NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-064 **Prepared by: New York City Regional Office**

Issue Date: 12/28/2015

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: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 08/19/2015
Initial Date OCFS Notified: 08/19/2015

Presenting Information

On 8/19/15, the SCR registered two reports concerning the death of the SC.

The first report alleged that the mother placed the SC to sleep with her on the bed at 12:00 A.M. The mother awoke at 2:00 A.M to feed the SC and once again placed him to sleep with her on the bed. The mother was reportedly lying on her left side with the SC lying on his side facing away from her. When the mother awoke at 8:00 AM on 8/19/15, the SC was faced down and dead. The report noted the SC was an otherwise a healthy child.

The second report alleged that the mother placed the SC to sleep with her on the bed and at some point rolled over on the SC and suffocated him.

Executive Summary

The SC was one month old at the time of his death. An autopsy was completed; however, as of 12/17/15 the ME has not issued the autopsy report or provided a verbal determination of the cause and manner of death. The death certificate reflected that the cause of death is pending.

At the time of the SC's death, ACS had an open investigation of a report that was registered with the SCR on 7/8/15. The report was made after the mother gave birth to the SC in the commode of a relative's home. The report noted that the mother was homeless and had no provisions for the child. The SC was treated at Brooklyn Hospital. Despite the mother having an extramural delivery, the SC was subsequently discharged, in good health, to her. ACS accompanied the mother with the SC to the Prevention Assistance and Temporary Housing (PATH) office and the mother and SC were placed in a family shelter; they remained in the shelter until the SC's death.

On 8/19/15, the SCR registered two reports with allegations of DOA/Fatality and IG of the SC by the mother.

ACS' investigation revealed that the mother placed the SC to sleep with her on a twin size bed after feeding him at 2:00 A.M. The mother indicated that she was positioned sideways (right side) at the end of the bed and the SC was on her (the BM) upper inner arm. The mother covered the SC with a receiving blanket from his chest down to his feet; and covered herself with a separate sheet. The mother awoke at 8:00 A.M. and found the SC was no longer below her upper arm; he was face down on the bed and lifeless. The mother then turned the SC over and noticed he was not breathing.

The mother called 911. EMS was dispatched to the case address at 8:05 A.M., and arrived at 8:08 A.M. EMS found the SC lying in a supine position on the bed. Rigor mortis and liver-mortis had already set in, which indicated the SC had been dead for a while (time not specified). EMS pronounced the SC dead at 8:10 A.M. The ME also responded to the home at 11:06 A.M.; and the coroner transported the body to the morgue.

Neither the NYPD nor the ME had any concerns of foul play involving the SC's death. The ME indicated there were no signs of abuse or trauma on the SC's body. The shelter staff had no concerns about the mother's ability to care for

the SC. Contact with the pediatrician revealed the mother kept medical appointments and the SC was a well-child. Prior to the SC's death, the mother had received safe sleep information from the pediatrician, ACS, shelter staff and Brooklyn Hospital; however, in spite of being informed of the dangers of co-sleeping, the mother disclosed that she frequently co-slept with the SC because he would often cry when she placed him in the crib. Literature of safe sleep information was observed in plain sight in the mother's room. When asked, the mother denied any use of drugs or alcohol.

The father was involved in the SC's life; however, he resided separately and had no firsthand information concerning the circumstances that led to the SC's death. The father provided some monetary support for the SC, but had no childcare responsibilities.

On 10/16/15, ACS indicated the 8/19/15 reports against the mother citing that she was educated on the dangers of co-sleeping but placed the SC at risk of harm by co-sleeping with him.

As of 12/22/15, ACS had not received the autopsy report.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
N/A

Was the decision to close the case appropriate? Yes

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

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

Explain:
N/A

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: 08/19/2015 **Time of Death:** 08:10 AM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 08:00 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
How long before incident was the child last seen by caretaker? 6 Hours
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	Mother	Alleged Perpetrator	Female	30 Year(s)
Other Household 1	Father	No Role	Male	45 Year(s)

LDSS Response

Following the receipt of the fatality reports, ACS investigated the 7/8/15 and 8/19/15 reports simultaneously.

ACS' investigation revealed that on 8/19/15 the mother placed the SC to sleep with her on a twin size bed after feeding

him at 2:00 A.M. The mother indicated that she was positioned sideways (right side) at the end of the bed and the SC was on her upper inner arm. The mother covered the SC with a receiving blanket from his chest down to his feet, and covered herself with a separate sheet. The mother awoke at 8:00 A.M. and found the SC was no longer under her arm; he was faced down on the bed and was not moving. The mother called 911 after she turned the SC over and noticed he was not breathing.

