Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-17-051

Prepared by: New York State Office of Children & Family Services

Issue Date: Jun 01, 2018

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: Monroe
Gender: Female
Date of Death: Unknown
Initial Date OCFS Notified: 12/31/2017

Presenting Information

On a daily basis, the father and grandmother would physically assault the mother to the point that she was covered in bruises on her body. This would occur while the 2-year-old child was in the home. There were no known injuries to the 2-year-old. The father and grandmother kept the mother captive in the home and did not allow her to leave. On 12/31/17, the father and grandmother physically assaulted the mother, and at 7PM, during the assault, the mother went into labor and gave birth to a baby girl. The father and grandmother proceeded to assault the mother during delivery and following the child's birth. The mother was kept separated from the baby during this time. The baby was discovered deceased at 9:05PM on 12/31/17.

Executive Summary

This fatality report concerns a child who was stillborn on 12/31/17. A report was made to the SCR on the same date regarding the newborn's alleged death. The mother lived in the home with her 2-year-old son and his father (who she was no longer in a relationship with), the paternal grandmother and her husband. There were also concerns the mother had been physically assaulted in the presence of her 2-year-old son by the child's father, the father's girlfriend, the paternal grandmother, and the paternal grandmother's husband (with whom she lived). The 2-year-old child was the only child living in the home.

Monroe County Department of Human Services (MCDHS) coordinated efforts with LE upon receipt of the fatality report. MCDHS and LE performed joint interviews and LE supplied the caseworker with all relevant documentation and information obtained during interviews. The record did not reflect if criminal charges were pursued as a result of the assault on the mother.

The mother reported that on 12/31/17, she'd been physically assaulted in the presence of her 2-year-old son by the father of the 2-year-old, the father's girlfriend, the paternal grandmother and the paternal grandmother's husband. The mother was then pushed down a set of stairs into the basement. Once she could stand, she pulled herself up to sit on a stool. The mother said this is when she felt something fall down her leg, which was the stillborn child. The mother denied knowing she was pregnant. All the adults living in the home denied knowing the mother was pregnant. The mother was later assessed to have been approximately 32 weeks pregnant. The mother called for help from the basement and eventually was assisted in bringing the child upstairs. 911 was not called until approximately 2 hours later. There was a delay in calling 911 as the paternal grandmother said she was afraid and didn't know what to do. When EMS arrived, they did not observe the child to be alive at any point. The mother was transported to the hospital due to the injuries she sustained that day. Subsequently, the 2-year-old child was removed from the home and placed in foster care for a week until the mother was discharged from the hospital and able to care for him.

MCDHS gathered information about the stillbirth from EMS, LE, the hospital, the mother, and relatives. MCDHS spoke with all first responders, LE, and hospital staff regarding the events of that day.

MCDHS offered the mother services such as mental health counseling and a domestic violence advocate.

An autopsy was performed and the medical examiner concluded the child's stillbirth was due to prematurity.

During the investigation MCDHS did not complete a CPS history check within one day, complete the 24-hour fatality

report within 24 hours, complete the 24-hour safety assessment within 24 hours, and some progress notes were not entered contemporaneously.

MCDHS made the appropriate determination and indicated the allegations of Inadequate Guardianship against the father of the 2-year-old, the paternal grandmother, and the paternal grandmother's husband. MCDHS discovered the father's girlfriend was 17 years old and did not live in the home, therefore she was not added to the report and no allegations were made against her. The allegation of DOA/Fatality was unsubstantiated as the child was not deemed to have been alive upon delivery or any time after.

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?** Yes
- **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?** 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? N/A

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

Was there sufficient documentation of supervisory consultation? No

Explain:
The level of casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour fatality report should have been completed by 1/1/18 and was not done until 1/4/18 and not approved until 1/5/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	24-hour Fatality Reports must be completed within 24 hours of receipt of a report.

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour safety assessment was completed three days late.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	24-hour safety assessments will be completed within the first 24 hours upon receipt of a fatality report.

