NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-062 **Prepared by: New York City Regional Office**

Issue Date: 3/25/2016

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 08/16/2015
Initial Date OCFS Notified: 08/16/2015

Presenting Information

The report alleged that on 8/16/15, an otherwise healthy male infant (age two months) died while in the care of the mother and stepfather. The infant was sleeping in a car seat located in the same bedroom as the mother and stepfather. At approximately 3:00 AM the infant awoke for a feeding. The mother fed the infant, and placed the infant back into the car seat in the fetal position. At 2:00 PM, the mother awoke and found the infant blue and unresponsive. The mother woke up the stepfather and together they walked the infant to the emergency room. The infant had no visible injuries. The infant had no pre-existing health concerns. On 8/14/15, the infant was taken for a child well check appointment and no medical concerns were documented at that time.

Executive Summary

The male infant died on 8/16/15 and on the same day the SCR registered a report with allegations of DOA/Fatality and IG of infant by the mother and stepfather. The autopsy report listed the cause of death as Positional Asphyxia and manner of death as Accident (Face Down in Soft Bedding in Car Seat) .

ACS investigation revealed that on 8/10/15 the mother had moved to the stepfather's home. The mother did not have a crib for the infant in the STF's home; therefore, the infant had been sleeping in a car seat. On 8/16/15, at about 6:00 AM, the mother fed and then placed the infant on his side in the car seat. The mother explained that when she put the infant to sleep in the car seat, she placed a fleece blanket in the car seat with the edges hung over the sides then wrapped the infant in another blanket and laid him on his right side. The infant was not strapped in the car seat. Following the 6:00 AM feeding, the mother went to sleep and did not wake until about 2:00PM. She checked the infant and saw that he was face down in the car seat with the blanket over his head. When she picked him up his face was purple. The stepfather took the infant to the step-paternal grandfather who told them to call an ambulance. The stepfather walked with the unresponsive infant to the hospital as the hospital was only one block away.

ACS documented that at the STF’s home the mother and stepfather slept on the bottom of the bunk bed while the three-year-old half sibling slept on sheets on the floor. The infant slept in the car seat. ACS observed the room which the mother occupied with her two children. The mother shared the bed with the half sibling and she had a bassinet at the foot of the bed. Later, the mother informed ACS that the half sibling slept on a comforter on the floor in the room.

On 8/17/15, the ME reported there were no injuries found on the infant except for an abrasion on the chest which was due to the resuscitative efforts by hospital staff.

The STF admitted he had used marijuana since the infant died but denied that it was in the presence of the half sibling. The STF said he did not need drug treatment. ACS' documentation reflected that there was no evidence the mother used drugs.

ACS met with Family Court Legal Service (FCLS) on 8/21/15 to file an Article Ten Neglect petition against the mother and STF and request COS. The petition was delayed for additional information to establish a cause of action for neglect. The family was then referred to PPRS with the Boys Town New York, Inc. to provide bereavement

counseling, support for the father, and Early Intervention (EI) services for the sibling. On 9/22/15, a joint home visit with the PPRS agency Boys Town occurred. Boys Town documentation reflected that the agency terminated PPRS. The mother was noncompliant. ACS informed Boys Town that the child was residing outside of NYC.

The Safety Assessments were not adequately completed as the selected safety factors and comments of the 8/17/15 Safety Assessment generally pertained to the deceased infant and not the surviving half sibling. Also, the 9/18/15 Safety Assessment had comments about the STF's drug use which did not support the selected safety factor as it did not indicate how the STF's drug use negatively impacted his ability to supervise the child.

On 3/15/16, ACS substantiated the allegation of IG of the infant by the mother. ACS based their decision on the mother's own account that she placed the infant in the car seat and the STF's accounts also confirmed the mother's account that she placed the infant in the car seat, an unsafe sleep environment, repeatedly over a two month period. The mother confirmed she received safe sleep information and therefore understood the infant's sleep environment was compromised by soft bedding, and infant's sleep position.

ACS unsubstantiated the allegations of DOA/Fatality by the mother and STF and IG by the STF. The infant's death was deemed to be accidental.

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?** 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:
NA

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

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:
NA

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The 9/18/15 Safety Assessment reflected that the comment of the STF's drug use did not support the safety factor as it did not indicate how the STF's drug use negatively impacted his ability to supervise the child.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(b)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations 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:	Failure to provide notice of report
Summary:	Although ACS provided the Notice of Existence (NOE) to the mother and STF, the Event List did not reflect that the step-paternal grandfather or the biological father of the 3-year-old was provided one despite being named in the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations 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: 08/16/2015 **Time of Death:** 03:10 PM

Time of fatal incident, if different than time of death: 02:00 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? 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: Not impaired.

