NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-14-116 **Prepared by: New York City Regional Office**

Issue Date: 4/30/2015

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 Still Born
Age: Unknown
Jurisdiction: Kings
Gender: Unknown
Date of Death: Unknown
Initial Date OCFS Notified: 11/01/2014

Presenting Information

On 10/31/14 or 11/1/14, the mother gave birth to a male child in the home. The child was born at 35 weeks gestation. On 11/1/14, the mother stated she was asleep and not aware that she had given birth. It was subsequently determined the child had no pulse and was not breathing; the child was later pronounced dead. The mother's explanation was suspicious and implausible.

Executive Summary

This report involves the alleged death of a male child which the mother had spontaneously delivered at a friend's home on 11/1/14. The ME determined this was a stillborn male fetus. The gestational age was approximately 35 weeks. The ME listed the cause of death as stillbirth due to acute and chronic villitis and chorioamnionitis and the contributing cause of death as maternal cocaine use.

On 11/1/14, the SCR registered a report which included the allegations of DOA/Fatality and IG of a newborn infant by the mother.

ACS conducted a comprehensive investigation of the report which included obtaining information through face-to-face contacts with the Brookdale Hospital physicians, mother, ME and ME investigator, NYPD, relatives, and other collaterals.

ACS found on 10/31/14, during the night; the mother visited a male friend and told him she had pain and other symptoms. The friend offered to seek medical assistance but the mother refused the offer. The mother went to sleep in the friend's bedroom while the friend slept in the living room. On 11/1/14, at approximately 1:30 AM, the friend woke to the mother's cries, observed the mother had given birth and contacted 911 for assistance. At approximately 2:00 AM, EMS responded and transported the mother and still born child to Brookdale Hospital where the mother was admitted for medical care. The attending physician said on 11/1/14, the mother tested positive for cocaine.

On 11/3/14, the mother was discharged from the hospital. Subsequently, the Specialist made diligent efforts to locate and interview the mother and friend, however, their whereabouts remained unknown. According to the ACS case record, there were no surviving children in the mother's care. Although the mother gave birth to three surviving children: a female child who was six years old and two male children: seven and three years old; the mother no longer had legal custody of these children. ACS verified the surviving children were in the care and legal custody of separate family relatives; the children received adequate care and the mother had not maintained contact with them.

On 12/31/14 ACS unsubstantiated the allegations of DOA/Fatality and IG of the newborn by the mother on the basis that the mother gave birth to a stillborn child in the night or early morning hours and the mother said she probably became unconscious during the process. The ME did not find any unnatural cause associated with the death.

ACS inappropriately added to the SCR report and substantiated the allegation of Parent's Drug/Alcohol Misuse of the stillborn child by the mother. In the CPS Investigation Summary, ACS noted the toxicology was positive for cocaine and the mother admitted using cocaine prior to the birth. However, ACS did not appropriately apply the elements of

maltreatment to the case circumstances as the evidence showed the mother delivered a stillborn child and not a live child. Additionally, the pre-birth activity did not impact a live child.

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?** N/A

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?** No

Explain:
The ACS case record showed the mother delivered a fetus and there were no surviving children in her care. However, ACS added to the SCR report and substantiated the allegation of Parent's Drug/Alcohol Misuse of the infant by the mother.

Was the decision to close the case appropriate? Yes

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 mother did not have any other children in her care and following her discharge from the hospital, her unknown remained unknown.

Required Actions Related to the Fatality

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

Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS substantiated the allegation of Parent's Drug/Alcohol Misuse of the infant by the mother. However, for the 11/1/14 report, the evidence showed the mother delivered a stillborn child and the mother's activity did not impact a live child.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	0 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)

LDSS Response

ACS' staff interviewed the mother, family members, medical staff, assigned NYPD and relevant collateral contacts. The mother's account of events remained consistent.

On 11/1/14, the Specialist visited Brookdale Hospital and interviewed the physicians, ME and mother. The mother said she was aware of her pregnancy but did not seek prenatal care or prepare for the infant's birth. According to the mother's account, on 10/31/14, at approximately 9:00 PM she visited a friend in his home. On 11/1/14, during the early morning, while she was alone in the bedroom, she believed she gave birth to an infant. The mother said she observed the infant move his lips slightly, but the infant did not cry or move. She explained that she attempted to call 911, but probably became unconscious. When she woke, she observed the friend who provided sheets and blankets to wrap infant until EMS responded. She denied knowing the paternity of the infant and she also denied she used drugs or had a mental health condition.

The Brookdale Hospital physicians provided information which showed on 11/1/14, at 2:30 PM, the mother arrived in the hospital and at that time the umbilical cord was still attached to the mother. The stillborn infant was administered CPR but remained unresponsive. The time of death was listed as 2:35 PM. The physician explained the mother had a pre-existing medical condition which likely affected a fetus at any stage of development. Also, on 11/1/14, the mother tested positive for cocaine and was not fully coherent.

The ME examined the infant at the hospital and observed a three inch torn area on the stillborn infant's back. The ME explained this was normal as the stillborn infant's skin was delicate and sensitive and tore on the pad on which the body was placed. The ME investigator found there was no obvious trauma to the body, no rigor and lividity. The mother had a history of marijuana and cocaine use. ACS maintained adequate contacted with the ME and received the final autopsy report.

