Child Fatality Report

Report Identification Number: NY-19-061

Prepared by: New York City Regional Office

Issue Date: Nov 29, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Still Born
Age: Unknown
Jurisdiction: Queens
Gender: Male
Date of Death: Unknown
Initial Date OCFS Notified: 06/01/2019

Presenting Information

The report alleged that on 6/1/19 the mother seemed to be having a miscarriage and 911 was called at about 11:00 A.M. EMS responded to the home and transported the mother and the alleged father to the hospital. At about 2:00 P.M., NYPD and EMS returned to the home after being notified by the hospital staff that the mother had given birth. An active search for a newborn ensued, and the body of a male child was found in the family's bathroom. The report alleged the parents were the sole caregivers of the newborn, and they were unable to provide an explanation for the circumstances surrounding the death of the newborn. The sibling was in the custody of the NYPD and the parents were at the hospital.

Executive Summary

On 6/1/19 the SCR registered a report with allegations of DOA/FATL and IG against the parents based on the information that the mother delivered a full-term child in the home and when she arrived at the hospital she did not have the newborn with her. The body of the newborn was later found. However, by 6/3/19 the ME preliminarily determined the mother had delivered a stillborn fetus; this was later confirmed to be true.

The parents resided in an unfinished basement with their 2-year old child in the private home of the paternal great grandmother (PGGM). The PGGM and the paternal grand cousin (PGC) resided on the upper levels of the home.

The parents were not known to ACS as subjects of any report or to the Family Court system. They had no criminal history or domestic incidents reports (DIRs) registered with the NYPD

On 6/1/19, ACS' Emergency Children Services (ECS) initiated the investigation and assessed the 2 yo child to be in immediate danger of serious harm based on the alleged death of "a child" and the conditions of the basement. ECS conducted an emergency removal, had the 2 yo medically cleared and placed her with A PGA. None of the collaterals revealed any safety concerns about the care the 2 yo received from the parents. In addition, the parents had strong support from the paternal relatives and the father was observed to interact appropriately with the 2 yo.

On 6/3/19, ACS' Queens Field Office (QFO) filed an Article 10 Neglect Petition at the Queens County Family Court (QCFC) on behalf of the 2 yo naming the parents as the respondents. The QCFC judge granted the remand for the 2 yo and issued OOPs against the parents. The QFO did not conduct an adequate evaluation for the removal and did not present factual information in the initial court action summary. ACS misrepresented the family's circumstances as they referred to the fetus as a child and used this information to justify the failure to make diligent efforts to consider a broad range of safety-oriented responses, other than removal, to protect the child without requiring CPS to take protective custody. At the time ACS filed the petition, the child was in the care of the PGA who was cleared, and her home was assessed to be safe; this could have been considered as a safety plan. The imminent risk of harm pertaining to the 2 yo was based on the condition of the home, not on the death of a sibling.

ACS did not properly complete the safety assessments during this investigation and did not provide OCFS with a basis for pursuing the remand of the child. ACS had not approved the RAP and modification to their responses was needed.

On 10/7/19, ACS received confirmation from the ME which indicate the mother delivered a stillborn full-term fetus; yet, there was no documentation to indicated that ACS corrected the information they had provided to the QCFC.

The child remains in kinship placement and is adjusting well. The foster parents have worked to include the parents in all decisions pertaining to the child regarding her education and all other related services.

At the time of the writing of this report, ACS had not made a determination of this report.

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?** No
  - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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

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 case remained open for foster care services.

Required Actions Related to the Fatality

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

Issue:	Adequacy of case planning
Summary:	..
Legal Reference:	18 NYCRR 432.2 (b)(2)
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 selected a safety decision which noted the sibling was in immediate danger of serious harm but chose safety factors that did not apply to the family's circumstances. ACS provided a non-related comment to support their selection.
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 30-Day Safety Assessment
Summary:	This assessment was not completed timely and was repetitive with the incorrect safety decision.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
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:	Overall Completeness and Adequacy of Investigations
Summary:	The overall investigation reflected a clear disregard of the information gathered, no updates to correct erroneous information, and there were no directives to properly reassess the family's circumstances.
Legal Reference:	SSL 424.6 and 18 NYCRR 432.2(b)(3)
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:	Adequacy of Progress Notes
Summary:	ACS' documentation in their progress notes did not reflect that crucial details of the investigation provided by collaterals were shared with others involved in the investigation and/or the CP.
Legal Reference:	18 NYCRR 428.5
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:	While timely, the SA was not adequately completed as the safety decision was incorrect and should have been modified based on new information obtained.
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.
Issue:	Adequacy of Child Protective Services casework contacts
Summary:	ACS made some relevant casework contact, but failed to use relevant information properly, which led to poor decisions and recommendations throughout the investigation. This led to a service plan that has not focused on the family reunification goal.
Legal Reference:	432.2(b)(4)(vi)

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:	Assessment as to need for Family Court Action
Summary:	ACS did not follow protocol and misrepresented the family's circumstances as it referred to the fetus as a live child. ACS used erroneous information to justify the failure to make diligent efforts to prevent the removal of the child.
Legal Reference:	SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
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:	Appropriateness and adequacy of child's foster care placement
Summary:	ACS did not justify the need for a removal and or foster care placement as they did not make diligent efforts to consider other safety responses.
Legal Reference:	18 NYCRR 430.11(c) or (d)
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:	Adequacy of Documentation of Safety Assessments
Summary:	The documentation of all the safety assessments revealed there was not a clear understanding of the safety instrument. In addition, they contained irrelevant and fictitious information, yet they were continuously approved.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
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

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	27 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	28 Year(s)

LDSS Response

ACS initiated the investigation by contacting the hospital, NYPD and interviewing the family members.

