Child Fatality Report

Report Identification Number: NY-17-063

Prepared by: New York City Regional Office

Issue Date: Dec 19, 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 Deceased
Age: 1 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 06/24/2017
Initial Date OCFS Notified: 06/24/2017

Presenting Information

On 6/24/17, the SCR registered a report alleging DOA/FATL and IG of the one-month-old female subject child (SC). The SC's biological parents (BPs) were the subjects of the report.

The narrative of the report stated the SC resided with her BPs, and three siblings; ages eleven, nine, and five. At approximately 12:00 A.M. on 6/24/17, the SF fed the SC, and then fell asleep with the SC in his arms. At about 8:45 A.M., the SM awoke and went downstairs to check on SC and found her not breathing. The SM called 911 and the SC was transported to the hospital where she arrived DOA at 9:00 A.M. She was pronounced dead at 9:21 A.M. The report also stated the SC was an otherwise healthy child who was born at thirty-five weeks and did not have any preexisting medical conditions. The SC had a small bruise on the side of her face believed to be from laying on the SF's arm. Upon admission to the emergency room, the SC did not show any other signs of trauma.

Executive Summary

On 6/24/17, the SC died while in the care of her BPs. According to ACS documentation, the SF fed the SC then fell asleep with the SC in his arms. At approximately 8:45 A.M., the SM checked the SC and found her unresponsive. The BPs were bed-sharing with the SC at the time. The SF called 911 and EMS responded and transported the SC to the hospital where she arrived DOA; however, she did not show any indications of trauma. At 9:21 A.M., the hospital staff pronounced the SC dead. The ME determined the SC's cause of death was positional asphyxia and the manner of death was accidental.

The BPs had the SC in common. The SF had the five-year-old surviving sibling (SS) from a previous relationship. The BF of the eleven and nine-year-old SS did not reside in the home and had no contact with the SC.

On 6/24/17, ACS received the SCR report and initiated the CPS investigation in a timely manner by contacting the family and relevant collaterals. The information obtained by ACS revealed the SC had a history of respiratory distress since birth. She had had prior hospitalizations and also had been under medical care. LE did not make any arrests and there were no criminal charges.

Following the fatality, ACS visited the family's neighbor who was temporarily caring for the SS and assessed the SS to be safe. The children's doctor (Dr.) reported the children were up-to-date with their medical appointments and immunizations.

During the investigation, ACS held a child safety conference (CSC). The outcome of the CSC was COS for the family. Consequently, ACS filed an Article 10 Neglect Petition in Bronx Family Court (BxFC). The BxFC granted a release of the SS to the BPs with COS. The family was referred to preventive services, FPP services and assistance with funeral expenses.

Also during the investigation, the SM did not agree with ACS speaking with the mother of the SF's other child about "anything" with the family. However, ACS contacted the older SS' BF. He stated he did not wish to have any conversation with ACS and that he had not had any contact with his children in over three years because BxFC granted a full stay away OOP against him for the SM.

At the time of writing this report, ACS has not yet determined the SCR report. The family had began PPRS and

bereavement services. The children and SF also continued to attend their therapy appointments with New York Psychotherapy that was previously servicing them.

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?** Unable to Determine

Was the decision to close the case appropriate? N/A

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:
ACS had not determined the report; however, the family continued to engage in services.

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: 06/24/2017 **Time of Death:** 09:21 AM

Time of fatal incident, if different than time of death: 08:45 AM

County where fatality incident occurred: Bronx

Was 911 or local emergency number called? Yes
Time of Call: 08:59 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
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 2
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)

LDSS Response

On 6/24/17, the Specialist contacted BLH medical staff, LE personnel, and the family. BLH staff reported that the SC arrived at the ER DOA without any indications of trauma, neglect or maltreatment. LE told the Specialist that preliminary findings deemed the SC's death accidental and no arrest was made pending the autopsy report. LE also stated the family's home was assessed and deemed safe. The BPs provided a timeline of the events leading up to the SC's death which was consistent with the information that was already known. They disclosed the SC had been resuscitated in the past and also a day before her death due to her medical condition. The SM stated she received CPR training at the BLH prior to the SC's discharge. Also, the BPs stated they had been bed-sharing with the SC since birth, and at the time of the incident despite being knowledgeable of safe sleep practices. The family members did not report any concern about the care the BPs gave to their children.

