Report Identification Number: NY-16-135

Prepared by: New York City Regional Office

Issue Date: Jun 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: 0 day(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/24/2016
Initial Date OCFS Notified: 12/24/2016

Presenting Information

On 12/24/16, the SCR registered three reports regarding the death of this newborn male SC. The reports alleged at approximately 11:12 A.M. on 12/24/16, the BM gave birth to a baby boy at her home. The baby was born still in the amniotic sac. The baby was on the bed next to the mother in the amniotic sack and in need of medical intervention. After the amniotic sac was broken, the baby had a faint pulse and took one to two spontaneous breaths before CPR was administered. The baby subsequently died at the hospital. The baby was approximately 28 gestational weeks at the time of birth. The BM did not have prenatal care. The BM and an unknown home member were present at the time of the baby's death. The BM was disoriented and unaware of her surroundings. The BM's lips were burned, there were bruises on her stomach and bruising around her wrists.

Executive Summary

At approximately 11:12 A.M. on 12/24/16, EMS responded to a 911 call from the case address stating; “patient in labor.” There were two female unrelated home members (UHM) in the home at the time of the incident. One of the UHM called 911. Upon EMS’ arrival, one of the UHM's called again to cancel the initial request for emergency medical assistance and the other tried to deny EMS access to the home. EMS pushed their way into the home and observed the BM disoriented, laying naked on the bed, and had already given birth to the SC at approximately 28 gestational weeks. EMS observed the SC still encased in the amniotic sac with the umbilical cord. EMS staff cut the amniotic sac open and gave the SC CPR. EMS transported the BM and the SC to the hospital and continued CPR on the SC until his arrival at the hospital. The BM was disoriented and unaware of her surroundings; her lips were burned and there were bruises on her face, stomach, and restraint marks around her wrists. At 12:25 P.M., hospital staff pronounced the SC deceased. The SC’s cause of death was complications of acute chorioamnionitis and funisitis (infection of placenta and umbilical cord). The manner of death was undetermined. According to the ME, the BM’s placenta was infected with acute phencyclidine intoxication (PCP) and passed to the fetus - (PCP given to the mother and passed to the baby). There were no other children observed in the home.

On 12/24/16, the ACS Specialist initiated the CPS investigation by contacting the LE, hospital staff, EMS, and relevant collaterals. The information obtained from the collaterals revealed the BM was seven-months pregnant and had been held captive by the UHM since 12/17/17. During that time, the UHM cared for the BM and gave her unknown medication and substances. The BM became unconscious and could not recall what occurred afterwards. On 12/24/16, the BM woke up at the hospital and the Drs. told her that the SC was deceased.

On 12/28/16, the UHM was arrested and charged with two counts of reckless endangerment in the 1st degree, unlawful imprisonment in the 1st degree, and endangering the welfare of a child. ACS was unable to interview the UHM regarding the fatality due to the active criminal investigation.

During the course of the investigation, the DA reported there was ongoing criminal investigation concerning the BM’s paramour, and her mentor. ACS was unable to obtain additional information from the BM’s paramour, and her mentor due to the active LE’s involvement. The DA also reported the BM recanted her account stating the UHM did not give her any medication. There were no charges against the BM and her whereabouts remained unknown.

On 3/24/17, ACS substantiated the allegation IG against UHM. ACS based its decision on the BM's account stating that the UHM was staying in her home for several days and during that time she cared for her and gave her medication. Also, the UHM interfered with getting the SC prompt emergency medical care. While the UHM initially called 911 to help, she called back to cancel the ambulance and physically barred the EMT personnel from entering the home.

ACS unsubstantiated the allegation IG against the BM. The BM was given unknown medication and substances that put her intensive care unit for several days and was unaware that she had given birth or that the SC had died.

ACS also unsubstantiated the allegation DOA/Fatality against the BM and the UHM. According to the ME, the SC's cause of death and manner of death were pending. At the time of completing this report, the BM's whereabouts remained unknown.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Was the decision to close the case appropriate? Yes

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

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

Explain:

ACS did not provide further/additional information about the second female UHM present the home with the BM and the UHM at the time of the incident. On 5/26/17, NYCRO contacted ACS and requested clarification regarding the second UHM. As of the time of completing this report, ACS has not responded to NYCRO's contact.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS did not provide further/additional information about the second female UHM present in the home with the BM and the UHM at the time of the incident.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	The Administration for Children's Services (ACS) must submit a Program Improvement Plan within

	45 days that identifies what action it has, or will take, to address the citation(s) 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: 12/24/2016 **Time of Death:** 12:25 PM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 11:12 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Child was being delivered

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☒ Other: Unknown Substance/Drug

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	Male	0 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	50 Year(s)

LDSS Response

On 12/24/16, the Specialist contacted the LE, hospital staff, EMS personnel and relevant collaterals. They all confirmed the incident and reported the BM was seven-months pregnant and had delivered a baby boy at the case address. EMS responded to the home and attempted to resuscitate the SC. EMS transported the BM and the SC to the hospital and continued CPR on the SC until his arrival at the hospital. The BM appeared drowsy and confused. She was unaware of her surroundings. She had bruises all about her body.