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Several progress notes were not entered contemporaneously to the event date (more than 30 days after).
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:	Review of CPS History
Summary:	CPS history was not reviewed until 10 days after receipt of the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	Within 1 business day of the oral report date, the child protective service must review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded and FAR reports where the current report involves a subject of the unfounded or FAR report, a child named in the unfounded or FAR report or a child's sibling named in the unfounded or FAR report.

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	Female	
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	50 Year(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	55 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	23 Year(s)

LDSS Response

On 12/31/17, MCDHS received the fatality report from the SCR. MCDHS initiated their investigation within 24 hours and coordinated efforts with LE. MCDHS contacted the source of the report, completed a CPS history check, and notified the ME and DA of SC's stillbirth. There was a 2-year-old surviving sibling living in the home.

BM stated she had not left the home in over a year and did not know she was pregnant. BM said that throughout the day on

12/31/17, she had been physically assaulted by her ex-boyfriend, his new girlfriend (GF), the PGM and PGM's husband. BM said as she was about to walk down the stairs to the basement, she was hit in the back with a shovel and fell down the stairs. She eventually stood up, sat on a stool for a few minutes and then felt something fall down her leg and it was the baby. BM said the baby never took a breath or moved. She said she called out for help and finally the PGM and GF came downstairs to help. PGM put the baby in a towel and brought the baby upstairs. All the adults living in the home reportedly never saw the baby take a breath or move. The family waited 2 hours before calling 911. The 2-hour delay in calling 911 was because PGM feared what would happen and did not want anyone calling 911. The 911 call was received around 9PM.

MCDHS spoke with all first responders on scene and they reported they did not witness the child to be alive at any point. When BM was being transported to the hospital, she told EMS workers about the physical abuse she suffered at the hands of the other members of the home. She also told them she was scared to go back home and was concerned for her 2yo child who was still in the home.

BM was admitted to the hospital due to extensive injuries she suffered as the result of physical abuse by the other household members. BM was very dehydrated, had bruising all over her body in various stages of healing, rib fractures, and a lower spinal fracture. A doctor said her injuries were not consistent with a ground level fall. She was not under the influence of any substances upon her arrival to the hospital. BM disclosed the physical abuse happened in front of her 2yo son. BM also disclosed the BF, PGM, and PGM's husband would drink alcohol and smoke marijuana to the point of impairment while caring for the 2yo. They would not let BM touch the 2yo or care for him.

MCDHS arrived at the home to assess the safety of the 2yo child. The child appeared comfortable in the care of the PGM. The child did not have any obvious marks or injuries. CW tried getting the child to engage with CW and the child would not. PGM, PGM's husband, and the BF of the 2yo all denied physically assaulting BM. PGM said the BM lies.

The ME confirmed the child's stillbirth was due to prematurity. BM was suspected to have been approximately 32 weeks pregnant.

LE informed MCDHS that GF disclosed PGM and her husband assaulted BM and the PGM's husband struck BM in the back with a shovel, causing her to fall down the stairs. Another relative also came forward and said she was aware of the physical abuse BM suffered.

While BM was in the hospital recovering from her injuries, she signed a consent for removal of the 2yo child. The child was placed in foster care on 1/9/18 and returned to BM on 1/16/18 when she was discharged from the hospital. A neglect petition was filed against the 2yo's father.

BM believed the father of the stillborn child was a man she had a brief relationship with; he was not contacted.

MCDHS provided BM with information on mental health counseling and a domestic violence advocate.

The record does not reflect if LE pursued criminal charges against the adults who assaulted BM. The allegations of DOA/Fatality, Fractures, and IG were unsubstantiated as the child was not born alive. The allegation of IG was substantiated against the 2yo's BF, PGM and her husband for physically assaulting BM in front of the child. The case was indicated and opened for CPS services on 3/4/18.

