NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-058 **Prepared by: New York City Regional Office**

Issue Date: 1/13/2016

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	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: 3 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 07/28/2015
Initial Date OCFS Notified: 07/28/2015

Presenting Information

The SCR report registered on 7/28/15 alleged that the the father was co-sleeping on the same bed with the three-month-old infant. When the father awoke, he found the infant unresponsive. The police and EMS arrived and tried to revive the infant enroute to the hospital. The infant was pronounced dead at 11:24 AM. The report stated that the mother was at work during this time and an 11-year-old sibling who was in the home had an unknown role.

Executive Summary

On 7/28/15, the SCR registered a report regarding the death of this 3-month-old male child. According to the narrative of the report, it was alleged that the child had been co-sleeping with his BF on the parents' queen size bed. The child had been placed face up on the bed between two pillows and when the BF awoke, the child was unresponsive. The child was pronounced dead at 11:24 AM on 7/28/15 at the hospital where he was taken by EMS. The allegations of the report were DOA/Fatality and IG by the BF. ACS later added IG of the SC by the BM. The cause of death was positional asphyxia due to bed sharing in an adult bed with soft bedding and the manner of death was listed as accident.

ACS Bronx Field Office (BxFO) conducted the investigation and made contact with the family on the same day the report was received. The statements provided by the adults and the surviving sibling remained consistent throughout the investigation. During the investigation the surviving sibling relocated to New Jersey (NJ) to reside with his MGM. ACS contacted the NJ CPS and requested courtesy visits to the family's home. The child was assessed as being safe with his extended family.

On 10/9/15, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the BF on the basis that the BF created a dangerous environment by co-sleeping with the SC and allowing an accident to occur. ACS documented that the father's actions directly contributed to the SC's death.

ACS added and substantiated the allegation of IG of the SC by the BM. ACS documented that the mother also created a dangerous environment when she removed the child from the playpen and placed him between two pillows on the bed.

ACS initiated the investigation within the mandated time frame and made contacts with the appropriate collaterals; however, the Risk and Safety Assessment forms were not completed accurately. Information obtained during the course of the investigation was not appropriately applied to the responses thereby elevating the level of risk and improperly identifying the need for services.

ACS exhibited good practice in reaching out to NJ CPS to ascertain the safety of the surviving sibling who had moved to NJ following the death of the 3-month-old child.

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?** Yes
- **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The Specialist made contact with the appropriate collaterals and sought the assistance of other entities as needed.

Was the decision to close the case appropriate? No

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 closed the case; however, in the Investigation Determination Safety Assessment which was approved two days before closing, ACS documented that there were safety factors which placed the child in immediate or impending danger of serious harm. ACS further documented that a Safety Plan was necessary; however, the documentation did not reflect the details of the plan.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The Safety Assessment was not timely or adequate. Although there were no safety factors that presented an immediate or impending danger to the child(ren), caseworker recorded safety decision #3 and did not record a safety plan.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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:	There were no safety factors that placed the surviving sibling in immediate or impending danger of serious harm; however, the Specialist documented there were those factors, and did not create a plan

	to control the situation.
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:	Investigation Conclusion Safety Assessments
Summary:	Although there were no safety factors that presented an immediate or impending danger to the child(ren), caseworker recorded safety decision #3. ACS did not complete safety plan which would have been necessary for the safety decision choice.
Legal Reference:	NYCRR 432.2(b)(3)(iii)(b)
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:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The Risk Assessment Profile was inaccurately completed. Questions 2, 3, 4, 5, 13, and 15 were incorrectly answered and the first question in the elevated risk section was incorrect. The final rating was high; however, this was due to the inaccuracies
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(b)
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: 07/28/2015 **Time of Death:** 11:24 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: 10:50 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
How long before incident was the child last seen by caretaker? 003 Hours
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: 001

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	003 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	024 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	029 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)

LDSS Response

On 7/28/15, following the receipt of the SCR report, the ACS Specialist reviewed the case for history; the BF's and BM's history as children and the BM's as an adult were reviewed. The history noted past episodes of domestic violence where the BM was the victim and an ex-partner was the perpetrator. In anticipation of the Initial Child Safety Conference (CSC) and possible service engagement, the ACS specialist opened a Family Services Stage.