EMS found the SC lying in a supine position on the bed. Rigor mortis and liver-mortis had already set in, which indicated the SC had been "dead for a while." EMS could not exactly how long the SC had been dead. EMS pronounced the SC dead at 8:10 A.M. The ME also responded to the case address and transported the body to the morgue.

The mother denied any use of drugs or alcohol. The NYPD noted that she did not appear to be under the influence of drugs or alcohol and there were no drug paraphernalia observed in the room. Neither the NYPD nor the ME had any concerns of foul play involving the SC's death. The ME indicated there were no signs of abuse or trauma on the SC's body.

The NYPD noticed an "imprint" on the side of the SC's face and ruled the death a "rollover"; however, the ME explained that the imprint could have been the result of the blood pooling after a person dies. The ME did not provide a verbal determination regarding the cause and manner of death.

Prior to the SC's death, the mother had received "Safe Sleep" information from ACS, shelter staff, a visiting nurse, and Brooklyn Hospital. Literature of safe sleep practices and a poster over the SC's crib were observed in the mother's room. In spite of being informed of the dangers of co-sleeping, the mother disclosed that she frequently co-slept with the SC because he would often cry when she placed him in the crib. ACS contacted the SC's pediatrician, visiting nurse and the shelter staff who reported having no concerns about the mother's ability to care for the SC.

The father had no childcare responsibilities. The SC's father initially reported that he resided in a rented room that was not appropriate for the child. He had no firsthand information concerning the circumstances that led to the SC's death.

The father separated from his wife in 2009 and had three minor children. ACS visited his family and assessed those children were safe in their mother's care. While the family was aware of the SC's death, none of the family members had met the SC.

ACS offered the parents and extended family bereavement counseling; they all declined.

On 10/16/15, ACS substantiated the allegations of DOA/ Fatality and IG from the 8/19/15 reports against the mother citing that she placed the SC at risk of harm by co-sleeping with him. ACS further cited that the mother was educated on the dangers of co-sleeping with the SC, but did not apply the information.

As of 12/22/15, ACS had not received the autopsy 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: 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 OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
019621 - Deceased Child, Male, 1 Mons	019622 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
019621 - Deceased Child, Male, 1 Mons	019622 - Mother, Female, 30 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?	☒	☐	☐	☐

Additional information:
N/A

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
ACS requested funds for the funeral and cremation, but as of 11/30/15 the payment is pending.
ACS discussed shelter for the mother and continued to advocate for housing after the SC's death. As of 11/30/15, a response from ACS' housing subsidy is pending.

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. However, ACS provided resources for the parents to receive bereavement counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
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? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/08/2015	4391 - Deceased Child, Male, 2 Days	4392 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	Yes
	4391 - Deceased Child,	4392 - Mother,	Inadequate Food /	Indicated	

Male, 2 Days	Female, 30 Years	Clothing / Shelter	

Report Summary:
On 7/7/15, the SCR registered two reports noting that the mother was homeless and had given birth to the SC in the toilet of a relative's home. There were concerns that the mother had no provisions for the SC and had a history of neglect pertaining to another child who was no longer in her care.

The SC was treated at Brooklyn Hospital after his birth and was subsequently discharged in good health. The father resided separately in a furnished room that was not adequate for the SC. ACS escorted the mother to PATH and she and the infant were placed in a shelter.

Determination: Indicated | **Date of Determination:** 09/04/2015

Basis for Determination:
ACS substantiated the allegations of IFCS as the mother was homeless and did not have provisions for the SC at the onset of the investigation.

ACS substantiated the allegation of IG citing that the mother placed the SC at risk of harm by co-sleeping with the SC despite receiving safe sleep education from the SC's pediatrician and visiting nurse. ACS noted that the SC died while co-sleeping with the mother.

OCFS Review Results:
ACS held a CSC and decided that an Article 10 Petition for COS was warranted, primarily based on the mother's ACS history. FCLS deferred the petition citing the mother's willingness to accept services and that she had entered the shelter to secure housing. FCLS also noted there was not sufficient information to establish that the mother's prior behaviors that led to the TPR of her first child currently existed.

The mother was referred for VN services and had received safe sleep information; however, she often co-slept with the SC. On 8/19/15, the SC died while co-sleeping with the mother and a report was registered with the SCR.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The safety decision #3 selected for the 7 Day safety assessment noted safety factors were present that placed the SC in immediate or impending danger of serios harm; however, ACS did not list any safety factors.
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:
Provision of Notice of Indication
Summary:
The CONNECTIONS event list reflects that there was no NOI issued for the parents.
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.

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

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

Known CPS History Outside of NYS

The family had 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

The mother had a child who was removed from her care; the child was subsequently adopted.

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 management review with staff the guidelines for opening a Family Services Stage.

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