Child Fatality Report

Report Identification Number: NY-18-008

Prepared by: New York City Regional Office

Issue Date: Jul 06, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
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
CPS-Child Protective Services		
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-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 29 day(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 01/16/2018
Initial Date OCFS Notified: 01/23/2018

Presenting Information

On 1/23/18, the SCR registered a report alleging that on 1/16/18 the 29-day-old SC's father was driving while under the influence of an unknown substance and crashed. The mother and the 29-day-old SC died as a result of the crash, and the 7-year-old sibling sustained internal injuries and a concussion that needed follow up medical care. The accident occurred in Pennsylvania (PA).

Executive Summary

The SC was 29 days old when he died on 1/16/18. The death certificates of the SC and the mother listed their cause and manner of death as blunt force trauma due to a motor vehicle accident.

The death of the SC and mother occurred in Pennsylvania (PA). The family was visiting a home they purchased in September 2017, but had not yet occupied. The Coal Township Police Department (CTPD) initially determined the father's vehicle slipped on ice and struck a tractor trailer. The SC's father and the sibling were transported to Geilsinger Shamokin Hospital (GSH). The father's prognosis was poor; he was placed on life support and was not expected to survive. The sibling was treated for multiple injuries and discharged from the hospital to his maternal relatives on 1/22/18. It was later learned the SC's father was driving while intoxicated (DWI), which may have contributed to the fatal accident. Due to his medical condition, no charges had been filed.

On 1/23/18, the SCR registered a report concerning the death of the SC. The allegations of the report were DOA/Fatality, IG and PD/AM of the SC by the father and II, PD/AM and IG of the sibling by the father. The sibling's father resided out of state and efforts to contact him were unsuccessful.

On 1/23/18, ACS initiated the investigation and assessed the sibling was safe in the care of a MU who remained at the case address. This MU resided with the mother, SC and sibling prior to the mother's death. There were no safety concerns related to the condition of the home. The sibling appeared comfortable in the home with the MU.

On 2/5/18, the MU filed a petition for guardianship of the sibling at the Bronx County Family Court (BCFC). The sibling remained in the physical custody of the MU pending the outcome of the petition. ACS conducted the required database checks for the MU's spouse who assisted the MU with caring for the sibling.

ACS made relevant collateral contacts and obtained significant information about the family that helped to assess for the needed services. ACS learned that the MU and his spouse smoked marijuana. ACS determined their use of marijuana did not have a negative impact on their ability to care for the sibling. The MU and spouse submitted to random drug screenings and based on the toxicology results they discontinued their use of marijuana.

ACS made appropriate safety decisions and adequately assessed concerns that arose throughout the investigation. However, the information in the safety assessment instruments and the RAP was not consistent with the case circumstances. The safety assessments and RAP documents were approved although the information was not consistent with the case circumstances. The ACS case record showed there were several progress notes that were not entered contemporaneously. Some of the events that occurred on 3/1/18 and 3/26/18 were not entered until 5/1/18 and 5/2/18, respectively.

On 6/18/18, ACS substantiated the allegations against the father based on the circumstances of the accident which caused the SC's death and the injuries of the sibling. ACS explained that the father's toxicology report revealed he was under the influence of numerous drugs which could have contributed to the fatal accident.

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

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	The selected safety decision and safety factors were not consistent with the case circumstances.
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 PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The selected safety decision and safety factors were not consistent with the case circumstances.
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 PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The CPS team took appropriate steps to assess the safety of the sibling; however, the safety assessments were approved even though the information contradicted the case documentation.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(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 PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP instrument did not include accurate information as responses to the questions listed were not explored and/or not consistent with the case circumstances.
Legal Reference:	18 NYCRR 432.2(d)
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 PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The selected safety decision and safety factors were not consistent with the case circumstances.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS did not enter progress notes contemporaneously. Some of the events that occurred on 3/1/18 and 3/26/18 were not entered until 5/1/18 and 5/2/18, respectively.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a PIP 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: 01/16/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Out Of State
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was:

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

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	29 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	7 Year(s)

LDSS Response

On 1/23/18 and 1/24/18, ACS contacted the CTPD and GSH to follow up on the events that led to the SC's and the mother's demise.

