Child Fatality Report

Report Identification Number: NY-17-011

Prepared by: New York City Regional Office

Issue Date: Aug 07, 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		
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-Cardiopulmonary 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	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

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 02/03/2017
Initial Date OCFS Notified: 02/03/2017

Presenting Information

On 2/3/17, the SCR registered a report alleging the mother placed the SC to sleep in her (SC) crib at about 12:30 A.M. The report alleged that when the mother checked the SC at 3:00 A.M., the child was unresponsive. The mother said she took the SC to the bathroom and splashed water on the SC's face to wake her, but was unsuccessful. The report stated the parents brought the SC to the hospital in a cab. The report noted there was no explanation for the SC's death.

The report also alleged the mother reported the SC had a medical condition since birth, but she had not taken the SC for medical care since the SC's birth. The report further alleged the home was filthy, cluttered, and unsanitary. The report stated it was unknown whether these issues contributed to the SC's death.

Executive Summary

The SC was 5 months old when she died on 2/3/17. The ME reported the cause and manner of death as Undetermined, but mentioned the potential for unsafe sleep situation.

The family had an open investigation dated 1/21/17, which involved an incident of domestic violence. This altercation led to the father's arrest, and the mother was issued a full stay away Order of Protection (OOP). The father was arrested twice for DV. After the incident reported on 1/21/17, the mother relocated to Connecticut (CT) with the SC to stay with a MA. During this investigation, the family resided in an apartment that ACS found was in deplorable conditions.

On 2/3/17, the SCR registered a report concerning the death of the SC. The allegations of the report were DOA/Fatality and Inadequate Guardianship of the SC by the parents.

According to the mother, on 2/2/17 she came to NY to pick up her belongings from the case address and planned to return to CT on 2/3/17. The mother indicated the father was not staying at the case address.

The mother reported that on 2/2/17 she last fed the SC sometime between 10:00 P.M. and 11:00 P.M. The mother said she played with the SC and when she noticed the child was falling asleep she placed the child in the bassinet. The mother said the bassinet was empty and she laid the SC on her back with a pacifier. The mother then fell asleep and woke up at about 3:00 A.M. to check the SC who was unresponsive. The mother said she called the father who was at work and then she called 911. The mother said the father arrived prior to EMS; therefore, they decided to take the SC to the hospital via taxi. ACS learned the 911 called was made by the father at 3:30 A.M. The documentation did not reflect two calls were made to 911.

The medical staff from Mount Sinai Hospital (Queens) stated the parents arrived at the hospital with the SC who was pulseless. The attempts to resuscitate the SC were to no avail and the SC was pronounced dead at 4:00 A.M. Neither the medical staff nor the ME found signs of abuse or maltreatment on the SC's body.

The NYPD found no suspicions involving the parents in the SC's death;therefore, no arrest was made pending the results of the autopsy.

The mother provided an account concerning the medical condition reported to the SCR and stated the SC's medical

insurance had been cancelled. The mother said she was in the process of reactivating the insurance.

After the death of the SC, ACS had minimal contact with the parents. The father's whereabouts were unknown and the mother returned to her native country.

On 4/14/17, ACS unsubstantiated the allegations against the parents. However, based on the conditions of the home, ACS had some credible evidence to substantiate the allegation of Inadequate Guardianship. ACS documented the parents responded appropriately by taking the SC for medical attention. ACS also cited the ME's verbal report which noted the SC appeared well nourished and had no signs abuse or maltreatment. However, the ME did not provide a preliminary cause and manner of death.

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?** No,sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
5. Based on the parents' lack of communication, ACS had limited contact with the family. The father's whereabouts were unknown and the mother returned to her naïve country.

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Based on the conditions of the home, ACS had some credible evidence to substantiate the allegation of Inadequate Guardianship.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/03/2017 **Time of Death:** 04:00 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 03:30 AM
Did EMS to respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? N/A
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:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

ACS conducted the investigations of the 1/22/17 and the 2/3/17 fatality reports simultaneously.

On 1/21/17, the parents had a physical altercation. The mother left SC asleep with the father and went to the local precinct to file a domestic incident report. When the mother returned with police officers, the door was closed. Once the police gained entry to the home, they found the SC asleep in her bassinet and alone. The officers observed bruises on the mother; but the SC had no injuries.

ACS' made a visit to the case address on 1/22/17 and assessed the home was in a deplorable condition as there was garbage, old food, and bags of clothing strewn about the apartment. In addition, there was mold in the refrigerator. The parents reported they were moving out of the home in 3 days. ACS discussed the health risks the current living conditions presented for the SC. ACS documented the SC seemed healthy and did not appear to have any developmental delays.

On 1/22/17, the father was arrested and charged with Endangering the Welfare of a Child and Assault in the 3rd Degree. A temporary full stay away OOP was issued by the Queens County Criminal Court against the father on behalf of the mother and the SC. The documentation did not reflect any information concerning the father's release from police custody. ACS interviewed the father prior to his arrest and he denied the allegations.

After the issuance of the OOP, the building superintendent reported the mother went with the SC to stay with the MA and the father remained at the case address.

On 2/3/17, the SC died of unknown causes. There were concerns the SC's alleged pre-existing condition or the condition of the home could have contributed to the SC's death. The report noted the mother had not taken the SC for medical care since his birth. However, the ME did not confirm these conditions contributed to the SC's death.