ACS made diligent efforts to locate the mother after her discharge from the hospital on 11/3/14. However, the mother did not have a documented residence and family members did not know her whereabouts. The family members reported that the mother did not have stable housing. ACS found the mother did not have children in her care. She has three other children who are in the care of family members. The Specialist contacted the family members and assessed the children received adequate care and did not have identified service needs.

ACS obtained information from NYPD which was obtained through police interviews with the mother's friend. The assigned detective found the friend appeared forthcoming with information. The friend said he knew the mother for approximately one year. The detective showed the Specialist photographs of the friend's home. The Specialist observed a full sized mattress with blood on it (the area in which the mother delivered the stillborn child). According to the detective

the ME interviewed the mother who added she was not aware of the time she gave birth. The NYPD closed the investigation based on the preliminary ME's report. There was no criminality noted.

The ACS case record showed the friend said on 11/1/14, at about 12:00 AM; the mother arrived in his home. The mother said on 10/31/14 at about 9:30 PM, she arrived in the friend's home. However, ACS did not clarify this discrepancy. Also, the ACS case record did not include the friend's observations on 11/1/14 at the time he contacted 911 for assistance. The Specialist made diligent efforts to contact the friend who did not make himself available for contact.

On 12/31/14, ACS inappropriately added to the report and substantiated the allegation of Parent's Drug/Alcohol Misuse of the stillborn infant by the mother.

ACS appropriately unsubstantiated the allegations of DOA/Fatality and IG of the stillborn infant by the mother.

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 this local district.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
015941 - Deceased Child, Male, 0 Day(s)	014841 - Mother, Female, 31 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
015941 - Deceased Child, Male, 0 Day(s)	014841 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
015941 - Deceased Child, Male, 0 Day(s)	014841 - Mother, Female, 31 Year(s)	DOA / Fatality	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:
There were no "other persons named" in the report.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
On 11/3/14, the mother was discharged from the hospital and subsequently, her whereabouts remained unknown. There were no other children in the mother's care.

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 other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
ACS' staff interviewed the mother while she was hospitalized. Following the mother's release from the hospital, her whereabouts became unknown and she did not make herself available for ACS contact.

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)
02/18/2013	2026 - Sibling, Male, 3 Years	2033 - Mother, Female, 32 Years	Excessive Corporal Punishment	Unfounded	No

Report Summary:
While on a visit the mother hit the then five-year-old sibling with a plastic hanger on his knees. This was done as a form of punishment for jumping. The role of the maternal grandmother and father were unknown.

Determination: Unfounded | **Date of Determination:** 03/22/2013

Basis for Determination:
ACS substantiated the allegation of Excessive Corporal Punishment of the then five-year-old sibling by the mother on the

basis of lack of credible evidence. The determination was based on information gathered through collateral contacts and observations by the Specialist.

OCFS Review Results:
ACS appropriately investigated the allegations and found no credible evidence to substantiate the allegation of the report.

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

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

The mother was known as a subject in four reports dated 10/4/06, 12/20/07, 9/20/10 and 11/8/11. ACS substantiated the allegations of Educational Neglect, Inadequate Guardianship Lack of Medical Care, Lack of Supervision and Parent's Drug/Alcohol Misuse. ACS unsubstantiated the allegation of Inadequate Food, Clothing, and Shelter was unsubstantiated. These reports were regarding the mother's children who are no longer in her care. ACS indicated these reports and the family received services to address identified needs.

Also, the mother was listed as having "No Role" in a report dated 9/30/10. This report was unfounded.

Known CPS History Outside of NYS

The family has no known CPS history outside of NYS.

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

On 11/1/06. ACS opened the case in the Family Services Stage to provide support services to the family and address educational needs of the female child who was then five years old. The family received parenting education, counseling and drug treatment services for the mother and case management for the sibling. In May 2008, services ended as the half sibling relocated to another state with his biological father.

Between 10/6/10 and 12/8/10 the family received preventive services: including drug treatment, prenatal care, domestic violence counseling, and case management services for the children. The preventive services case was closed after the family no longer accepted the services.

Between 11/10/11 and 9/9/13 the family received parenting education, individual counseling, drug rehabilitation and Play Therapy for the then four-year-old child and supervised visits with the children who had been placed in the custody of a biological father and maternal grandmother on 9/3/13. ACS closed the case utilizing case closure reason: no further supervision ordered.

Required Action(s)

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

Foster Care Placement History

On 11/15/2011, the mother's male children who were then four years old and one year old were removed from the mother's home and placed in the care and custody of the Commissioner of Administration for Children's Services. ACS filed an Article Ten Neglect petition in Kings County Family Court on behalf of these two children naming the mother as the respondent. The allegations pertained to the mother being under the influence of illegal substances such as marijuana, cocaine and alcohol while caring for the children. The mother maintained very little contact with the children and on 9/3/13, the separate family relatives were granted legal custody of the children. The female child resides with her birth father out of ACS' jurisdiction.

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:**
11/15/2011	Adjudicated Neglected	Return to Relative
Respondent:	014841 Mother Female 31 Year(s)	
Comments:	The then two year old male child was released to father on a final custody docket and the then six-year-old child was released to the MGM under a final custody docket.	

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