The CTPD determined the inclement weather caused the fatal accident; however, the father's toxicology revealed he was DWI. The CTPD reported that due to the father's medical state no charges had been filed. The CTPD stated the parents were not carrying any identification; the family was identified by medical documentation that was in the car for the SC.

Concerning the allegation of the MUs "reeking of marijuana," the GSH staff stated the nursing supervisor and the auxiliary manager followed up and found no smell of such during the MU's visit. In addition, it was reported the MUs were interviewed and responded appropriately. The GSH stated the MUs seemed concerned for the father who remained in a coma and asked to see him; however, the MGM became very angry as she blamed the father for the mother's death. The MUs disclosed the MGM had clinical issues.

On 1/23/18, ACS visited the case address and met the MU, his spouse and the sibling. ACS assessed the sibling to be safe in the care of the MU who resided with the mother and the children prior to the fatality. The MU reported he intended to care for the sibling and remain at the case address to provide some stability by remaining in the home and the same school. The MU reported the sibling's father had not been involved in the sibling's life. ACS found an out of state address for the sibling's father and mailed a NOE, but did not receive a response.

The sibling was interviewed privately and he expressed a desire to remain with the MU. The sibling said that at the time of the accident, he had his seat belt fastened and the SC was sitting to his right in a car seat. The sibling said the ambulance transported him to the hospital where he remained alone for several days until his family arrived and brought him home. The GSH located the family through the sibling's school as the MU was listed as the emergency contact. The sibling had no knowledge of any drug use in the home.

On 2/1/18, the MGM went to the case address and assaulted the MU when she learned that he intended to file for custody of the sibling. The MGM threatened to take the sibling and assaulted the MU in the presence of the sibling. The MU obtained an OOP and agreed to keep the sibling away from the MGM. The sibling was interviewed and stated he did not want to have contact with the MGM. A report was registered with the SCR and indicated against the MGM who had a history of MH and aggressive behavior.

On 2/5/18, the MU filed a custody petition for the sibling; the next court date was scheduled for 6/27/18. ACS submitted a report to the Family Court.

The MU and his spouse made certain the sibling kept all his medical appointments and followed up on ACS' recommendations. ACS coordinated medical, education, therapeutic and bereavement services for the sibling through his school and Montefiore Hospital. The MU and his spouse submitted to random drug screening and discontinued their use of marijuana.

On 2/23/18, ACS held a Child Safety Conference to discuss the incident with the MGM and the use of marijuana by the MU and the second MU whom the Specialist observed smoking in the building hallway. The MU and his spouse accepted PPRS. The MU was adamant he would not allow the MGM access to the SC and that the other MU had no child care responsibilities concerning the sibling. ACS determined there was no need for court intervention.

The MU informed ACS that he intended to relocate to PA with the sibling once the custody issue was resolved in Family Court. ACS withdrew the referral for PPRS; however, maintained an open service case until the custody was resolved.

On 6/18/18, ACS indicated the report.

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: Coroner

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
043942 - Sibling, Male, 7 Year(s)	046491 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
043942 - Sibling, Male, 7 Year(s)	046491 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
043942 - Sibling, Male, 7 Year(s)	046491 - Father, Male, 35 Year(s)	Internal Injuries	Substantiated
046793 - Deceased Child, Male, 29 Day(s)	046491 - Father, Male, 35 Year(s)	DOA / Fatality	Substantiated
046793 - Deceased Child, Male, 29 Day(s)	046491 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
046793 - Deceased Child, Male, 29 Day(s)	046491 - Father, Male, 35 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:

There were supervisory and managerial progress notes that were not entered contemporaneously.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine

Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☐	☒	☐	☐
At 30 days?	☐	☒	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐
Explain: The safety assessments were inadequate as the safety decisions and safety factors were not consistent with the case documentation or circumstances.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
The MU kept the sibling in his care and filed for guardianship.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
ACS obtained medical examinations for the sibling.

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

Explain:
The mother died in the reported accident, and the father was in a coma in Pennsylvania. ACS immediately assessed the SC was safe in the care of the MU and provided medical information for the MU to obtain medical clearance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

This mother was known in an indicated report dated 8/14/12 and closed 10/12/12. The report listed several subjects; however, the allegation of IG concerning the mother was unsubstantiated.

Known CPS History Outside of NYS

The family had no known CPS history outside of NYS.

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