NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-104 **Prepared by: New York City Regional Office**

Issue Date: 5/11/2016

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: 8 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/22/2015
Initial Date OCFS Notified: 12/22/2015

Presenting Information

The narrative of the report alleged at 11:00 A.M. on 12/22/15, the BF put the eight-month-old male SC to sleep in his crib. At 1:20 P.M., the BF went to awaken the SC but found him unresponsive. The BF attempted CPR but was unsuccessful. The BF then took the SC to a DC located downstairs from the home and asked for help. A staff member at the DC attempted CPR but was also unsuccessful. At 1:25 P.M., the BF called the police. The police and EMS responded to the scene and transported the SC to the hospital. The ER staff at the hospital applied CPR but they could not revive the SC. At 1:55 P.M., ER staff pronounced the SC dead. The SC did not have any preexisting medical conditions which deemed his death suspicious.

Executive Summary

On 12/22/15, the SCR registered a report regarding the death of this eight-month-old male SC. According to ACS' investigation, at 11:00 A.M. on 12/22/15, the BF put the SC on his stomach to sleep in his crib. At 1:20 P.M., the BF checked the SC and found him unresponsive. The SC's face was stuck between the crib bumper pads. The BF called 911 and then gave the SC CPR but was unsuccessful. He ran with the SC to a DC located downstairs from the home where a staff member gave the SC CPR and was also unsuccessful. The first responders came to the scene minutes later and attempted to revive the SC. EMS transported the SC to the hospital where ER staff pronounced him dead at 1:55 P.M. The ME stated the cause and manner of death was pending further studies. At the time of the incident, the BF was the only one supervising the SC. The BM was at work and the two surviving siblings (SS) children were at school.

The biological parents (BPs) had the SC in common. The BF had a set of nine-year-old female twins from a previous relationship. The girls resided out-of-state with their BM and the BF did not have any contact with them. The SS's BFs were incarcerated and not involved with the family.

ACS initiated the CPS investigation on the same day the report was received. The Specialist made contacts with the hospital staff, assigned detective and the family. The accounts of the incident provided by the BPs and relevant collateral sources were consistent throughout the investigation.

ACS identified concerns of future risks to the SS and convened a child safety conference. On 1/5/16, ACS filed an Article 10 Petition in Bronx Family Court (BxFC) on behalf of the SS. The BPs were the respondents. BxFC granted a temporary full-stay-away OOP against the BF for the SS. The SS were released to the BM with supervision.

ACS referred the family for preventive services and on 2/18/16; the family signed up for services with the Leake and Watts agency.

On 2/23/16, ACS substantiated the allegation of IG of the SC and the SS by the BF based on the information obtained during the investigation which indicated the BF had an untreated clinical health condition and should not have been caring for the children. Also, the BF admitted to using marijuana and was not enrolled in drug treatment. Additionally, the BF admitted to using corporal punishment as a method of discipline for the SS.

ACS substantiated the allegation of IG of the SS by the BM. The BM was aware that the BF had an untreated clinical health condition, smoked marijuana and used corporal punishment to discipline the SS but allowed him to care for her children.

ACS unsubstantiated the allegation of DOA/Fatality of the SC by the BF based on the ME's report which stated the final autopsy report was pending further studies.

ACS could have substantiated the allegation IG of the SC by the BM. The BM was aware that the BF had an untreated clinical health condition, smoked marijuana, and used corporal punishment to discipline the children but still allowed him to care for the SC.

Although the BFs of the SSs were incarcerated and not involved with the family at the time of the facility, the Specialist should have made diligent efforts to contact and explore the SSs' paternal families as future resources to the surviving siblings, should there be the need.

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

Explain:
Although there was a documentation of supervisory consultation during the investigation, the Specialist did not make diligent efforts to locate the BFs of the surviving children. Also, the children's paternal families were not contacted and explored as future resources should there be the need.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
The family had been referred for supportive and therapeutic counseling. The surviving siblings were attending school regularly. The school staff noted a behavior change in the nine-year-old child and arranged for school based services for the 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 unsubstantiated the allegation IG of the SC by the BM. The BM was aware that the BF had an untreated clinical health condition, smoked marijuana, and used corporal punishment to discipline the children but allowed him to care for the SC.
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.
Issue:	Diligence of Efforts
Summary:	Although the SS's BFs were incarcerated and not involved with the family at the time of the facility, ACS did not make diligent efforts to contact and explore the SS's paternal families as future resources to the SS should there be the need.
Legal Reference:	NYCRR 430.12D
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.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-Hour S/A was completed timely but was not approved until 12/28/15, six days after the report was received.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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: 12/22/2015 **Time of Death:** 01:55 PM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: 01:25 PM
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 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	8 Month(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	51 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	12 Year(s)

LDSS Response

On 12/22/15, the ACS Specialist began the investigation by contacting the hospital staff and the assigned detective. The hospital staff did not report any signs of abuse to the SC. The detective did not find any criminality about the SC's death suspicious and no arrest was made. The detective did not report any concerns for the surviving siblings (SS).

Later that same date, the Specialist visited the family for an assessment. The biological parents (BPs) provided an account of the incident which was consistent with the information already known. They denied the SC suffered from any medical condition. The BF reported being a father of nine-year-old female twins from a previous relationship. The girls resided out-of-state with their BM. The BF admitted to being a registered sex offender and denied any contact with the girls. He also admitted to having an untreated clinical condition. He voluntarily stopped treatment in April 2015 because he wanted to be a full time parent to the SC. He denied suicidal ideations. The BM did not report any concerns about the care the BF gave to the SC.

