NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-14-106 **Prepared by: New York City Regional Office**

Issue Date: 4/8/2015

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-plumonary 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 Suprevision
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

Jurisdiction: Nyc Regional Office

Date of Death: 10/10/2014

Age: 5 month(s)

Gender: Male

Initial Date OCFS Notified: 10/10/2014

Presenting Information

On 10/10/14, the 5-month-old child died while in the care of the PGM. The PGM fed the child and placed him on his side on an adult bed to sleep and a while later the child was found unresponsive with blood coming from his nose and mouth. It was unknown what time the mother fed the child and it was unknown how much time elapsed between placing the child in bed and finding him unresponsive. The PGM and a relative drove the child in their car and en route saw a policeman who attempted CPR without success. The police transported the child to the hospital where the child was pronounced DOA. There was no explanation for the child's death of this otherwise healthy child.

Executive Summary

The mother left the home for work at 8:00 A.M. on the morning of 10/10/14 with the five-month-old infant left in the care of the PGM. Later that morning, at 11:30 A.M., the PGM fed the infant and placed him on his side on a full sized adult bed alone to sleep. She placed the child in the bed, then went downstairs. She indicated that she checked the child periodically although she could not recall exact times.

On the same date, at 12:20 P.M., a paternal cousin (PC) visited the home to see the infant. The PC and PGM went to the PGM's bedroom where they found the infant lying on his back, unresponsive, with blood coming out of his mouth and on his face. The father was called home and a PU, who was in the home asleep, drove the father, infant, PGM and PC to the Kings County Hospital (KCH) E/R with a LE patrol car escort they secured while in transit. An officer attempted to resuscitate the infant on the way to KCH. The infant was pronounced DOA upon arrival at KCH.

ACS' BFO initiated the investigation on 10/10/14 by interviewing medical staff and family members. The interviews with family members resulted in a discrepancy as to who the caretaker of the infant was at the time of the incident, the PGM or the PGGM. Both members stated they were the caretaker when the infant was found unresponsive. Despite this discrepancy ACS maintained the PGM as the sole subject of the report when based on its own documentation, the PGGM could have been added to the report as a subject because the investigation revealed she was caring for the infant.

On 10/14/14, the Specialist interviewed the KCH physicians who attended to the infant, the father, PGM, PGGM, PU, and the to obtain information regarding the infant's death. During these accounts both the PGM and PGGM again stated they were both caring for the infant on the morning of 10/10/14.

The Specialist contacted the NYPD on 10/17/14 and was told the ME informed LE there was no indication of trauma, neglect or abuse to the infant and based on this finding no arrest or criminal charges would be sought by LE regarding the infant's death. ACS continued to make visits with the family and obtain collateral information, particularly about the well being of the twelve-year-old PA.

On 2/2/15, ACS unsubstantiated the allegations of the report against the PGM. ACS based the decision on the ME's statement the child died of natural causes due to SIDS and the death was not caused by neglect or abuse by the PGM.

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

Explain:

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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.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Progress Notes
Summary:	The progress notes of this investigation were confusing and at times difficult to follow. There were relationship errors throughout that made it difficult to discern if the information was documented for the appropriate family member.
Legal Reference:	18 NYCRR 428.5
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:	Adequacy of Child Protective Services casework contacts
Summary:	Throughout this investigation there were numerous inconsistencies identified by ACS supervision yet they were not resolved prior to determining this report regarding the care of the infant. The interviews with the PGM and PGGM remained inconsistent.
Legal Reference:	432.2(b)(4)(vi)
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:	Overall Completeness and Adequacy of Investigations
Summary:	This investigation was not adequately investigated. The directives around the statements provided by the PGM and PGGM remained unresolved. If both were caring for the infant the PGGM should have been added to the report and the allegations unfounded.
Legal Reference:	SSL 424.6 and 18 NYCRR 432.2(b)(3)
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: 10/10/2014 **Time of Death:** 02:11 PM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 1 Hours
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 01

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age

Deceased Child's Household	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Grandparent	No Role	Male	56 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	54 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)
Deceased Child's Household	Other Child	No Role	Female	12 Year(s)
Other Household 1	Father	No Role	Male	26 Year(s)
Other Household 1	Grandparent	No Role	Female	80 Year(s)

LDSS Response

On 10/10/14, ACS initiated an investigation into the death of the five-month-old infant and contacted Kings County Hospital (KCH) for information. Hospital personnel reported the PGM usually cared for the infant while the mother worked.

