NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-051 **Prepared by: New York City Regional Office**

Issue Date: 12/2/2016

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
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: 1 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 05/19/2016
Initial Date OCFS Notified: 05/19/2016

Presenting Information

The SCR registered a report alleging that on 05/19/16, around 8:00 A.M., the-one-month-old SC was found unresponsive in his playpen by the mother. The SC appeared pale and had a faint pulse. The report alleged that the mother gave the SC a slight shake to arouse him, but he remained unresponsive. The report noted that EMS was called and Cardiopulmonary Resuscitation (CPR) was administered, but the SC was pronounced dead at the scene. The report also noted that the SC was an otherwise healthy child.

Executive Summary

The SC was a month old when he died on 5/19/16. An autopsy was completed; however, as of 10/26/16, the report had not been issued and the ME had not provided a preliminary cause or manner of death.

On 5/19/16, the SCR registered a report concerning the death of the SC. The allegations of the report were DOA/Fatality and Inadequate Guardianship of the SC by the parents. Approximately one hour later, a duplicate report was registered regarding the death of the child.

The family's case address was located in a family shelter where they were placed on 2/22/16. The shelter was operated by the Department of Homeless Services. The SC was born seven weeks premature and was discharged from the hospital in good health two weeks after his birth.

According to the parents' account, on 5/19/16 the mother last fed the SC at 1:00 A.M., burped him, and then placed him on his back to sleep in his bassinet. The parents indicated that the SC usually slept through the night. The mother said that at about 8:00 A.M., she went to get the SC ready for an appointment and noticed the child was unresponsive, stiff, and pale. The mother said she yelled out for the father who began to administer CPR until EMS arrived. The SC was transported to Bronx Lebanon Hospital (BLH) where he was later pronounced dead.

At the time of the incident, the shelter staff was alerted and the director assisted with administering CPR to the SC and calling 911. Shelter staff were interviewed and indicated that the sibling was present at the time of the incident, but was removed from the scene and escorted to the shelter's day care.

ACS assessed the safety of the surviving sibling within the required timeframe and had no concerns for his safety. The sibling was interviewed by ACS and provided an account that was contrary to that of the parents as he reported that the SC co-slept with the parents on a daily basis. However, the parents were interviewed by the NYPD and medical staff and their account was consistent to the information they provided to ACS. The parents maintained that the SC always slept in his bassinet, including on the day of the incident .

The NYPD reported that no arrest would be made as there was no criminality suspected concerning the SC's death. The documentation reflected that the 911 was made at 8:14 A.M. and EMS arrived at the hospital at 8:48 A.M.; the specific time of death was not documented. The doctor from the ER noted that the SC arrived at the ER with a

temperature of 89 degree Fahrenheit, which was indicative of someone who had been dead for a while. The doctor noted that the cause of death was unknown; however, based on their examination the SC could have died of Sudden Infant Death Syndrome.

The ME and the doctor from the BLH found there was no evidence of abuse or trauma.

On 7/21/16, ACS indicated the report. The allegations were substantiated based on the account provided by the 6-year-old sibling and the fact that the parents had received safe sleep information. However, according to the parents, they were not co-sleeping with the SC. ACS' documentation of the investigation did not specify how they determined that the sibling's account was more credible than that of the parents.

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?** — No
  - **Safety assessment due at the time of determination?** — Unable to Determine
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** — No

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?** — Unable to Determine

Explain:
N/A

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Timeliness of completion of FASP
Summary:	ACS did not launch the initial FASP in a timely manner after the completion of the investigation.

Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to Provide Notice of Indication
Summary:	The NOE was not issued to the father.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	ACS indicated the report using an account provided by the 6 year old sibling which contradicted the parents'. There was no relevant collateral to support this decision. The autopsy has not been issued.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS indicated the report using an account provided by the 6-year old sibling which contradicted the account provided by the parents. There was no relevant collateral to support this decision. The autopsy has not been issued.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS completed the 7-day Safety Assessment; however, neither the selected safety factors nor the decision reflected the circumstances of the case or was supported by the documented comments.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	During the investigation, ACS learned of a physical altercation involving the parents; however, there was no exploration of the circumstances surrounding the incident to determine the safety of the child in the home.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date

	of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/19/2016 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 08:42 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: 08:15 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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:

☐ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☒ Asleep
☐ Distracted ☐ Impaired by illness
☐ Impaired by disability ☐ Other:

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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)

Other Household 1	Other Child	No Role	Female	01 Year(s)

LDSS Response

Following the fatality report, ACS contacted the NYPD, medical and shelter staff, and family members to investigate the allegations. None of the parties interviewed had concerns about the parents' ability to care for the children.

The SC was the only child of the parents' relationship. The 6-year-old sibling was from the mother's former relationship. The father had a minor child who resided with her mother and with whom he had limited contact. ACS made no effort to contact this child or her mother.