On 6/1/19, ECS observed the father's interaction with the child was appropriate. The father said he worked until 12:30 A.M. on 5/31/19 and when he arrived at the home, the mother was in pain, complained about severe cramps, and asked for him to apply cold compresses. The father said the mother's pain worsened, but she did not want to go to the hospital. The father said at approximately 10:00 P.M., the mother went to take a shower and he noticed there was a brown spot on the bed that appeared to be dried blood. He said he entered the bathroom and noticed there were blood spots on the floor, but the mother said she was having "stomach problems" and again refused to go to the hospital. The father said based on the mother's bleeding he was convinced she was having a miscarriage and called 911. The father said at the hospital he was informed the mother had a placenta, but no child. The father said he was in shock as he had not witnessed the mother's delivery and was unaware the mother was pregnant as they did not have an intimate relationship. According to the father, he and the mother separated, and she had recently returned to the home. They decided to live together to co-parent their child as the mother had no place to stay and was unemployed. The father said the mother was a good parent and took good care of the child.

The PGGM and the PGC corroborated the father's account and stated the mother had not informed anyone she was pregnant. They also stated the mother was "heavyset" and there was no physical indication that she was pregnant. ACS assessed the PGGM's home and there were no safety factors noted. The NYPD deemed the basement a crime scene and reported the home was "deplorable." ACS removed the child from the parents care but made no effort to explore with the PGGM the possibility of allowing the family to stay with her temporarily pending further investigation. The child was observed to be free of marks or bruises and was medically cleared.

The mother reported she delivered the baby while in the shower; the baby did not cry, move, or breathe. The umbilical cord was not attached and she picked up and held the body for a few minutes. The mother said she did not know what to do, so she wrapped the body in a shirt and placed it under the bathroom sink. The mother said she was alone in the bathroom and did not tell anyone about the incident; however, she continued to bleed and to feel dizzy. The mother said the father entered the bathroom and tried helping her to shower, but she was unable to stand, therefore, he called 911. The mother said she had not received pre-natal care because she had only decided to keep the baby a month prior to the incident. The mother said she did not tell anyone in the home of the location of the body.

ACS spoke to the police officer (PO) who responded to the 911 call which indicated the mother was having a miscarriage. The PO said at 11:25 A.M. upon arrival at the case address officers went to the basement apartment where they met the father and assessed the mother was alert and breathing. The PO stated once EMS arrived the mother was transported to the hospital. During the medical examination, doctors found an umbilical cord, but no child. Two hours later, the NYPD was contacted by EMS and they returned to the home to locate the child. The PO said they searched the basement and found the approximately 6lbs, full-term male child under the bathroom sink. ACS was informed there was no evidence pertaining to the presence of drug use. The result of the mother's 6/1/19 drug screening was negative.

On 6/12/19, the ME's primary verbal report indicated the mother's delivered a stillborn fetus. However,
ACS did not inform Family Court of this information and the removal of the family's only child was predicated on the death of the fetus.

ACS has not yet determined this report.

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No

Comments: There was no documentation of a MDT investigation; however, the investigation adhered to previously approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: This was a stillborn.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050332 - Deceased Child, Male, 0 Days	050333 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Pending
050332 - Deceased Child, Male, 0 Days	050334 - Father, Male, 28 Year(s)	Inadequate Guardianship	Pending
050332 - Deceased Child, Male, 0 Days	050334 - Father, Male, 28 Year(s)	DOA / Fatality	Pending
050332 - Deceased Child, Male, 0 Days	050333 - Mother, Female, 27 Year(s)	DOA / Fatality	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS determined the 2 yo could not be interviewed.

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 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?	☐	☐	☒	☐
Explain: The 24 hour safety assessment reflected an incorrect safety decision that led to the removal of the 2 yo child.				

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 condition of the home did not required foster care services. The family should have been provided with other options such as moving to the PGGM's home, temporary voluntary placement.				

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS filed for a remand and it was granted; however, the information presented in Family Court was not accurate as there was no fatality. The condition of the home presented a danger of serious harm, but the family was not offered a safety plan and/or services.

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:**
06/05/2019	There was not a fact finding	There was not a disposition
Respondent:	050333 Mother Female 27 Year(s)	
Comments:		

Have any Orders of Protection been issued? Yes	
From: 06/05/2019	**To:** Unknown

Explain:
ACS requested an OOP against the parents on behalf of the sibling.

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	☐	☐	☐	☐	☐	☒	☐

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

The parents had no CPS history.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

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