Child Fatality Report

Report Identification Number: NY-17-057

Prepared by: New York City Regional Office

Issue Date: Nov 27, 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	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: Bronx
Gender: Male
Date of Death: Unknown
Initial Date OCFS Notified: 06/16/2017

Presenting Information

The 6/16/17 SCR report alleged that the SM suffered from severe MH issues. It was believed the SM's current MH status had deteriorated to the point where she was not able to effectively or safely care for her three children ages; 17, 12 and 11 years. The SM also had the body of her newborn in a casket in the right-side corner of the floor of her bedroom closet. It was unknown when the SM gave birth. The birth or death of the SC nor how the SC died were unknown.

Executive Summary

This report involves the death of a male stillborn infant (SC) the SM delivered spontaneously at New York Presbyterian Hospital on 3/14/11. An autopsy was not conducted as no body was found. On 8/15/17, NYCRO received the Certificate of Spontaneous Termination of Pregnancy document issued by the City of New York-Department of Health and Mental Hygiene. The estimated gestation age of the SC was listed as 22 weeks. According to the document, the SC was born without a heartbeat and no movement of voluntary muscle. The SC was pronounced dead at 8:36 AM. Shortly thereafter, the SC was cremated.

On 6/16/17, the SCR registered a report including the allegations of DOA/Fatality and IG of the SC and IG of the three SS by the SM.

The family resided in a 2-bedroom apartment which was observed with window guards and working carbon monoxide/smoke detector. The family had adequate sleeping arrangements, a sufficient supply of provisions, and the home conditions were satisfactory. There were no hazardous conditions in the home.

ACS interviewed the SM regarding the circumstances leading to the death of the SC. The SM stated she was aware she was pregnant with the SC at the third month of pregnancy. The SM was uncertain of her ability to care for a fourth child and did not seek prenatal care as she was concerned of how the pregnancy would affect her daily substance abuse treatment. The SM stated she went into premature labor and the SC did not survive.

ACS observed the SM's bedroom closet. There was no dead body of an infant in a casket observed in the home. The SM had a memory box containing the cremation ashes of the SC stored in a bag along with ultra sounds, death transcript, photo and shoes of the SC after the delivery in the SM's bedroom closet. The SM presented to be mentally stable during the home visit.

ACS obtained supporting documentation relevant to the investigation from LE, child welfare and social service history databases, medical and treatment providers as well as the children's school records.

On 8/15/17, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SM as there was no dead body observed in the apartment. Stored in a box in the mother's bedroom closest, were the cremated ashes and a few items that belonged to the SC.

ACS unsubstantiated the allegation of IG of the three SS by the SM on the basis that there were provisions in the home for the children. The children did not have observable injuries and they appeared to be in good health condition. The SM

appeared to have provided the children's basic needs and evidence gathered during the investigation showed the SM provided adequate and proper guardianship of the children.

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?** Yes
- **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?** 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 notes a consultation took place, but no details noted.

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	The SCR report was dated 6/16/17 and the 7-Day Safety Assessment was not approved until on 6/27/17.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
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 the Investigation Progress Notes contemporaneously. The review revealed progress notes dated 6/16/17, 6/23/17, 6/29/17 and 6/30/17 were entered on 8/11/17, 8/14/17 and 8/15/17.
Legal Reference:	18 NYCRR 428.5
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:	Diligence of Efforts
Summary:	Although identified, the documentation did not include ACS efforts to notify the BFs of the allegations involving their children or provide them with the required NOE.
Legal Reference:	NYCRR 430.12D
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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	0 Minute(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	11 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	17 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	12 Year(s)

LDSS Response

On 6/16/17, ACS conducted a home visit to the case address. The SM presented to be mentally stable during the visit. The apartment was assessed to be sanitary and appeared safe for the three SS. The SM denied the allegations. ACS observed the SM's keepsake box containing a copy of the SC's vital records, a photo and clothing. There was no dead body of an infant in a casket observed in the home.

The Specialist conducted a home visit to assess the three SS. The children appeared to be well cared for and were observed to be free of marks or bruises. There were no safety concerns. The children were interviewed separately. The 12 and 17-year-old SS denied the allegations and stated the SM provided adequate care of the children. The 11-year-old SS could not provide a response to questions as the SS was nonverbal with significant developmental disabilities. The SS received related services in school. The children were observed to have a very strong bond with the SM during the home visit.

