Child Fatality Report

Report Identification Number: NY-16-131

Prepared by: New York City Regional Office

Issue Date: May 30, 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	

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	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-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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 12/16/2016
Initial Date OCFS Notified: 12/16/2016

Presenting Information

The night of 12/16/16 the SM, SF, 10-year-old SS, and SC traveled in the SF's semi-truck to a store for the SF's work delivery. At such delivery location, the SM and SF left the SS and SC unattended, on a bed in the back part of the truck cab for approximately 2-3 hours while the parents unloaded the truck. The SM went back inside the truck to change SC's diaper and noticed the SC was unresponsive. SC was reportedly a healthy child who perished in the care of the parents on 12/16/16 for unknown reasons. The cause of death was unknown. The SS had an unknown role.

On 12/16/16, the SF made a delivery to New York from the State of Connecticut with his family, SM, SS, SC traveling in the truck with him. The SF pulled over and when the SM went to change the SC's diaper the SM found the SC unresponsive. The SM and SF contacted emergency services. The police arrived and CPR was performed on the SC; however, the child was still unresponsive.

Executive Summary

The 1-year-old SC died on 12/16/16. As of 5/30/17, NYCRO has not received the ME report.

The allegations of the 12/16/16 report were DOA/Fatality, LS and IG of the SC by the SM and SF.

ACS documentation reflected that the SC was found unresponsive while sleeping in the back of an 18 wheeler truck on 12/16/16. On 12/17/16, the attending Dr. stated that the SM said the SC sleeping when she found the SC unresponsive the SM called 911. The attending Dr. stated the attempts to resuscitate the SC were unsuccessful. ACS learned that LE found the SC cold to touch when they arrived at the scene. LE transported the SC to the hospital and administered CPR and other rescue techniques. ACS documented that the SC arrived at the New York Presbyterian Hospital at 8:56 p.m. DOA. The SC was declared deceased at 9:17 p.m.

On 12/17/16, ACS made face-to-face contact with subject family at the New York Presbyterian Hospital ER. The SM and SF provided ACS with a time line of events which showed the SM took a cab with the subject children from Connecticut (CT) to New York to spend a day with the SF. The SF was reportedly a truck driver. The SM assisted the SF in unloading his work truck. The SM said she periodically checked the SC and SS; who were in the back cabin of the truck watching movies. According to the parents, the SC fell asleep around 6:30 p.m. The SM changed the SC's diaper between the 8:00 p.m. to 8:45 p.m. and noticed the SC was unresponsive. SM reportedly performed CPR while the SF called 911.

ACS made phone contact with the Medical Investigator (MI) who had examined the SC. The MI observed no signs of trauma to the SC's body. The MI concluded that the cause of death was undetermined at the time.

According to ACS, the hospital social worker (SW) reported unsuccessful attempts to interview the SM and SF because the detectives were conducting the police investigation. The SW informed ACS that SM, SF, SC and SS lived in CT. The SW said that the SM, SC, and SS took a cab to NYC so that the children could spend time with the SF.

ACS made phone contact with the Manchester Connecticut Department Children and Family Services (CT DCF) in order to coordinate the transport of SS back to CT. The ACS staff learned that the SS was temporarily living with the MGF and would be transported to CT to live with the MGM. ACS learned that the subject family resided with the MGM in CT.

ACS conducted an Initial Child Safety Conference (ICSC) and determined Family Court intervention was not needed. ACS recommended bereavement counseling for the MGF. ACS documented that bereavement counseling for SM, SF and SS would be provided by CT DCF.

According to the ACS case record, a safety agreement was put in place to exclude the SM from the home and place the SS with the MGM. On 2/15/17, ACS learned that the CT DCF did not indicate the case against the SM and SF. ACS learned that the SM was no longer excluded from the MGM's home. There were no surviving children in NYC.

On 3/16/17, ACS made collateral contact with the ME to obtain the autopsy report and learned that the report was pending. As of 5/30/17, ACS has not yet determined the 12/16/16 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?** Yes
  - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** 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:
As of 4/17/17, the investigation has not yet been determined.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Unable to Determine

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

Explain:
As of 4/17/17 the ACS investigation has not yet been completed.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS did not complete the 24-hour assessment within the required timeframe. The report was dated 12/16/16 and the 24-hour assessment was completed and approved on 12/19/16.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	The Administration for Children's Services (ACS) must submit a performance improvement plan within 45 days that identifies what action it has taken, or will take, to address the citation identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/16/2016 **Time of Death:** 09:16 PM

Time of fatal incident, if different than time of death: 08:45 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 08:45 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? No - but needed
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		1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)

LDSS Response

The ACS Instant Response Team initiated the investigation on 12/17/16. Upon arrival at the hospital, ACS learned that on 12/16/16, the SM was helping the SF unload his truck and when the SM went back to the truck to change the SC's diaper she found the SC was unresponsive. ACS learned that the SC arrived at the hospital at 8:59 p.m. and was pronounced deceased at 9:17 p.m. LE reported that the SC had blood in her nose and mouth.

