NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-008 **Prepared by: New York City Regional Office**

Issue Date: 7/24/2015

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 Deceased
Age: 3 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 01/25/2015
Initial Date OCFS Notified: 01/25/2015

Presenting Information

On 1/25/15, the SCR registered a report alleging that the three-month-old child died while in the father's care. The report stated that on the morning of 1/25/15, the child was coughing up blood. The father attempted CPR and at 3:18 A.M. called 911. At approximately 3:30 A.M., EMS and the NYPD arrived at the case address and found the child unconscious with cloudy and discolored eyes. The child had a bruised and distended belly, which was indicative of trauma to the infant's abdomen. The report noted that the father's explanation for the circumstances surrounding the child's death were inconsistent, which made the death suspicious. The child was transported to Jamaica Hospital and pronounced dead at 4:01 A.M. The mother was not home at the time of the incident; however, was en route to the hospital.

Executive Summary

The SC was three months old when he died on 1/25/15. An autopsy was performed; however, the results are pending. The ME has not provided a preliminary cause and manner of death.

On 1/25/15, the SCR registered a report alleging that the SC was coughing up blood and became unresponsive while in the care of the BF. EMS and the NYPD found the SC unconscious with blood around his mouth, and with discolored and cloudy eyes. The SC had a bruised and distended belly, indicative of trauma to the abdomen. The allegations of the report were DOA/Fatality and Inadequate Guardianship of the SC by the BF.

In this split level home, the MGM, MU and a 11-year- old FC resided on the main level. The BM had recently moved to the 3rd floor which was cluttered, but contained a crib for the SC. ACS observed there were several items in the crib; however, the BM denied they were present when the SC slept.

The MGM was in South Carolina at the time of the incident. ACS completed an assessment of the FC and ascertained that the FC was left with an appropriate caregiver. ACS' initial interviews with the MGM, MU and MGM's foster child (FC) indicated that at about 2:00 A.M. on 1/25/15, the MGM noticed via a dropcam (digital home monitor with camera and speaker) that the FC was awake. The MGM also heard noises and movement coming from the 3rd floor which was occupied by the BM. The MGM was aware that the BM was not home and became concerned. She told the FC to tell the MU to check the SC. The FC relayed the MGM's message and the MU immediately ran to the 3rd floor to check the SC. There was no one on the 3rd floor. The MU went to the main floor of the home and saw the BF holding the SC who was unresponsive. The MU took the SC and began to rub the SC's back and chest. The MU indicated that at that point, the SC took one last breath.

The BF called 911 at 3:21 A.M. EMS arrived at the case address at 3:23 AM. EMS found the SC in the BF's arms; no one was administering CPR. The SC was stiff, had no pulse and was not breathing. EMS attempted to resuscitate the SC, and then transported him to Jamaica Hospital where he was pronounced dead at 4:01 AM.

The BM reported that she left the home at about 9:45 P.M. on 1/24/15, to spend time with her friends. At approximately 2:45 A.M., she received a call from the MGM concerning the noises coming from the 3rd floor. The

BM showed ACS texts to that effect. The BF called the BM at 3:19 A.M.; and said that he thought something was wrong with the SC and that the SC was unconscious. The BM said she told the BF to call 911, but he did not know their home address. The BM's friend, who was with the BM, called 911. The BM arrived at the hospital as the medical staff were attempting to revive the SC; she was later informed that the SC died.

The BF reported to the NYPD and EMS that he was holding the SC, when the SC began coughing up blood and then stopped breathing. The BF reported that he performed CPR for thirty minutes prior to calling 911. Medical staff indicated that this would be a long time to perform CPR on a child. There was no additional information obtained from the NYPD. ACS attempted to interview the BF several times, but he refused to discuss the incident. ACS later learned that the BF relocated to New Jersey.

The medical staff noted the child's body temperature was 85 degrees Fahrenheit when he arrived at the hospital. The SC also had a distended stomach and rectal bleeding, which the medical staff noted was indicative of some type of trauma. However, the ME's preliminary examination was inconclusive. The SC appeared well cared for and had no outward signs of trauma. The NYPD made no arrest pending the results of the autopsy report.

ACS completed an assessment of the FC and ascertained that he was left with an appropriate caretaker. The FC was deemed safe in the home of the MGM.

As of 7/21/15, ACS has not made a determination.