According to LE, there was no evidence of the dead body of an infant observed in the home. There was a memory box in

SM's closet with some baby clothes and copies of the SC's death and cremation certificate. No arrests were made and the case was closed.

The neighbors of the family denied having had concerns regarding the family. There were no suspicious activities observed.

On 6/21/17, ACS learned that the family's rent was up to date. The history showed there were no complaints or child welfare concerns reported by anyone to the housing management office. There were no issues noted with the family.

On 6/23/17, the three SS medical Dr. stated all the children had their physical exam on 6/23/17 and the children were up to date with all physical examinations and immunizations. The 12 and 17-year-old SS had no medical condition, no prescribed medication and no developmental delays. The 11-year-old SS had developmental disabilities and a chronic illness, and was prescribed medication.

According to the SM's practitioner, there were no concerns regarding the care the SM provided the three SS. The SM was previously treated with therapy that resulted in good outcomes. The SM was medically stable to safely care for the three SS.

On 6/30/17, a drug treatment provider confirmed the SM attended the program daily to receive her prescribed medication and was allowed to take the medication home on the weekends. The SM had negative results for all other substances since her 2006 program enrollment. Since SM was never positive for other substances during random screenings, the SM was not selected for random screenings as often. The SM successfully completed groups sessions and attended her once monthly individual counseling session. The SM had not presented with any MH illness. The SM was compliant with treatment since enrollment and there were no concerns to report.

On 8/11/17, the three SS were assessed in the family home. The children appeared well and the home conditions were satisfactory. The SM continued her participation in substance abuse treatment and followed up on the YAI/National Institute for People with Disabilities service referral for the 11-year-old SS.

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
039064 - Sibling, Female, 17 Year(s)	039067 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
039065 - Sibling, Female, 12 Year(s)	039067 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
039066 - Sibling, Male, 11 Year(s)	039067 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated

042188 - Deceased Child, Male, 0 Minute(s)	039067 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
042188 - Deceased Child, Male, 0 Minute(s)	039067 - Mother, Female, 40 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 did not enter several of the Investigation Progress Notes contemporaneously. The identified BFs of the three SS were not informed of the reported allegations involving their child nor were they provided a NOE.

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 safety 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	☐	☐	☒	☐

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.

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	☐	☐	☐	☐	☐	☒	☐
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:
There were no services provided to the family in response to the fatality as the SC died in the hospital on 3/14/11. ACS offered services; however, prior to the investigation, the SS was evaluated and deemed eligible for services with YAI/National Institute for People with Disabilities.

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 was known to the SCR and ACS in 11 reports dated 10/16/00, 10/25/00, 11/23/00 (two reports), 11/30/00, 6/16/07, 3/20/08, 7/9/09, 9/7/09, 12/29/09, and 7/22/10. The allegation themes were LS, IG, L/B/W, S/D/S, PD/AM and IFCS of the SS by the SM.

The seven reports dated 10/16/00, 10/25/00, 11/23/00 (two reports), 11/30/00, 7/9/09, and 7/22/10 were indicated and ACS substantiated the allegations of LS, IG and IFCS, L/B/W, and PD/AM. The four reports dated 6/16/07, 3/20/08, 9/7/09, and 12/29/09 were unfounded and ACS unsubstantiated the allegations.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

The family received preventive services from 12/6/06 through 10/04/07. ACS closed the case after an ACS legal consultation reflected there was no abuse/maltreatment at the time of the case review.

The FSS stage was opened on 8/24/09 as a result of the 7/9/09 investigation due to the physical and hazardous condition of the home. The SM was monitored by FSU to ensure the repair of the conditions to the home. On 9/11/09, the Astor Family Services agency had began to provide services to the family. Per the March 2011 FASP, the SM had concerns with the pregnancy due to her substance abuse treatment and her lack of prenatal care during the pregnancy. The SM went into premature labor and the SC did not survive. After the death of the SC, the SM refocused on the care of the three SS and continued her services. The SM showed the preventive worker the keepsake box for the SC and proof the SC was cremated. The SM completed her services with the agency. The SM resided in a shelter awaiting the reinstatement of her housing benefit; she was able to adequately care for her children. The FSS stage was closed on 6/17/11 due to the family achieving their service goals.

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