Total number of deaths at incident event:

Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other	No Role	Female	60 Year(s)
Deceased Child's Household	Other	No Role	Male	60 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	29 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	18 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	22 Year(s)
Other Household 1	Grandparent	No Role	Female	54 Year(s)

LDSS Response

During the investigation, ACS interviewed the hospital social worker (HSW), examining Dr., mother, STF, SPGF, step-paternal grandmother (SPGM), MUs and children's Dr.

The HSW informed ACS that the infant was sleeping in a car seat located in the same bedroom as the mother and STF. At 2:00 PM, the mother awoke and found the infant blue and unresponsive. The mother woke the STF and they walked the infant to the emergency room (ER). The infant was taken for a child well check appointment on 8/14/15 and there were no medical concerns noted.

LE informed ACS that the ME observed the infant to be free of trauma, marks and bruises. LE said that according to the mother, the infant stopped breathing at about 2:00 PM.

The mother said she was asleep and was awaked by the infant at about 3:00 AM for a feeding. She fed him and laid him in the car seat. The infant awoke again at 6:00 AM for another feeding. The mother fed him and then placed him on his side into the car seat as usual. The mother went to sleep and did not wake until before 2:00 PM. The STF said his phone rang and he got up and left the room to speak. It was about that time she checked the infant and saw he was face down in the car seat with his face in the blankets that she placed in the car seat. When she picked him up his face was purple. She and the STF took the infant to the hospital ER. The three-year-old surviving sibling was left with the SPGM. The mother said the infant slept in the car seat as she did not have a crib. She said she knew about the dangers of co-sleeping. The mother said she had two obstructions in the car seat with the infant; a thin and thick blanket. The mother did not find it odd that the infant slept that long. She said he had a sporadic eating schedule. The mother informed ACS that the infant was healthy

and was seen by the Dr. on 8/14/15.

ACS visited the MGM's home and observed a bassinet and a queen-size bed which the mother shared with the surviving half sibling. Documentation reflected that the mother stated the infant slept in the bassinet at the foot of the bed. Later, the mother said when she put the infant to sleep in the car seat, she laid a fleece blanket in the car seat with the edges hung over the sides; the mother wrapped the infant in another blanket and laid him on his right side. The half sibling slept on a comforter on the floor in the room. The infant was not strapped in the car seat. When she checked the infant, she found him face down with the blanket over his head. The mother informed ACS that she was staying at the home of the SPGM's since 8/10/15 as she got into an argument with the maternal grandmother and she was asked to leave.

The STF's account was similar to the mother's account. He said that at about 2:00 PM, he woke when the step-paternal aunt (SPA) called him. The mother got his attention and when he looked at the infant in the car seat, his face was blue. The STF took the infant to the step-paternal grandfather (SPGF) who told them to call an ambulance. The STF decided to walk thought to the hospital which was only one block away. The mother and STF quickly walked one block with the infant to the hospital.

The child's Dr. informed ACS that the infant was seen on 8/14/15 and prior to that date as there was a concern the infant was not gaining weight. The infant received immunizations on 8/14/15. The infant gained weight and there was no concern about the care of the infant. The Dr. had no concerns for the half sibling.

On 8/17/15, the SPGF said he was in the kitchen around lunch time when the STF showed him the infant. The SPGF observed the infant was not moving so he told him to call 911. He stated the STF and mother decided to take the infant to the hospital as it would take too long for EMS to arrive. The SPGM was not home when the event ensued. Documentation reflected that the mother stated the infant's father was incarcerated and did not know the infant. ACS did not interview the infant's father.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to 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 NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

022341 - Deceased Child, Male, 2 Mons	022343 - Stepfather, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
022341 - Deceased Child, Male, 2 Mons	022342 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
022341 - Deceased Child, Male, 2 Mons	022342 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
022341 - Deceased Child, Male, 2 Mons	022343 - Stepfather, Male, 29 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

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?	☐	☒	☐	☐

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: Preventive Services

Additional information, if necessary:
The family was referred to preventive services with Boys Town to provide bereavement counseling, father support group and Early Intervention (EI) services. The STF declined to speak with the Certified Alcohol and Substance Abuse Counselor (CASAC) but agreed to submit to a drug screening.

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? Yes
Explain:
The family was referred to preventive services with Boys Town to provide bereavement counseling, father support group, and EI services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

The family was referred to preventive services with Boys Town to provide bereavement counseling, father support group, and EI 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 mother and stepfather (STF) were not known to the SCR or ACS as subjects.

Known CPS History Outside of NYS

There was 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