NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-050 **Prepared by: New York City Regional Office**

Issue Date: 12/16/2015

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	MN-Medical Neglect	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services		

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 06/16/2015
Initial Date OCFS Notified: 06/16/2015

Presenting Information

On 6/16/15, the SCR registered a report that alleged the BF was holding his six-month-old infant and realized the infant was unresponsive and not breathing. The BF attempted mouth to mouth resuscitation on the infant then ran to the hospital for medical assistance. The infant was an otherwise healthy child with no known history of medical conditions. The infant was later pronounced dead and there was no explanation provided for the infant's death.

Executive Summary

This six-month-old male child died on 6/16/15. The parents had been co-sleeping with the SC and his twin sister. ACS' investigation revealed that at the time of the incident the twins were asleep on the queen size bed while the BF was in the same room and the BM was in the kitchen. The allegations of the report were DOA/Fatality and IG of the SC by the parents. Although the surviving sibling shared the same circumstances as the SC, ACS did not add any allegations pertaining to the surviving sibling by the parents.

The parents reported the SC and his twin sister were asleep together on the bed and at 8:00 AM, the SC awoke and accidently bumped heads with his sibling. The sibling cried and went back to sleep. The BM placed the SC in the playpen, in the sight of the BF who was playing video games, and went to the kitchen to prepare breakfast. The MA and sixteen-year-old cousin were not at home. At approximately 9:30 A.M., the SC started fussing and the BF rocked him in his arms for about ten minutes before he fell asleep. The BF placed the SC prone with his right cheek on the bed, the sibling remained asleep. The BF explained that they usually placed the SC to sleep in a prone position because he slept better because when he is placed supine he appeared to be gasping for air. Fifteen minutes later, the sibling awoke and crawled over to the SC and tapped him. The BF noticed the SC's face was "down in the bed" and he turned him over to discover the SC was unresponsive. ACS documentation reflected the mattress was soft with loose sheets. The BF then alerted the BM who told him to take the SC to the hospital. The parents explained that at the time of the discovery, they did not call for emergency medical assistance because they reside two blocks from the hospital.

The parents stated that on 4/17/15, they informed the pediatrician that the SC had difficulty breathing and the pediatrician recommended the use of a humidifier; however, the parents discontinued the use and the Specialist did not observe a humidifier in the home. The BM stated that when the twins were born, the hospital staff informed her that laying the children on their backs to sleep was the safest; however, they did not discuss or receive information regarding co-sleeping.

The SW at Wyckoff Heights Medical Center reported the father arrived at the ER carrying the unresponsive SC at 10:00 A.M., on 6/16/15 . The Dr. pronounced the SC dead at 10:35 A.M. The SW added that the BF ran to the hospital wearing no shoes or shirt.

The ME reported there were no signs of abuse or neglect. The BF re-enacted the incident in the presence of the ME and LE. They found no suspicion of foul play. The cause and manner of death is pending.

ACS received information from the children's pediatrician who reported the children's' immunizations were current and as of 4/17/15, their last medical examination, they had no medical conditions. The pediatrician confirmed that a humidifier was recommended and there were no concerns as to the care the parents provided. Both parents attended all appointments and were consistent. ACS provided a crib, supplies and safe sleep information to the parents. The surviving sibling was medically examined and released to the parents.

NYCRO contacted ACS and it was reported that the MA and sixteen-year-old cousin were interviewed at the home and they reported the parents were good parents. ACS documented the cousin's school attendance is good however, the MA declined ACS' involvement. On 10/17/15, the BM and surviving sibling relocated to another state. The BF also relocated with no forwarding address.

ACS has not made a determination.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **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?** 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:
The Specialist visited the surviving sibling on 10/14/15 and documented that she appeared well and healthy. The BM informed the Specialist that she was relocating with the surviving sibling to another state on 10/17/15. ACS has not completed the safety assessment because no determination has been made.