The mother reported she did not return to the case address after the father's arrest. The mother said she returned from CT to NY on 2/2/17 to pick up her belongings and planned to return to the MA's home on 2/3/17. The mother said the SC was healthy and alert on 2/2/17.

The mother said she stayed at the case address on 2/2/17 and woke up on 2/3/17 at 3:00 A.M. The mother checked the SC and found the child lying on her back and unresponsive. The mother sprinkled water on the SC's face, but the child did not respond. The mother said she called the father at work and then she called 911. However, the NYPD reported the father called 911 at 3:30 A.M. The parents said they took the SC to Mount Sinai Hospital (Queens) in a taxi because EMS was taking too long to respond. The documentation did not specify whether the mother had also called 911. Once the SC arrived at the hospital, resuscitation efforts were made to no avail. The time of arrival at the hospital was not obtained.

The mother reported she came to the United States on a scholarship and her government was providing medical coverage. The mother said the SC was born premature at Mount Sinai Hospital (Manhattan). The mother indicated she had taken the SC for medical care and immunizations. However, on the four-month checkup the SC was not seen due to the cancellation of the medical insurance. The mother said she was in the process of getting the insurance reinstated. ACS requested the SC's medical record from Mount Sinai Hospital, but the case documentation did not reflect the record was received prior to the case determination. After the death of the SC, ACS had one contact with the mother, but the father did not respond.

The MA confirmed the SC was happy and alert on 2/2/17 when she left CT. The MA stated the mother was very attentive and affectionate towards the SC. The MA said the parents separated and the mother returned to her native country in mid-February.

On 4/4/17, the allegations of the report were unsubstantiated and the report was unfounded.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: Undetermined if injury or medical cause
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 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 NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
035401 - Deceased Child, Female, 5 Mons	035402 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
035401 - Deceased Child, Female, 5 Mons	035403 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated
035401 - Deceased Child, Female, 5 Mons	035402 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
035401 - Deceased Child, Female, 5 Mons	035403 - Father, Male, 22 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?				

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.

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	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:
The mother was provided with information for Safe Horizon due to the domestic violence in the home.

The family was offered monetary assistance for the SC's burial, but refused.

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:
No services were provided as the father's whereabouts were unknown and the mother left the country.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
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? N/A
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)	Status/Outcome	Compliance Issue(s)
01/21/2017	Deceased Child, Female, 5 Months	Father, Male, 22 Years	Lack of Supervision	Indicated	Yes
	Deceased Child, Female, 5	Father, Male, 22	Inadequate Food / Clothing /	Unfounded	

Months	Years	Shelter	
Deceased Child, Female, 5 Months	Father, Male, 22 Years	Inadequate Guardianship	Indicated
Deceased Child, Female, 5 Months	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded

Report Summary:
On 1/21/17, the father physically assaulted the mother and when she left the home to seek help, he left the SC unattended. The mother returned to the home with NYPD officers and found the SC alone. The NYPD arrested the father on 1/22/17 and he was charged with assault in the 3rd degree, harassment, and endangering the welfare of a minor.

A full stay away OOP was issued. The mother relocated to CT with the SC to stay with the MA. The father remained at the case address, but ACS was unable to contact him.

On 2/3/17, the SC died; and the fatality was reported to the SCR. The cause and manner of death were unknown.

Determination: Indicated | **Date of Determination:** 03/17/2017

Basis for Determination:
ACS substantiated the allegations of LOS and IG against the father citing that he hit the mother in the presence of the SC and was arrested. Additionally, ACS unsubstantiated the allegation of IF/C/S against the parents citing the family was in the process of moving. ACS also noted the SC was free of marks and bruises and there were provisions for the child in the home. However, CPS observed bags of garbage, old food, and mold in the refrigerator and explained the condition of the home placed the SC's health at risk.

OCFS Review Results:
NYCRO's review found ACS initiated the investigation within the required time frame and assessed the SC to be safe in the care of the mother. ACS made an appropriate decision to seek a legal consultation and was advised there was sufficient information to file an Article 10 Neglect Petition. However, the SC died on 2/3/17 and there were no surviving siblings. ACS did not utilize the information obtained when making the individual determination of allegations for each of the subjects. Based on the documentation, there was some credible evidence to substantiate the allegation of IG but did not do so.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The safety assessment was not completed properly. The safety decision and the comments to support the safety factors selected did not reflect the case circumstances.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination

Summary:
In the investigation documentation, ACS described inadequate conditions of the home and had concerns about health risks these conditions presented for the SC. Based on the case documentation, ACS failed to substantiate the allegation of IF/C/S of the SC by the parents.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

The parents had no CPS history for this time line.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

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.

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

Criminal Charge: Endangering the welfare of a child	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
01/22/2017	Father	Unknown	Unknown
Comments:	N/A		

Criminal Charge: Assault	**Degree:** 3		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Father	Pending	Unknown
Comments:	N/A		

Have any Orders of Protection been issued? Yes	
From: 01/22/2017	**To:** Unknown
Explain: A full stay away OOP was issued after the 1/21/17 domestic violence when the father was arrested. However, ACS did	

not document the issuance or expiration dates.

Additional Local District Comments

N/A

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