On 12/17/16 ACS made collateral phone contact with the New York Presbyterian Hospital attending Dr. who said the SC was found unresponsive in an 18-wheeler truck. ACS documented that the SC was sleeping while in the truck. The Dr. said the SM called 911 and NYPD attempted CPR. The SC was transported to the Presbyterian Hospital where she was cold to touch.

ACS spoke with the Medical Investigator (MI), who examined the SC and found no signs of trauma to the SC's body. ACS made phone contact with the hospital social worker and LE. ACS learned that the subject parents appeared distraught. The social worker said that the subject family was from Connecticut (CT). According to the reports of LE, CT DSS was contacted and there was no child welfare history regarding the subject family.

On 12/17/16, ACS conducted a clearance of SM and SF which revealed no prior history. ACS conducted a home assessment and data base clearances for the MGF, discussed the terms and provisions of an Emergency Home removal, and contacted the CT DSS to pick up the SS to return him to CT. ACS staff interviewed an attending Dr. who said the SS was healthy and ready for release to the MGF. The ACS Specialist consulted with the Investigative Consultant who reported the subject family had no history in New York.

The ACS Specialist documented that an interview with the SS did not take place at the hospital because he appeared to be in a fragile state. The ACS Specialist noted observing several family members at the hospital; ACS was unable to interview the family members because they were grieving.

On 12/18/16, at approximately 1:46 p.m., ACS visited the NYC Child Advocacy Center (CAC). The SS was interviewed by LE, ACS and MD staff. During the CAC interview of the SS, ACS learned that the SS did not remember the incident that occurred. The SS was able to tell the Specialist that the SM attempted CPR and the SF called 911.

On 12/19/16, ACS made collateral contact with the Manchester Connecticut Department Children and Family Services in order to coordinate the transport of SS back to CT. ACS transported SS to Bridgeport Connecticut Police Department where ACS met the MGM and CT DCF worker on 12/20/16. ACS released the SS to the MGM and CT DCF worker.

On 12/23/16, ACS held an Initial Child Safety Conference (ICSC) and determined court intervention was not needed.

On 2/15/17, ACS learned that the CT DCF would not indicate the case against the SM and SF. ACS learned that the SM was no longer excluded from the MGM’s home. ACS documented there were no surviving children in NYC and the family continued to reside in Connecticut.

ACS opened the Family Service Stage (FSS) on 12/22/16. The Family Services Progress Notes and the Investigation Progress Notes reflected that ACS made collateral contact with the ME to obtain the autopsy report on 3/16/17. ACS learned that the report was pending. ACS has not made a determination on this report.

Official Manner and Cause of Death

Official Manner: Pending
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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
036541 - Deceased Child, , 1 Yrs	036544 - Father, Male, 30 Year(s)	DOA / Fatality	Pending
036541 - Deceased Child, , 1 Yrs	036543 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Pending
036541 - Deceased Child, , 1 Yrs	036544 - Father, Male, 30 Year(s)	Inadequate Guardianship	Pending
036541 - Deceased Child, , 1 Yrs	036544 - Father, Male, 30 Year(s)	Lack of Supervision	Pending
036541 - Deceased Child, , 1 Yrs	036543 - Mother, Female, 30 Year(s)	DOA / Fatality	Pending
036541 - Deceased Child, , 1 Yrs	036543 - Mother, Female, 30 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐
Case Planners	☐	☐	☐	☒
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?	☒	☐	☐	☐

Additional information:
ACS did not obtain official records of the children's medical history.

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 safety 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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐

Explain as necessary:
On 12/17/16 ACS made collateral phone contact with the MGF who said he wanted to be a relative resource for the SS. ACS staff visited the MGF's home to make an assessment. ACS advised the MGF about the protocol for releasing surviving children into the care of a relative. ACS found that the home was adequate. The SS was picked up by ACS and released to the MGF's care. ACS documented that the SS resided with the MGF until CT DCF made arrangements to transport SS back to CT.

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:
ACS spoke with CT DCF. The SS was referred to bereavement counseling in the community. ACS did not document referral of services for SM and SF.

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:
ACS spoke with CT DCF, and learned there was no reported participation in services prior to the fatality. The SS received bereavement counseling in the community.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The ACS Specialist did not document in the case record whether the SM and SF were engaged in services to address their immediate needs related to the fatality.

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 was no CPS History more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS. ACS notified the Connecticut Department of Children and Family Services of the SC's death.

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