During the investigation, it was revealed the mother last fed the infant at 5:30 that morning. The mother told the ACS Specialist the infant awoke at 7:45 A.M.; she took him to the PGM's bedroom and prepared for work. The mother said the infant was fine, playing with the PGM when she left for work at 8:00 A.M. The mother also stated there were two adult female cousins in the home but both left before the incident.

On the same date, ACS went to KCH and interviewed the physician who attended to the infant. ACS learned that at 1:45P.M., the infant was observed to be unresponsive, not breathing, and was blue with no pulse. The physician added there was blood present around the nose and mouth but there were no signs of maltreatment or abuse and described the infant as "a healthy child," who had been examined and treated at KCH on 6/6/14 for a minor illness. The physician told the Specialist a paternal cousin went into the bedroom and found the infant unresponsive then called the father who immediately came home and they brought the infant to KCH by personal car.

Later on the same date, ACS visited the case address (C/A) and interviewed the PGM and PGF. The PGM stated she was not home at the time the mother went to work which is inconsistent with the mother's account. ACS documented the PGM was vague when responding to questions and she stated on the morning of 10/10/14 she arrived home at 11:00 A.M. and the maternal adult cousin was caring for the infant then left for school. The PGM said she fed, burped and played with the infant before putting him down for a nap.

On 10/12/14, the Specialist visited the C/A and interviewed the PGF who stated the family received a call from the ME’s office and were told it appeared the death was due to natural causes. The Specialist also interviewed the twelve-year-old PA who stated she was in school at the time of the incident but learned of the death after school when she was with the family at KCH. The PA said the infant was happy and playful the night prior to the incident. ACS documented the PA as well cared for with no indications of neglect or abuse.

ACS obtained information from KCH's medical staff on 10/14/14. The Dr. who was familiar with the case informed ACS that the father ran into the ER with the infant at approximately 1:50 P.M., and the infant was pronounced dead at 2:11 P.M.

On the same date, ACS visited the C/A and interviewed the relatives. The PU stated he was asleep when the PGM (his mother) and a male paternal cousin’s screams woke him. The family members explained the infant was deceased. The PU ran to get his car and he, the father, who was working on a car near the C/A, and PGM, drove to KCH.

The Specialist also interviewed the PGGM who resided elsewhere. She stated she was caring for the child at the time of

the incident. ACS documentation is confusing and this is a major discrepancy that remained unresolved during this investigation. On 1/10/15, the two adult cousins who were at the C/A prior to the incident confirmed the PGGM was in the home caring for the infant. ACS could have added the PGGM to the report as a subject of the report.

During this investigation, ACS made contact with the family, LE, the ME's office, and unsuccessfully tried to resolve the discrepancies in accounts. LE was contacted and told ACS no charges would be brought against the family as there was nothing suspicious found by the ME or LE to imply the infant was abused.

On 1/30/15, ACS called the ME and was told the death was attributed to SIDS. On the basis of the information received from the ME, ACS unsubstantiated the allegations DOA/Fatality on 2/2/15.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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 ACS investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no approved OCFS Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
014541 - Deceased Child, Male, 5 Mons	014544 - Grandparent, Female, 54 Year(s)	DOA / Fatality	Unsubstantiated
014541 - Deceased Child, Male, 5 Mons	014544 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated

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:

Documentation was timely; however the documentation regarding relationships was confusing. It was difficult to discern whether there were typographical errors regarding which relative was being identified: the PGM or PGGM.

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?	☐	☐	☒	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents refused all services offered by ACS.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No

Explain:
The family declined services.

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 needs related to the fatality. The parents had no other children and the twelve-year-old PA was assessed as in good health, safe and doing well in school.

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?	N/A
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

Family has no CPS history.

Known CPS History Outside of NYS

There is no 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