NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-045 **Prepared by: New York City Regional Office**

Issue Date: 12/22/2015

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
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	MN-Medical Neglect	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		

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 06/06/2015
Initial Date OCFS Notified: 06/06/2015

Presenting Information

At 4:30 A.M. on 6/6/15, the BM fed the SC. The parents played with the SC and then put the SC in her stroller to sleep. The SC usually woke up at 8:00 A.M. When the SC did not wake up as expected, the BM checked the SC and found her with blood and vomitus on her clothing. The SC was unresponsive. The BF called 911 and EMS brought the SC to the hospital at 8:48 A.M. Hospital staff made efforts to revive the SC but they were not successful. The SC was pronounced dead at the hospital at 9:23 A.M. The SC did not have any preexisting medical conditions.

Executive Summary

On 6/6/15, the SC died in the home of her BF. The BM and SC were visiting the father at the time of the incident. At approximately 10:00 P.M. on 6/5/15, the BM fed, burped and put the SC to sleep in her stroller because there was no crib in the BF's home for the SC. At approximately 2:30 A.M. on 6/6/15, and again at about 4:30 A.M., the BM fed and burped the SC. At 5:00 A.M., the BM placed the SC on her back in a slightly elevated stroller and the parents and SC fell asleep. At 8:00 A.M., the BM awoke, checked the SC and found that the SC had vomitus and blood on her nose and mouth. The BM alerted the BF and told him to call 911 while she performed CPR. The EMS ambulance arrived at the home five minutes after the call was placed and continued the CPR efforts. EMS transported the SC to the hospital where medical staff pronounced her dead at 9:23 A.M. According to ACS' documentation, the SC was born healthy and did not have any preexisting medical conditions. The BM was a teen parent who was in foster care under the supervision of the Catholic Guardian Services agency at the time of the fatality. The SC did not have any surviving siblings and was not in foster care placement.

On 6/6/15, ACS' ECS began the investigation by contacting LE, the hospital SW and the ME. The SW and LE did not report any outward signs of trauma to the SC. LE also informed ACS that the ME's preliminary findings ruled out any criminality regarding the fatality and there would be no arrest. Additional information obtained by ACS from the foster mother (FM), the FM's adult children and the SC's primary Dr. did not reveal any concerns regarding the care the BM provided the SC. The FM described the BM as a loving and caring mother.

Following the fatality, the foster care agency (FCA) identified grief counseling services for the BM; however, the BM declined the offer of services and stated she was receiving support from family members. The FCA stated the BM did not report the SC needed a crib in the BF's home.

On 6/8/15, the ME reported preliminary autopsy results which showed no injuries and no obvious cause of death. According to the ME, the SC's airway was not blocked.

On 6/11/15, LE closed their investigation and reported that pending the final autopsy report, there was no criminality regarding the SC's death.

Between 6/22/15 and 7/15/15, ACS made several attempts to interview the BF regarding the incident. He remained uncooperative for the duration of the investigation.

During the investigation, the FM stated she did not notify the FCA that the BM was out of the FH for about three days. The ACS' Specialist informed the FM of her obligations as a foster parent to notify the FCA whenever a FC did not return to the home within a reasonable period of time regardless of the FC's age. Also, at the time of completing the CPS investigation, the BM had consented to remain in foster care.

ACS did not find credible evidence to definitively state that the SC's death was caused by her parents. According to ACS, the ME's preliminary autopsy findings did not indicate any obvious cause of the SC's death or any suspicious findings. Consequently, on 8/4/15, ACS unsubstantiated the allegations of the report against the parents.

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

Explain:
ACS conducted the investigation appropriately.

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:
There was no need for further LDSS' engagement with the family.

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: 06/06/2015 **Time of Death:** 09:23 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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

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	Female	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

On 6/6/15, ACS' ECS began the CPS investigation by contacting LE, the hospital SW and the ME. The SW and LE stated that the parents' account of the events that led to the SC's death was consistent. The BM had disclosed that she put the SC to sleep in the stroller because there was no crib in the BF's home. According to LE, pending the ME's final report, there was no suspicion of foul play regarding the incident.

The Specialist then visited the foster mother's (FM) home. The FM and other family members did not report any concerns for the BM and the SC. The FM described the BM as a loving and caring mother.

Also on 6/6/15, the Specialist contacted the foster care agency (FCA). The FCA was aware of the SC's passing but was unable to engage the BM because the BM was distraught. The FCA identified grief counseling services for the BM but she declined ACS' offer of services. The BM stated she was receiving support from family members. According to the FCA, the BM did not report the SC needed a crib in the BF's home. There was no documentation the parents were provided with safe sleep information.

