results of the BM's drug screening. She tested negative for all substances.

On 10/31/18, ACS held a CSC. The participants at the CSC agreed that family court intervention was not needed for the family. The CSC recommended services to the family and that the MGM continued to be the SS' primary caretaker. The family was receptive to services.

Also on 10/31/18, ACS received the 3 minor children's medical information from their medical providers. Their immunizations were current and there were no concerns regarding their medical care.

On 11/26/18, ACS made casework contact with the MGM and the SS at the CAC. There were no concerns for the SS. He appeared well groomed and free of any marks or bruises. The MGM reported the family had begun services pending other documentation.

At the time of writing this report, the fatality investigation remained open awaiting the final autopsy report.

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)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

Comments: New York City does not have an 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
047879 - Deceased Child, Female,	047880 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
047879 - Deceased Child, Female,	047880 - Mother, Female, 26 Year(s)	DOA / Fatality	Pending

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?	☒	☐	☐	☐
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 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	☒	☐	☐	☐
Explain: ACS did not offer the BF services.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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	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	☐	☐	☐	☐	☐	☒	☐

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? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/20/2015	Sibling, Male, 18 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
On 10/20/15, the BM had an altercation with her adult brother in the presence of her now surviving son. The BM poured cooking oil on the floor and attempted to set it on fire. As a result, the BM was arrested for attempted arson and child endangerment. Consequently, ACS filed an Article 10 Neglect Petition in Manhattan Family Court. The court released the SS to the MGM with ACS supervision.

Report Determination: Indicated **Date of Determination:** 12/16/2015

Basis for Determination:
During the investigation, ACS obtained sufficient credible evidence to support the fact that the BM substantially failed to meet a reasonable minimum standard of care for the child. The BM had an altercation while the child was present. The BM had also placed child in plausible danger by trying to start a fire. She was arrested and there was full stay away OOP for the child.

OCFS Review Results:
ACS conducted the investigation appropriately.

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

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

Sometime before 3/18/11, the MGM was arrested and since then the now BM had been caring for her 8 and 4-year-old brothers. The MA was supposed to help but it was unknown if she resided in the home or looking in on the family from time to time. Since 3/18/11, the 8-year-old had been wearing the same street clothes and was not wearing his uniform. On 4/8/11, the 8-year-old sibling left his home being sick and had a 101-degree fever. Attempts to reach the now BM and the MA were unsuccessful. The child needed medical attention and there was no way to reach a responsible adult.

The allegation of IG was unsubstantiated against the BM regarding her brother. When the BM finally received the call that her brother was sick, she picked him up from after school and took him home. When ACS arrived to the home, the BM was willing to take her brother to the ER. ACS escorted the family to the hospital.

Known CPS History Outside of NYS

The family did not have any known CPS history outside of New York State.

Preventive Services History

FSS Stage was opened for the family on 10/29/15 due to concerns of IG related to the BM's out of control behavior and alcohol misuse in the presence of the now SS. There was also a concern of untreated mental health condition by the BM. During ACS' involvement with the family, the BM was resistant to engaging in services and was referred to the Bridge for MICA services. The SS was released to the care of his MGM, while the BM engaged in services. The BM was participating in her program and the SS was returned to her care. She continued attendance for several months but stopped attending around April 2017. She refused to re-engage in MICA services and follow the court orders. She later stated she was not ready to commit to any program. Due to her refusal to complete any services, the BM agreed to give custody of her son to the MGM. On 12/8/17, full custody of the SS was granted to the MGM.

The last documented home visit was conducted on 1/19/18 by ACS. There were no immediate safety concerns for the SS.

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: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/29/2015	Adjudicated Abused	Return to Relative
Respondent:	047880 Mother Female 26 Year(s)	
Comments:	On 10/20/15, the BM had an altercation with the MU in the presence of the now SS. The BM then poured cooking oil on the floor and attempted to set it on fire. As a result, the BM was arrested for attempted arson and child endangerment. On 10/29/15, ACS filed an Article 10 Petition filed in Manhattan Family Court (MFC). The MFC released the SS to the MGM. The MFC granted the BM supervised visits with her son.	

Have any Orders of Protection been issued? Yes	
From: 10/29/2015	**To:** Unknown
Explain: On 10/20/15, the BM had an altercation with the MU in the presence of the now SS. The BM then took cooking oil and poured the cooking oil on the floor and attempted to set it on fire. As a result, the BM was arrested for attempted arson and child endangerment. On 10/29/15, ACS filed an Article 10 Petition filed in Manhattan Family Court (MFC). The MFC released the SS to the MGM. The MFC granted a full stay away Order of Protection for the SS against the BM.	

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