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

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

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

Explain:
The case has not been determined.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/16/2015 **Time of Death:** 10:35 AM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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 2
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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Month(s)

LDSS Response

On 6/16/15, the ACS Specialist responded to the report registered by the SCR within the required time frame by interviewing the ME and LE who both reported the SC had no visible signs of injury and the autopsy was pending. The Specialist obtained information from the Wyckoff Heights Medical Center (WHMC) staff and interviewed both parents whose accounts were consistent. The parents reported the SC and his twin sister were asleep together on the bed and at 8:00 AM, the SC awoke and accidently bumped heads with his sibling. The sibling cried and fell back asleep. The BM placed the SC in the playpen in the sight of the BF who was playing video games; the BM went to the kitchen to prepare

breakfast. The MA and the sixteen-year-old cousin were not at home at the time of the incident.

At approximately 9:30 A.M., the SC started fussing and the BF rocked him in his arms for about ten minutes before he fell asleep. The BF placed the SC prone with his right cheek on the bed, the sibling remained asleep. The BF explained that they usually placed the SC to sleep in a prone position because he slept better because when placed in a supine position he appeared to be gasping for air. The BF stated that fifteen minutes later the sibling awoke and crawled over to the SC and tapped him. The BF noticed the SC's face was down in the bed and he turned him over to discover the SC was unresponsive.The BF stated he ran with the SC two blocks to the WHMC at approximately 10:00 A.M. to seek medical assistance. The SC was pronounced dead by the attending physician at the WHMC at 10:35 A.M. The surviving sibling, who arrived with the BM a short time after the BF, was medically examined and released to the parents.

ACS' investigation revealed the twins had been co-sleeping with the parents on a queen size mattress that was approximately one foot high from the ground because the SC and surviving sibling had no bedding of their own. Although the parents did not receive co-sleep information, they were advised that babies sleep safest in a supine position. According to the parents, both infants were usually placed in a prone position when put to bed, especially the SC because he appeared to have difficulty breathing. The parents reported their concerns to the pediatrician and it was recommended that they use a humidifier and they complied. However, the parents discontinued using the humidifier but provided no explanation. ACS case documentation reflected no humidifier was observed in the home and the queen size mattress the family slept on was soft with loose sheets.

On 6/16/15, LE was interviewed by ACS by telephone and told the Specialist the BF demonstrated how the SC was placed when he was found unresponsive. The BF also explained that on 6/11/15, the SC had fallen off of the mattress and hit his head but there were no marks or bruises and the parents did not seek medical attention.

ACS obtained information from the children's pediatrician who reported they were healthy with no medical conditions and their immunizations were current. The pediatrician confirmed the recommendation for the humidifier. There were no concerns regarding the care provided by the parents.

Between 6/16/15, and 10/17/15, ACS monitored the family and made numerous attempts to have the parents engage in services; however, the parents consistently declined all services except for the early intervention evaluation for the surviving sibling. The surviving sibling was evaluated for early intervention but was denied because it was determined the infant had met all of the developmental milestones for her age. The BF moved from the case address to an unknown location.

On 10/17/15, the BM and the surviving sibling relocated and now reside in another state. The final autopsy report is pending and at the time of the writing of this report ACS has not made a determination on the case. ACS did not add any allegations for the surviving sibling to the 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 ACS 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 approved OCFS Child Fatality Review in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
022241 - Deceased Child, Male, 6 Mons	022243 - Father, Male, 25 Year(s)	DOA / Fatality	Pending
022241 - Deceased Child, Male, 6 Mons	022243 - Father, Male, 25 Year(s)	Inadequate Guardianship	Pending
022241 - Deceased Child, Male, 6 Mons	022242 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Pending
022241 - Deceased Child, Male, 6 Mons	022242 - Mother, Female, 28 Year(s)	DOA / Fatality	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

Records pertaining to the fatality investigation were reviewed via the CONNECTIONS database.

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 and 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?	☐	☒	☐	☐
Explain as necessary: .				

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Bed for surviving sibling, diapers, E.I.

Additional information, if necessary:
ACS referred the surviving sibling for Early Intervention (EI). However; on 9/16/15, the BM provided a letter stating it was determined the surviving sibling was not eligible for EI because the infant met her developmental milestones and there was no need for the service. The BF moved from the case address and the BM relocated to another state on 10/17/15. The parents declined other services.

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? No
Explain:
The parents declined other services except for an E.I. evaluation and on 10/17/15, the BM and surviving sibling have relocated and now reside in another state.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents declined all other services except for an E.I. evaluation for the surviving sibling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No