According to the parents' account concerning the SC's death, on 5/19/16 the mother last fed the SC at 1:00 A.M. and then placed him on his back to sleep in his bassinet. The parents indicated that the SC usually slept through the night; however, the mother said the child was fed every two hours. The discrepancy was not addressed. The mother said that at about 8:00 A.M., she went to get the SC ready for an appointment and noticed the child was unresponsive.

The father said the mother noticed the SC was not breathing and brought the SC over to the bed where he began to administer CPR until the shelter staff arrived. The father said the six-year-old sibling was present, "watching and crying." The parents indicated that they received safe sleep information from the hospital when the SC was discharged and from the shelter. The parents reported that the SC usually slept in the bassinet with a blanket underneath him to "prop him up."

The shelter director indicated he was certified in CPR and provided assistance when he responded to the family's unit. ACS interviewed several staff at the shelter who indicated they had no concerns about the parents. The parents were both employed and shared the responsibility of caring for the children as one worked during the day and the other in the evenings.

The NYPD indicated the mother was asked to demonstrate how the SC was placed to sleep and she indicated she placed the SC to sleep in the bassinet and used a blanket to further cushion the bassinet. The detective noted that there was nothing in the bassinet to restrict the SC's breathing. The mother told the NYPD when she went to wake the SC she noticed he was stiff and unresponsive to her touch. The mother reported that she alerted the father who then began to administer CPR on the SC. The NYPD noted no arrest would be made as there was no criminality suspected concerning the SC's death.

On 5/20/16, ACS documented information of the sibling's attendance noting that he had missed 20 days of school. However, the parents noted that the sibling was going to graduate from kindergarten on 6/23/16.

The parents were offered bereavement counseling, clinical services, and PPRS which they accepted. However, after the death of the SC the parents' separated due to a domestic violence incident. The mother reported that she and the father were involved in a physical altercation on 6/11/16 and as a result she called law enforcement. The mother informed ACS that she did not want to pursue a case against the father and alleged this was an isolated incident and the sibling was not present. The mother reported that the father was arrested on 7/13/16 and an order of protection (OOP) was issued against him, which led to his removal from the shelter. There was no diligent exploration of the circumstances reported by the mother.

On 7/8/16, the mother was discharged from the shelter and referred to PATH due to her non-compliance with the curfew. The mother informed ACS she was feeling lonely at the shelter and wanted to spend the 4th of July weekend with her

family. The mother said the shelter caseworker denied her a pass because she did "not have a court order."

On 7/21/16, ACS indicated the report and kept an open Family Services Stage in CONNECTIONS as they had offered the family PPRS. A referral for PPRS was pending at the time of the determination.

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 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 OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
028922 - Deceased Child, Male, 1 Mons	028924 - Father, Male, 22 Year(s)	DOA / Fatality	Substantiated
028922 - Deceased Child, Male, 1 Mons	028923 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
028922 - Deceased Child, Male, 1 Mons	028923 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
028922 - Deceased Child, Male, 1 Mons	028924 - Father, Male, 22 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?	☐	☐	☒	☐

Explain:
ACS completed the 24 Hour and the 7 Day safety assessments timely. However, the 30 Day safety assessment was not completed timely. In all three safety assessments, the selected safety decision and safety factors did not reflect the circumstances of the case and were not supported by the comments.

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: N/A				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

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:
There were no immediate services needed for the sibling after the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate services needed after the fatality.

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 in NYS within three years prior to the fatality.

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

The mother was listed as a maltreated child in 6 SCR reports, 3 were indicated. The allegations of the reports were: EdN, L/B/W, PD/AM and IG.

On 4'18'10, the mother was listed as a subject in a report for allegations of IFCS and IG of her then 5-month-old child.

On 5/15/10, ACS filed an Article 10 Petition of Neglect at the Bronx Family Court against the MGM on behalf of the mother, who was then 15 years old, due to Inadequate Guardianship. The mother was remanded and was placed with the MGGM. in The mother was later placed in New York Foundling De Sales Maternity/Mother-Child Blended Residence with her then 6-month-old child until she was trial discharged to the MGGM on 3/1/11; the final discharge was 7/28/11. New York Foundling closed the mother's case on 9/8/11.

On 8/31/10, the mother was listed as a subject of a report for allegations of LOM and IG of her then 2 year old child. The report was unfounded on 10/29/10. ACS found that the mother was adequately caring for the child.

Known CPS History Outside of NYS

Between 1996 and 2007, the mother resided in Connecticut with her MGM. The mother had two episodes of foster care placement in that state. The mother was discharged from FC in Connecticut and returned to her mother who resided in NYC.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☐Yes ☒No

Preventive Services History

Preventive services, through Good Shepherd Services, were offered to the family, which included the mother's first child, from 3/14/11 until 3/19/12.

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 ACS Supervisory Team 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