Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-026

Prepared by: New York City Regional Office

Issue Date: Aug 29, 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: 2 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 03/12/2017
Initial Date OCFS Notified: 03/12/2017

Presenting Information

On 3/12/17, the SCR registered two reports alleging the 2-year-old SC was visiting the MGM with the mother and the fiancée when for unknown reasons, the SC stopped breathing and had no pulse. The reports alleged the SC regurgitated and had blood coming from her nose. The report stated the SC was left in the lobby with parent substitute while the mother went back inside the building for something. The SC was resuscitated and transported to Beth Israel Hospital where she expired at 7:50 P.M. The report noted there was no clear explanation as to what happened to the the SC.

Executive Summary

The SC was 2 years old when she died on 3/12/17. The autopsy report listed the cause of death was due to cardiac arrhythmia, etiology undetermined (non-traumatic) and the manner of death natural.

On 3/12/17, the SCR registered a report with allegations of DOA/Fatality, Choking/Twisting/ Shaking, and Inadequate Guardianship of the SC by the mother and her fiancée.

The mother was known to the SCR and ACS as a maltreated child. The reports revealed the mother was abused by her parents, was in foster care, suffered from clinical issues and had a history of unstable housing. The mother had three other children, two resided with their respective fathers and one with the MA. ACS assessed these children were safe in their respective homes.

According to the mother, she was in and out of the shelter system since 2009, and on 2/12/17 she was placed at the Saratoga Family Shelter, a shelter in Brooklyn operated by the Department of Homeless Services.

The fiancée did not reside at the shelter and had only been dating the mother for 6 months. Based on the information gathered by ACS, the fiancée was not a person legally responsible as he did not have any child care responsibilities for the SC.

The SC's father, who resided out of state, had contact with the child and provided some financial support.

According to the information gathered by ACS, on 3/12/17 the SC and the mother visited the MGM in Manhattan. The MGM and the MU who were present during the visit reported the SC appeared to be well. The MU said the fiancée came to pick up the mother and the SC to accompany them back to the shelter. When the fiancée arrived at the MGM's home, the mother had stepped out to the store. The fiancée went down to the lobby with the SC to meet the mother. When the mother arrived, she left the fiancée in the lobby with the SC and returned to the MGM's home to use the bathroom. The mother then went to meet the fiancée and the SC in the lobby. After the mother left the home to meet the fiancée, a neighbor knocked on the MGM's door to say there was something wrong with the SC.

According to the mother and the fiancée, while they were in the lobby, the SC began having difficulty breathing. The fiancée called 911 and the mother administered CPR as instructed by the operator. EMS arrived and the SC was resuscitated. The NYPD indicated the building cameras confirmed the account provided by the mother and the fiancée.

The hospital staff reported the SC arrived at the hospital by ambulance at 7:00 P.M. However, continued resuscitation efforts, by the medical staff at Beth Israel Hospital, failed and the SC was pronounced dead at 7:50 P.M.

Neither the medical staff, the ME or the NYPD found signs of abuse on the SC's body.

On 5/30/17, ACS unsubstantiated the allegations of the report against the mother and the fiancée based on the ME's report which determined the cause of death was natural and there were no signs of trauma on the SC's body.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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:
The mother had no children in her care, therefore, the closing of the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The CONNECTIONS event list reflects there was no NOE issued for the SC's father.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
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.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS completed the safety assessment to reflect there were safety concerns, but there were no children in the mother's care. The comments to support the selected safety factors were not relevant to the case circumstances.

Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS completed the safety assessment to reflect there were safety concerns, but there were no children in the mother's care. The comments to support the selected safety factors and not relevant to 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 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: 03/12/2017

Time of fatal incident, if different than time of death: 07:50 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Sitting in a stroller

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age

Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Other Household 1	Mother's Partner	Alleged Perpetrator	Male	34 Year(s)

LDSS Response

After the fatality, the mother was distraught and initially refused to be interviewed by ACS. However, ACS initiated their investigation by contacting the fiancée and other family members to address the allegations of the report.

Based on the information gathered, the fiancée was not a person legally responsible as he had no child care responsibilities for the SC and did not reside in the home.

According to the NYPD, the accounts provided by the mother and the fiancée's were consistent and were corroborated by family members. The NYPD also viewed the security cameras in the building which showed the fiancée picking up the SC from MGM and going down the elevator. The video later showed the fiancée, mother and the SC in the lobby. The mother left the SC in the care of the fiancée while she went to use the bathroom in the MGM's home. The SC began having problems breathing and the fiancée called 911. The mother returned and took the SC from the stroller and began administering CPR until EMS arrived. The NYPD noted food was suctioned out of the SC's airways. The SC was transported to the hospital where she was pronounced dead. The NYPD did not suspect any criminality surrounding this incident and no arrest was made.

The MGM said the mother visited her on 3/12/17 with the SC who appeared fine, playful and happy. The MGM said the SC ate a small bowl of Lo Mein and half of a slice of pizza.

The MGM said the mother usually visited her about twice a week with the SC and the fiancée would then come to pick them up to take them to the shelter. The MGM said at the time the fiancée arrived the mother was at the store. Therefore, the fiancée went down to the lobby with the SC to wait for the mother. The MU and the MGM reported the SC was happy and ran towards the fiancée when he arrived. They said the SC was not fearful of the fiancée and they did not suspect he would do anything to hurt the SC.

ACS contacted the ME, hospital medical staff, the SC's pediatrician and none reported any signs of trauma, abuse, or maltreatment of the SC.

The case manager (CM) from the Saratoga Shelter indicated the mother was cooperative in keeping her appointments and adhered to the shelter's curfew. The mother also kept her room in good condition and there were no issues concerning her ability to care for the SC. The CM indicated the mother was referred for a clinical evaluation based on her disclosures. ACS later obtained a copy of the evaluation. On 3/29/17, the mother was interviewed and reported she was not in treatment.

ACS interviewed the SC's father who said he had no concerns about the mother's fiancée. The father noted he had some concerns about the mother's mental state as in January 2017, she left the SC at a local precinct and then ran towards the east river to hurt herself. The father said the mother was admitted to the hospital and the fiancée contacted him to pick up the SC. The father stated he cared for the SC for about two months until the mother was discharged from the hospital. The father said the mother picked up the SC from his home to take the SC to an appointment, but never returned the child. The father explained he wanted to file for custody of the SC, but had not signed the birth certificate. He also worried that a paternity test could reveal he was not the biological father and the mother would then refuse to have him contact the child.

On 5/30/17, ACS unfounded the report.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

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
039721 - Deceased Child, Female, 2 Yrs	039723 - Mother's Partner, Male, 34 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
039721 - Deceased Child, Female, 2 Yrs	039723 - Mother's Partner, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated
039721 - Deceased Child, Female, 2 Yrs	039722 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
039721 - Deceased Child, Female, 2 Yrs	039722 - Mother, Female, 27 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
039721 - Deceased Child, Female, 2 Yrs	039723 - Mother's Partner, Male, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
039721 - Deceased Child, Female, 2 Yrs	039722 - Mother, Female, 27 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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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	☒	☐	☐	☐

Explain:
The SC was the child in the mother's care. There were three surviving siblings who ACS assessed to be safe in the care of their respective fathers and a MA. There were no surviving siblings residing in the home with the BM.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐

Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The siblings' fathers and MA were offered bereavement services, but declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother and caretakers were offered bereavement services, but declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

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

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

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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