The Specialist observed the SS and deemed them safe in the home. The Specialist observed a crib for the SC and counseled the family regarding safe-sleep practice.

Between 12/23/15 and 12/30/15, the Specialist made contacts with the family and they did not provide any new information about the fatality. The nine-year-old SS reported the BF had used a belt to discipline him in the past. The BM described the BF as controlling and aggressive. She confirmed the BF had used corporal punishment to discipline the SS. The family's neighbors did not report any concern for the family; however, the MGM had concerns about the BF's past sexual offenses.

On 1/4/15, ACS held a child safety conference (CSC) with the family and the CSC decided that a neglect petition be filed against the BPs. On 1/5/16, ACS filed an Article 10 Petition in Bronx County Family Court (BxFC), both parents were the respondents. BxFC granted a temporary full-stay-away OOP against the BF for the SS. On 1/16, ACS referred the family for preventive services.

Between 1/21/16 and 2/19/16, ACS made multiple contacts with collaterals and the family to obtain additional information about the CPS investigation. On 1/29/16, the school staff reported having no concerns about the SS's attendance and academic performance. There was a behavior change noted in the nine-year-old child and the staff arranged for school based services for the child. On 2/5/16, ACS received the SS's medical information which indicated their immunizations were current. The twelve-year-old SS had a breathing condition and the BM was compliant with his medical visits, medications/treatment and there were no reported concerns.

On 2/9/16, the CW working with the BF's twin girls denied there was an OOP in place against the BF for the twins. On 2/18/16, the family signed up for services with Leak and Watts.

On 2/23/16, ACS substantiated the allegation of IG of the SC and the SS by the BF based on the information obtained during the investigation which indicated the BF had an untreated clinical health condition and was using marijuana. The BF admitted to using a belt on multiple occasions to discipline the SS.

ACS substantiated the allegation of IG of the SS by the BM. The BM was aware that the BF had an untreated clinical health condition, smoked marijuana and used corporal punishment to discipline the SS but allowed him to care for her children.

ACS unsubstantiated the allegation of DOA/Fatality of the SC by the BF based on the ME's report which stated the final autopsy report was pending further studies.

ACS could have substantiated the allegation IG of the SC by the BM based on its determination of the allegation IG of the SS. Also, the Specialist should have made diligent efforts to contact and explore the paternal families of the surviving siblings as future resources to these children should there be the need.

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: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
027404 - Deceased Child, Male, 8 Mons	027648 - Father, Male, 51 Year(s)	Inadequate Guardianship	Substantiated
027404 - Deceased Child, Male, 8 Mons	027648 - Father, Male, 51 Year(s)	DOA / Fatality	Unsubstantiated
027650 - Sibling, Male, 8 Year(s)	027648 - Father, Male, 51 Year(s)	Inadequate Guardianship	Substantiated
027650 - Sibling, Male, 8 Year(s)	027647 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
027651 - Sibling, Male, 12 Year(s)	027648 - Father, Male, 51 Year(s)	Inadequate Guardianship	Substantiated
027651 - Sibling, Male, 12 Year(s)	027647 - Mother, Female, 29 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?	☒	☐	☐	☐

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?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☒	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Explain as necessary:
There was no removal regarding the surviving children.

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:**
01/05/2016	There was not a fact finding	There was not a disposition
Respondent:	027648 Father Male 51 Year(s)	
Comments:	On 1/5/16, ACS filed neglect petition in Bronx County Family Court (BxFC), both parents were the respondents. The BxFC granted a temporary full-stay-away OOP against the BF for the surviving children. The case was adjourned until 2/2/16.	

Have any Orders of Protection been issued? Yes	
From: 01/05/2016	**To:** Unknown
Explain: On 1/5/16, Bronx County Family Court granted a temporary full-stay-away OOP against the BF for the surviving children.	

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	☐	☐	☐	☐	☐	☒	☐

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 fetal alcohol effects or syndrome

☒ With neither of the issues listed noted in case record

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 BM had two prior indicated cases dated 8/6/03 and 7/6/09. The 8/6/03 report alleged IFCS, PD/AM and IG of the now twelve-year-old child by the BM and the child's BF. According to the case notes, the biological parents (BPs) used illegal drugs on an ongoing basis and did not have any means of support for the child. During the investigation, the BM admitted to using marijuana. The BF had never provided emotional or financial support to child and had an extensive criminal record. The BM made several DV reports against the BF and the child was constantly exposed to DV between the BPs.

On 10/2/03, ACS substantiated all the allegations against the BPs. The child was removed and placed in kinship foster care with the MGM. A service referral was made for the BM but her whereabouts were unknown. The BF did not make himself available for drug testing.

The 7/6/09 report alleged the BM used cocaine and drank large amounts of alcohol when caring for her then six and three-year-old children.

On 9/4/09, ACS substantiated the allegation PD/AM against the BM. During the investigation of the report, the BM tested positive for marijuana use. ACS referred the BM for appropriate services.

ACS unsubstantiated the allegation IG against the BM. ACS investigation revealed the BM provided both children with appropriate supervision either by herself or the MGM. ACS provided the BM with ACD voucher and she was researching day care centers in her neighborhood for the three-year-old child.

Known CPS History Outside of NYS

The family did not have any 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

Action:	OCFS is recommending that the ACS Supervisory Teams review with the Specialists the CONNECTIONS Step-by-Step Guide: Training for CPS workers (rev 3/1/07) page 204, which addresses Safety Assessments, and to review the Safety Assessments submitted for this report.

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