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046021 - Deceased Child, Female,	046025 - Unrelated Home Member, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
046021 - Deceased Child, Female,	046025 - Unrelated Home Member, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
046021 - Deceased Child, Female,	046025 - Unrelated Home Member, Male, 23 Year(s)	Fractures	Unsubstantiated
046021 - Deceased Child, Female,	046024 - Unrelated Home Member, Male, 55 Year(s)	Inadequate Guardianship	Unsubstantiated
046021 - Deceased Child, Female,	046023 - Grandparent, Female, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
046021 - Deceased Child, Female,	046024 - Unrelated Home Member, Male, 55 Year(s)	DOA / Fatality	Unsubstantiated
046021 - Deceased Child, Female,	046023 - Grandparent, Female, 50 Year(s)	DOA / Fatality	Unsubstantiated
046026 - Sibling, Male, 2 Year(s)	046023 - Grandparent, Female, 50 Year(s)	Inadequate Guardianship	Substantiated
046026 - Sibling, Male, 2 Year(s)	046024 - Unrelated Home Member, Male, 55 Year(s)	Inadequate Guardianship	Substantiated
046026 - Sibling, Male, 2 Year(s)	046023 - Grandparent, Female, 50 Year(s)	Internal Injuries	Unsubstantiated
046026 - Sibling, Male, 2 Year(s)	046025 - Unrelated Home Member, Male, 23 Year(s)	Inadequate Guardianship	Substantiated

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?	☒	☐	☐	☐

Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
Some case notes were entered more than 30 days after the event date.

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?	☒	☐	☐	☐
Explain: The 24 hour safety assessment was completed three days late.				

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 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:
The 2yo child was removed due to being present while his father, the father's girlfriend, PGM, and her husband physically assaulted his mother. Mother was in the hospital due to injuries she sustained and was not able to care for the child until she was discharged and physically capable.

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:**
01/12/2018	There was not a fact finding	There was not a disposition
Respondent:	046025 Unrelated Home Member Male 23 Year(s)	
Comments:		

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
Mental health counseling and a domestic violence advocate were offered to the mother, however it is unclear if mother ever engaged with these services.

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/19/2017	Sibling, Male, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Far-Closed	No
	Sibling, Male, 1 Years	Mother, Female, 25 Years	Lack of Medical Care	Far-Closed	
	Sibling, Male, 1 Years	Mother's Partner, Male, 22 Years	Lack of Medical Care	Far-Closed	
	Sibling, Male, 1 Years	Mother's Partner, Male, 22 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 1 Years	Grandparent, Female, 49 Years	Lack of Medical Care	Far-Closed	
	Sibling, Male, 1 Years	Grandparent, Female, 49 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 1 Years	Unrelated Home Member, Male, 54 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 1 Years	Unrelated Home Member, Male, 54 Years	Lack of Medical Care	Far-Closed	

Report Summary:
The SCR report alleged the 1-year-old male child had been throwing up for several days. The mother, PGM and her husband failed to obtain medical attention in a timely manner. The child had poor hygiene, had been wearing clothes with holes in them, and had been in a soiled diaper for an extended period of time.

OCFS Review Results:
MCDHS spoke to several appropriate collaterals including hospital staff and the child's pediatrician. CW obtained

documentation from the hospital and the pediatrician's office. Both confirmed the child made all of his appointments and was up to date on his immunizations. The hospital could not give a reason as to why the child was ill. MCDHS followed FAR protocol.

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

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.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Foster Care Placement History

The 2-year-old child was placed in foster care as a result of the fatality report. The mother was physically assaulted by the 2-year-old's father and the other members of the household while the child was present in the home. The mother spent several days in the hospital due to her injuries. The child entered foster care on 1/9/18 and was discharged to the mother on 1/16/18 when she was stable and had adequate housing for her and the child.

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

Additional Local District Comments

“CPS did go out and assess safety of the surviving sibling within 24 hours of the receipt of the report and it is documented in the progress notes. However, it was not entered into the fatality assessment portion of the system."

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