On 6/8/15, the ME reported preliminary autopsy results did not reveal any injuries to the SC and no obvious cause of death. According to the ME, the SC's airway was not blocked.

Later that same day, the Specialist visited the FM's home. The FM reported that between 6/3/15 and 6/6/15, the BM was out of the home. The BM had told the FM she was visiting the MGM and she would soon return home but at no specific time. The FM did not notify the FCA that the BM was not present in the home at the time. On 6/6/15, the FM received a phone call from the BM saying she was in the hospital with the SC. The FM was not aware the BM and the SC had been with the BF prior to the incident. The Specialist told the FM that as a foster parent, she was obligated to notify the FCA whenever a FC did not return to the home within a reasonable period of time regardless of the FC's age.

The Specialist interviewed the BM regarding the incident. She reported that at about 10:00 P.M. on 6/5/15, she fed, burped and put the SC to sleep in her stroller. The BM stated that at about 2:30 A.M. and again at 4:30 A.M. on 6/6/15, she fed and burped the SC. The BM also stated that at 5:00 A.M. she placed the SC to sleep on her back in a slightly elevated stroller. At 8:00 A.M., the BM awoke, checked the SC and found that the SC had vomitus and blood on her nose and mouth. The BM alerted the BF and told him to call 911, while she gave the SC CPR. EMS arrived at the home five minutes after the call and continued the CPR efforts on the SC. EMS then brought the SC to the hospital where medical staff pronounced her dead at 9:23 A.M. The BM stated she did not request a crib for the SC to take to the BF's home because the BF resided in a small room. She denied being overwhelmed as a parent and declined ACS' offer of bereavement counseling. The BM denied that she or the BF used drugs of alcohol.

On 6/11/15, LE reported that pending the final ME report, there was no criminality regarding the SC's death and the case was closed.

On 7/10/15, the Specialist contacted the MGM and she declined ACS' offer of bereavement services. ACS made several attempts to interview the BF regarding the incident but he did not make himself available for an interview. The SC's primary Dr. did not report any concerns for the SC.

On 7/ 13/15, the BM consented to remain in foster care and was replaced with a FM different than the FM she resided with at the time of the SC's death.

On 8/4/15, ACS unsubstantiated the allegations of the report against the parents. ACS did not find credible evidence to definitely state the SC's death was caused by her parents. According to ACS, the ME's preliminary autopsy findings did not indicate any obvious cause of the SC's death and no suspicious findings.

Official Manner and Cause of Death

Official Manner: Unknown
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 approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
022221 - Deceased Child, Female, 5 Mons	022223 - Father, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
022221 - Deceased Child, Female, 5 Mons	022223 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
022221 - Deceased Child, Female, 5 Mons	022222 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
022221 - Deceased Child, Female, 5 Mons	022222 - Mother, Female, 19 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?	☒	☐	☐	☐

Additional information:
ACS made several attempts to interview the BF regarding the incident; however, he remained uncooperative.

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	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	☐	☐	☐	☐	☐	☒	☐

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:
There were no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The BM declined services.

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 within three years prior to the fatality.

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

The BM did not have any SCR history as a parent; however, between 3/28/97 and 12/17/03, she was listed in multiple closed cases as an abused child. The allegations of the reports were IG, LMC and B/S against her parents. According to the reports, the MGM had a history of untreated clinical condition. She had placed hot pennies on the BM's face as a remedy

to cure ring worms. As a result, the BM sustained burns to the right side of her cheek and under her chin.

Following the incident, ACS removed the BM and took her to the hospital for a medical check. The MGF was granted custody of the BM and there was an OOP in place against the MGM for the BM; however, the MGF allowed the MGM to visit with the BM unsupervised. The BM was placed into the kinship foster home of her MA.

The BF was known in two SCR reports dated 8/1/06 and 8/24/07, with the BM of his older child. The allegations of IG, IFCS, LMC and PD/AM of the reports were substantiated against the parents and their child was placed in foster care. The parents were also referred to FPP. On 10/19/07, ACS closed the case and there had been no recent ACS involvement with the BF. The BF's older child was not named in the current report. According to OSI case records, the child was adopted in 2012.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS for this family.

Services Open at the Time of the Fatality

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.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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

Action:	The FM reported that between 6/3/15 and 6/6/15, the BM was out of the home. The FM did not notify the FCA that the BM was not present in the home and she was not aware the BM and the SC had been with the BF prior to the incident. ACS must emphasize to the FCA the policy regarding absentee foster children. The FCA must remind foster parents about their obligation to notify the FCA whenever a FC did not return to the home within a reasonable period of time regardless of the foster child's age.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No