ACS staff assessed the SS at the home of the family's neighbor. The neighbor did not allow the SS to be interviewed but the staff observed them to be well. The neighbor did not report any concerns regarding the care of the children by the parents.

Also on 6/24/17, the Dr. stated the SC was born with respiratory distress, was in the BLH for six days and was discharged with medication. According to the Dr., the BPs had been consistent with the children's medical care and appointments.

On 6/26/17 and 6/27/17, ACS made follow-up visits to the family. The SS were seen and interviewed. There were no concerns for the SS during the visits. The nine-year-old SS reported child care responsibilities for the SC and stated he was "tired of changing the SC's diapers and hearing her cry." The BF disclosed receiving treatment at New York Psychotherapy for a clinical health condition.

On 6/27/17, ACS held a CSC and the participants at the CSC recommended COS for the family. During the CSC, the SM did not agree with ACS speaking with the mother of the SF's other child about "anything" regarding the family.

On 6/28/17, ACS filed an Article 10 Neglect Petition in BxFC. The BxFC granted a release of the SS to the BPs with COS. The family was referred to preventive services, FPP services and assistance with funeral expenses.

On 6/29/17, ACS contacted the older SS' schools. The school staff reported concerns of lateness for both SS and there were academic and behavioral concerns for the nine-year-old SS. There were no behavioral concerns reported for the eleven-year-old SS.

Also on 6/29/17, ACS contacted the older SS' BF. He declined an interview with ACS and stated he had not had any contact with his children in over three years due to a full stay away OOP against him for the SM.

On 7/11/17 and 7/17/17, ACS visited the family. They stated they had begun bereavement counseling and the BF had been attending therapy. The SF stated that his attorney had advised him not to discuss the SC's death with ACS. The Specialist observed all the SS to be safe at the time of the visit.

On 7/24/17, the family's therapist reported that bereavement services were not meeting the family's needs because they were dealing with the trauma differently.

On 8/14/17, ACS encouraged the family to seek bereavement counseling through another agency. On 8/15/17, the family signed up for preventive services with New York Foundling.

Between 8/2/17 and 11/1/17, ACS made several casework contacts with the family and relevant collaterals. At every contact, ACS deemed the SS to be safe in the care of the BPs and the family continued to engage in services. The BF's therapist reported that the BF was attending all his appointments and taking his medication. The five-year-old SS was in receipt of school based services for speech and language delays. The ME reported that the SC's cause of death was positional asphyxia and the manner of death was accidental.

ACS has not yet not determined this report.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: The investigation adhered to 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
039187 - Deceased Child, Female, 1 Mons	039188 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
039187 - Deceased Child, Female, 1 Mons	039188 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
039187 - Deceased Child, Female, 1 Mons	039244 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
039187 - Deceased Child, Female, 1 Mons	039244 - Father, Male, 34 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
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 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?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

06/27/2017	There was not a fact finding	There was not a disposition
Respondent:	039188 Mother Female 33 Year(s)	
Comments:	On 6/27/17, ACS held a CSC and the outcome was to request Family Court for COS for the family. ACS filed an Article 10 Neglect Petition in Bronx Family Court and COS was granted for the family who were mandated to continue their current services and any additional services required.	

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Medication Management							

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? Yes
Explain:
The SS are all engaged in PPRS and therapeutic counseling and are court mandated to continue these services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

The family was referred to PPRS services and were engaged with New York Foundling. The family was also receiving bereavement services. The nine-year-old SS and the BF continued to attend their therapy appointments with New York Psychotherapy.

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? Yes

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)	Status/Outcome	Compliance Issue(s)
08/29/2014	Sibling, Male, 6 Years	Father, Male, 32 Years	Excessive Corporal Punishment	Indicated	No
	Sibling, Male, 6 Years	Father, Male, 32 Years	Lacerations / Bruises / Welts	Indicated	

Report Summary:
The BF hit the six-year-old male child in the face with a belt. The child sustained an open wound to the left side of his face from his check to his mouth. There was a welt on his left arm and a welt on his left side torso.

Determination: Indicated
Date of Determination: 10/23/2014

Basis for Determination:
During the investigation, the child reported he was hit with a belt and his nine-year-old sister confirmed the incident. The ACS Specialist also viewed photos of the child's face with bruises and blood.

OCFS Review Results:
ACS Bronx Field Office investigated the report and appropriately indicated the allegations of the report against the BF.

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

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

There is no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

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

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