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?** 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

Explain:
N/A

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS has not made a determination.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The collateral contacts with the NYPD and the ME's Office did not focus on obtaining relevant information concerning the details of the SC's death or establishing a timeline of events.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to provide notice of report
Summary:	The CONNECTIONS event list does not reflect that a Notice of Existence was issued for the parents.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action 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: 01/25/2015 **Time of Death:** 04:01 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: 03:18 AM
Did EMS to respond to the scene? Yes
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 2
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:

Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	22 Year(s)
Other Household 1	Grandparent	No Role	Female	56 Year(s)
Other Household 1	Other	No Role	Male	11 Year(s)

LDSS Response

The BM resided on the 3rd floor of the MGM's home with the SC. The BF had moved into the home two weeks prior to the incident. The MGM resided with a MU and a foster child (FC) on the main levels of the home. The MGM was in South Carolina at the time of the incident. The MGM had a dropcam installed in the home, which allowed her to communicate with the FC.

On 1/24/15, the BM left the home at about 9:45 P.M. to spend time with her friends and left the SC with the BF. At about 2:00 A.M. on 1/25/15, the MGM noticed via the dropcam that the FC who slept on the 2nd floor was awake. She also heard noises coming from the 3rd floor. The MGM told the FC to have the MU check the SC. The FC related the MGM's message to the MU; and he immediately ran upstairs to check the 3rd floor.

There was no one on the 3rd floor. The MU then went to the main floor of the home and saw the BF holding the SC who was unresponsive. The MU took the SC and began to rub the SC's back and chest. At that point, the SC took one last breath. The EMS were called and the SC was transported to the Jamaica Hospital.

EMS received two 911 calls. The first call was received at 3:18 A.M. from a third party caller who was not at the case address. The caller stated that the SC was not breathing. The second call was received at 3:21 A.M. from the BF who indicated that the SC was not responsive. EMS arrived at the case address at 3:23 AM., and found the SC in the BF's arms and no one was administering CPR. The SC was stiff, had no pulse and was not breathing. EMS administered CPR and transported the SC to Jamaica Hospital where he was pronounced dead at 04:01 AM. ACS did not ask for an explanation of the delay with calling 911. The EMS team described the BF as calm, but he refused to go in the ambulance with the SC.

The BF reported to the NYPD and EMS that he was holding the SC, when the SC began coughing up blood and then stopped breathing. The BF reported that he performed CPR for thirty minutes prior to calling 911. The EMS' liaison indicated that this would be considered a long time to perform CPR on a child. ACS attempted to interview the BF several times, but he refused to discuss the case.

The medical staff noted the child's body temperature was 85 degrees Fahrenheit when he arrived at the hospital. Based on the father's account, the medical staff noted the child's temperature should have been higher. The SC also had a distended

stomach and rectal bleeding, which the medical staff noted that was indicative of some type of trauma. The ME had concerns about the distended stomach and rectal bleeding; however, the preliminary examination was inconclusive. The child appeared well cared for and had no outward signs of trauma. The NYPD made no arrest. The criminal investigation remains open pending the results of the autopsy report.

The BM contacted the BF and put him on a three-way call with ACS on the line. She asked him to give her a detailed account of the events leading to the SC's death.

The BF said the SC was asleep and was fine when he awoke. According to the BF, the SC began to cough and he picked him up. The BF put him down and the SC continued coughing. The BF said the SC's facial expression changed and the SC "gave out." When the BM asked why the BF did not call the police, he said that he only thought of reviving the SC. The BF reported that he administered CPR for about fifteen to twenty minutes. The BF's account did not mention that the SC was coughing up blood. The BF did not provide a timeline, location or details.

ACS assessed the MGM's FC to be safe in the home. The case planner from the foster care agency and school staff had no concerns about the care he received from the MGM. In addition, it was confirmed that the MU was cleared as the FC's back up caregiver.

ACS' investigation determination is pending the results of the autopsy report.

Official Manner and Cause of Death

Official Manner: Unknown
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: 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
014364 - Deceased Child, Male, 3 Mons	014366 - Father, Male, 28 Year(s)	DOA / Fatality	Pending
014364 - Deceased Child, Male, 3 Mons	014366 - Father, Male, 28 Year(s)	Inadequate Guardianship	Pending
014364 - Deceased Child, Male, 3	014365 - Mother, Female, 28	DOA / Fatality	Pending

Mons	Year(s)		
014364 - Deceased Child, Male, 3 Mons	014365 - Mother, Female, 28 Year(s)	Inadequate Guardianship	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:

The BF was not interviewed face-to-face; however, he was interviewed by police and provided information regarding the incident that led to the child's death.

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: No.							

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 immediate needs. The SC was that parents' only child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs. The SC was the parents' only child.

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

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

There is no CPS investigative history 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 parents had no CPS history outside 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

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.

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement 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