NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-085 **Prepared by: New York City Regional Office**

Issue Date: 4/11/2016

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	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		

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 10/18/2015
Initial Date OCFS Notified: 10/18/2015

Presenting Information

The reports registered by the SCR on 10/18/15 alleged at approximately 2:30 A.M. on 10/18/15, the BF came home and found the four-month-old SC unresponsive on the right side of the bed. The BM was co-sleeping in the bed with the SC and possibly rolled over on the SC. The report further alleged the area around the SC was in disarray, but did not pose a health hazard. The BF performed CPR on the SC and called 911. When the SC arrived at the hospital, staff also performed CPR on him. At 3:50 A.M., hospital staff pronounced the SC dead. The SC did not have any pre-existing medical condition and was otherwise healthy.

Executive Summary

On 10/18/15, the SCR registered two reports regarding the death of this three-month-old male SC. ACS' investigation revealed the BM fell asleep while feeding the SC in a "three quarter" size bed. Upon the BF's return home from work at approximately 2:30 A.M., he found the SC unresponsive and in the crux of the BM's arm . The BF attempted CPR on the SC and after failed attempts; he called 911. EMS responded to the home and transported him to the hospital where the ER staff continued resuscitative efforts. At 3:50 A.M., hospital staff pronounced the SC dead. According to the ME, the SC's cause and manner of death were undetermined; co-sleeping with an adult on a soft bed. The SC did not have any injuries or pre-existing medical condition that would have contributed to his death.

There were no other children in the home; however, the BF had an adopted son who resided out-of-state with his BM. The BF was involved with the support of this child.

ACS initiated the investigation within the mandated time frame. The ECS' Specialist made contacts with the BPs, medical, and police staff. The statements provided by the BPs were consistent. They cooperated with the investigation and shared information about the family dynamics. Additionally, they submitted to a drug screening and the results were negative.

ACS obtained information from both medical and police staff which deemed the SC's death accidental. ACS obtained additional information from family members, neighbors, babysitter, medical providers and EMS. There were no reported concerns for the family.

On 3/7/16, ACS unsubstantiated the allegations of the report. ACS determined there was no evidence that the BM "deliberately perpetrated any actions or behaviors that caused the untimely death of her son." The ME reported that the SC's cause and manner of death were undetermined; co-sleeping with an adult on a soft bed. ACS did not appropriately apply the legal standards in this determination as intent is not a factor in the determination of CPS reports. ACS could have substantiated the allegation IG of the SC by the BM, as the BM who had received safe sleep instructions and had a crib for the SC in the room, exhibited poor judgment in co-sleeping with the SC in the same bed. ACS did not incorporate this key information into the findings and inappropriately unsubstantiated the allegation IG.

ACS exhibited good casework practice by utilizing language services to interview the SC's babysitter who

communicated only in Spanish. In addition, ACS requested from the LDSS where the BF's adopted child resided, a courtesy home visit to assess the safety of that child. On 1/19/16, the LDSS assessed the child and deemed him safe with his BM.

At the time of the investigation closing, the BPs refused ACS' offer of grief counseling services. They reported receiving support from family members and planned to relocate out-of-state for "a new start."

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?** No,sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
ACS should have substantiated the allegation IG of the SC by the BM. During the course of the investigation, ACS obtained information which indicated the BM received safe sleep instructions and that the SC had a crib. ACS did not incorporate this key information into the findings and inappropriately unsubstantiated the allegation of IG of the SC by the BM.

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 exhibited good casework practice by utilizing language services to interview the SC's babysitter who communicated only in Spanish. In addition, ACS requested the LDSS to conduct a courtesy visit on the BF's adopted child.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS should have substantiated the allegation IG of the SC by the BM. ACS obtained information which indicated the BM received safe sleep instructions and that the SC had a crib. ACS did not incorporate this key information into its findings.

Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	The Administration for Children's Services (ACS) must submit a corrective action 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: 10/18/2015 **Time of Death:** 03:50 AM

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

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 02:46 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

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: Not 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	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

On 10/18/15, the ACS Specialist initiated the investigation and contacted by phone the hospital staff and the responding PO. The attending Dr. deemed the SC's death accidental, given that the SC did not have any signs of trauma. The PO stated there was no arrest made or planned at the time.

The Specialist then responded to the hospital where the SC was taken by EMS to interview the biological parents (BPs). The BM was too distraught to be interviewed regarding the incident. Consequently, the Specialist spoke with the BF and his statements were consistent with the information already known. He added the SC had a crib but the BM would breastfeed the SC in the bed with her and then place him in his crib once he went to sleep. The BF disclosed the SC was born at home and worked with a midwife. The SC had not had any medical issues since birth. The BF stated he was involved with his adopted child and reported a cordial relationship the child's BM.

On 10/19/15 and 10/20/15, the Specialist obtained additional information from family members, neighbors, babysitter and medical providers. They did not report any concerns regarding the family. In addition, the information obtained from the ME revealed the preliminary findings did not reveal any external injuries to the SC. The SC's cause of death was pending further studies.

On 11/6/15, ACS received the results of the BPs' drug screening conducted on 10/22/15. The results were negative for all substances.

On 11/16/15, ACS held a meeting with the family. At the meeting ACS and the family discussed and offered services to the BPs. The BM stated she was involved with a supportive group and found the group helpful. The BPs declined organized services and reported having the support of their family. They stated they planned to relocate out-of-state for a "new start."

On 11/18/15, the assigned detective reported there were no criminal charges against the BPs and the criminal investigation was closed.

Between 10/19/15 and 12/4/15, the Specialist made successful casework contacts with the BPs. They did not provide any new information regarding the incident.

On 1/19/16, the LDSS where the BF's adopted child resided assessed the child and deemed him safe with his BM. ACS had requested a courtesy visit to the child on 12/1/15.

On 1/20/16, the ME reported that the SC's cause of death was undetermined; co-sleeping with an adult on a soft bed.

On 2/4/16, the facility where the BM received pre-natal care disclosed that the BM had received safe sleep instructions during her visits.

On 3/7/16, ACS unsubstantiated the allegations of the report. ACS determined there was no concrete evidence that the BM deliberately perpetrated any actions or behaviors that caused the untimely death of her son. The ME reported that the SC's cause and manner of death were undetermined; co-sleeping with an adult on a soft bed.

Official Manner and Cause of Death

Official Manner: Undetermined

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 Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
022121 - Deceased Child, Male, 3 Mons	022123 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
022121 - Deceased Child, Male, 3 Mons	022123 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
022121 - Deceased Child, Male, 3 Mons	022122 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
022121 - Deceased Child, Male, 3 Mons	022122 - Mother, Female, 33 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? 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	☐	☐	☐	☐	☐	☒	☐

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:
No services were provided to the half sibling who resided elsewhere, and there were no other children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents declined services.

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 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.

Known CPS History Outside of NYS

The family did not have any CPS history outside of New York State.

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.

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