On the same day, the Specialist made a visit to the home and documented that there was an odor of marijuana; however, it could not be ascertained that the odor was emanating from the family's home. The Specialist documented that the PGM reported that she "did not drink"; however, she was noticeably inebriated. The Specialist noted her "stammered" words and that she was sweating "profusely." The Specialist interviewed the PGM who reported she usually visited the home on Tuesdays and Thursdays and that the SC had been in her home on the weekend prior to his death. The Specialist asked the PGM about the sleeping arrangements for the SC when he was in her home. The PGM reported that the SC shared her bed and that she placed pillows around him to prevent him from falling from the bed. While not required the documentation did not reflect that the Specialist used the opportunity to educate the PGM about safe sleeping surfaces for infants.The PGM did not report any health concerns for the SC.

The Specialist noted that the bedroom where the SC died was "messy;" however, no details were provided and the BM explained the family was about to relocate. According to the BM, the SC was born at Jacobi Hospital. He was full term and was discharged from the hospital the same day she was. He weighed 7 pounds and 13 ounces at birth and did not have any medical problems.

The BM said the SC had awakened at 9:30 pm on 7/27/15, and went to sleep at 12:30 AM on 7/28/15. The SC awoke at 5:30 AM on 7/28/15 at which time she removed him from the playpen, fed, burped him, and put him in the bed next to the father. The BM further stated that the BF was on the left side of the bed and the SC was on the right side of the bed. The BM explained there were about 3 or 4 pillows surrounding the SC.The BM said before she left she put the SC back in the

playpen. The playpen, according to ACS, had only a sheet inside; there were no other objects. The BM said that she left for work at about 7:00 AM and when she left, the SC was fine. The BM was described as 5'6" and about 130 lbs.

The BF said that a few minutes after the BM left he heard the baby moving around in the playpen. The BF said he took the SC from the playpen and placed him in the bed with him with one pillow on each side of him. The BF said that he slept on the edge on the bed and when he woke up, the SC "just didn't look right" and he "knew something was wrong." The BF said he panicked and a PU who was in the home called 911. The exact time of the call was not noted. The BF said he attempted to transport the SC to the hospital; however, when he was a short distance from the home, he heard sirens and knew EMS was coming so he drove back and met EMS at the house. The BF said EMS took the SC, but the technicians did not allow him to ride in the ambulance. The BF was 5'4" tall and weighed 159 lbs.

The surviving sibling said that he was in the living room playing video games when he heard the BF say that the SC was not moving. The sibling reported the SC always slept in the bed with the father. The Specialist documented the sibling was fine. Subsequent attempts to interview the sibling were unsuccessful and ACS learned that the sibling had relocated to NJ to reside with his MGM. There were no safety concerns noted for the sibling while in NJ.

On 10/9/15, ACS substantiated all the allegations of the report including IG which was added against the BM for the SC. ACS documented that the parents created a dangerous environment for the SC.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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 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
023122 - Deceased Child, Male, 003 Month(s)	023125 - Father, Male, 024 Year(s)	Inadequate Guardianship	Substantiated
023122 - Deceased Child, Male, 003 Month(s)	023124 - Mother, Female, 029 Year(s)	Inadequate Guardianship	Substantiated
023122 - Deceased Child, Male, 003 Month(s)	023125 - Father, Male, 024 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

Additional information:

There is no additional information for any of the above.

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:
The 11-year-old sibling was not removed. He relocated to NJ to reside with the MGM.

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	Offered,	Offered,	Needed	Needed	N/A	CDR

	After Death	but Refused	Unknown if Used	but not Offered	but Unavaliable		Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☒	☐	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☒	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☒	☐	☐	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☒	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents refused 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:
To address any immediate needs and support the sibling's well-being in response to the fatality, ACS planned to refer the sibling to bereavement counseling; however, the sibling relocated to New Jersey to reside with his maternal grandmother.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
To address any immediate needs and support their well-being in response to the fatality, ACS planned to refer the parents to substance abuse treatment, domestic violence counseling, parenting and problem solving skills training, and bereavement counseling. ACS also planned to support the family in seeking avenues to pay rent arrears and to assist with educational needs. Ultimately, the parents did not comply with substance abuse evaluations and refused all other 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?	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

The father had no history as an adult, but was known as a child on cases involving his mother. He was in foster care placement from June 1991 to June 2000.

The mother was known to the SCR and ACS in reports as a child. She was also in foster care placement more than three years before the fatality, and while in care, there were two reports in which she was involved. As an adult the mother was known to the SCR in a report registered on 5/5/09. The report alleged that the the mother and other adults in the home were often "high on marijuana" and on a regular basis they drank to the point of intoxication. The report alerted this occurred in the presence of the children. The report further alleged the adults including the mother could not provide a minimum degree of care to the children.

ACS investigated the report's allegations which included PD/AM, LOS, and IG of the children by the adults. ACS Bronx Field Office unsubstantiated the allegations of the report and closed the case on 7/2/09.

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