On 12/25/16, the ME reported that the findings of the SC's preliminary autopsy were related to the isolated subarachnoid hemorrhage spots that could be attributed to disease, trauma, clotting problem, or congenital abnormalities.

On 12/27/16, the Specialist visited the case address and made unsuccessful efforts to obtain collateral accounts from neighbors and the building superintendent regarding the incident or the BM.

On 12/29/16, the DA reported that the UHM was arrested for unlawful imprisonment and endangering the welfare of a child. The UHM gave the BM medication during the time the BM was being held in the home and also would not let the BM leave the home. Also, the UHM stopped EMS from entering the home to help the BM and the SC.

Also on 12/29/16, the Specialist interviewed the BM at the DA's office. She confirmed being held against her will by two unrelated women sent by her "mentor" to help her around the house because she was pregnant. Regarding the events that led up to the incident, the BM stated that on 12/17/16, she attended an office Christmas party where she ate food and drank which burned all the way down to her stomach. After the party, she went home and rested. She could not go out the next day because she did not feel well; then the UHM showed up at her home. The BM recalled she tried to leave the home but the UHM physically stopped her from leaving. The BM contacted her mentor who told her she was "in good hands." She attempted to leave the home again but did not remember if the UHM stopped her. The next thing she remembered was that she woke up at the hospital and the doctors told her that her baby was dead. The BM did not remember how she got the marks and bruises on her body.

The BM reported prior DV incidents with her paramour. She reported being afraid to go out by herself because her paramour threatened her life. The paramour had reportedly told the BM multiple times to abort the baby because he "could not afford" a baby. He had also accused the BM of having a relationship with her mentor. The BM denied any relationship with her mentor. She reported she worked at the medical office of her mentor and described the mentor as a friend who assisted in paying her bills. The BM did not have any other children.

Between 1/17/17 and 3/24/17, the Specialist made casework contacts with the ME and LE regarding the criminal investigation. The ME reported the autopsy was pending further tests. The DA stated there was ongoing criminal investigation concerning the BM's paramour, and the BM's mentor. The DA also stated the BM had recanted her account stating the UHM did not give her any medication. According to the DA, there were no charges against the BM and her whereabouts remained unknown. During the same period, ACS was unable to obtain additional information from the BM's paramour, and the BM's mentor due to the active LE's involvement.

On 3/24/17, ACS substantiated the allegation IG against UHM.

ACS unsubstantiated the allegation IG against the BM. ACS also unsubstantiated the allegation DOA/Fatality against the BM and the UHM.

On 5/4/17, the ME reported that the SC's cause of death was complications of acute chorioamnionitis and funisitis

(infection of placenta and umbilical cord. The manner of death was undetermined. The BM's placenta was infected with acute phencyclidine intoxication (PCP) and passed to the fetus.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical cause
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 approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
037821 - Deceased Child, Male, 0 Days	037823 - Unrelated Home Member, Female, 50 Year(s)	DOA / Fatality	Unsubstantiated
037821 - Deceased Child, Male, 0 Days	037822 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
037821 - Deceased Child, Male, 0 Days	037823 - Unrelated Home Member, Female, 50 Year(s)	Inadequate Guardianship	Substantiated
037821 - Deceased Child, Male, 0 Days	037822 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐

Was a death-scene investigation performed?	☐	☒	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐Family Court ☒Criminal Court ☒Order of Protection

Criminal Charge: Reckless endangerment **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
12/28/2016	Unrelated Home Member	Pending	The case remained active in criminal court
Comments:	The UHM was arrested and charged with the following: two counts of reckless endangerment, 1 count of acting in a manner to injure a child under 17 and unlawful imprisonment 1st degree. The BM was granted a full stay away order of protection against the UHM.		

Have any Orders of Protection been issued? Yes	
From: 01/17/2017	**To:** 07/17/2017
Explain: An additional active order of protection was issued on 1/17/17, for the BM against the UHM. The order would expire on 7/17/17.	
From: 12/28/2016	**To:** Unknown
Explain:	

The BM was granted a full stay away order of protection against the UHM.

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:
The BM was offered case management services; however, she could not be located after the initial contact.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The BM's whereabouts were unknown.

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?	N/A
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 in NYS within three years prior to the fatality.

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

The family did not have any CPS history prior to the fatality.

Known CPS History Outside of NYS

The family did not have any known CPS history outside of NYS.

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?

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: 09/25/2016	**To:** 03/25/2017
Explain: Following a DV incident between the BM and her paramour on 9/25/16, the BM filed a police report against the paramour. The paramour was arrested and an order of protection was issued against him for the BM.	

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