NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-057 **Prepared by: New York City Regional Office**

Issue Date: 12/19/2016

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
FM-Foster Mother	SS-Surviving Sibling	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 06/16/2016
Initial Date OCFS Notified: 06/16/2016

Presenting Information

The SCR registered a report noting that on 6/16 /16, at about 1:00AM, the parents fed the 2-month-old SC and there were no issues. The report noted that at around 3:00 A.M., the SC began to cry uncontrollably. The parents tried to feed the SC to stop him from crying; however, while the parents were feeding the SC, they noticed that the SC's eyes started to roll back into their sockets. The report noted that as a result, the parents took the SC to the hospital. The report stated that while the parents drove to the hospital the SC stopped crying. The report noted that the medical personnel at the hospital noted that the SC had no pulse and the parents had no explanation on how the SC passed away. The report stated that the SC had no known preexisting medical issues. There was no information concerning three other children who resided in the home.

Executive Summary

The 2-month-old SC died on 6/16/16. Due to religious reasons, the family refused an autopsy. The OCME completed a report of external examination and ruled the cause and manner of death as undetermined.

On 6/16/16, the SCR registered a report for allegations of DOA/Fatality and Inadequate Guardianship of the SC by the parents.

The parents had five children from their union, two were adults and resided in the home. An adult cousin also resided in the home. The father had two other minor children with his second wife. All the minor children were seen and assessed to be well cared for by their parents. The father would have all the minor children visit at the case address or at the home of his second wife.

During the month of June, the family was celebrating a religious holiday and were currently fasting and praying for the month. The father indicated that on 6/15/16 the SC was happy and playing with her siblings. At approximately 12:00 A.M., everyone in the home went to bed

According to the mother, the SC was sleeping in the bassinet and awoke at 3:00 A.M. crying. The mother said that she took the SC out of the bassinet to breast feed her, but the child refused the feeding and continued to scream. The mother said she placed the SC on her chest over her right shoulder to console the SC and eventually the child stopped crying and fell asleep within a few minutes. The mother said she placed the SC back in the bassinet and laid her on her (SC) right side facing the parents' bed. The mother prepared a meal for the family and then went to pray. The father noted that at about 3:45 A.M. the SC woke up again crying and the mother was unable to console her (SC).

The father said that the mother suggested they take the SC for medical care and the adult son drove them to Brooklyn Hospital. The father said he and the mother sat in the back seat of the car with the SC who stopped crying prior to their arrival at the ER. The father said he and the mother thought the SC had fallen asleep. However, once the triage nurse picked up the SC, the child went limb. The medical staff attempted to resuscitate the SC to no avail. The SC was pronounced dead at 5:12 A.M.

The NYPD and the OCME conducted a scene investigation and found no issues of concerns. The NYPD found there was no criminality surrounding the death of the SC and closed their investigation. The parents provided consistent accounts to the ME's investigator, the NYPD and ACS concerning the events leading to the SC's death.

The family was offered bereavement and preventive services, but declined.

On 8/15/16, ACS unfounded the report. ACS based their determination on the collateral contacts with the medical staff from the hospital, the SC's pediatrician and the ME's findings. According to these collaterals the SC appeared well cared for and showed no signs of trauma.

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? 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

Issue:	Failure to provide notice of report
Summary:	The NOE was issued for the subjects of the report, but none was issued for the adult siblings who resided in the home.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)

Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS selected a safety decision noting there were safety factors present that placed the children in immediate and impending danger of serious harm, but there were no safety concerns. The safety factors selected did not apply to the family .
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/16/2016 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 05:12 AM

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		2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	42 Year(s)
Deceased Child's Household	Other Adult	No Role	Male	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	20 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	23 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)

LDSS Response

Following the fatality investigation, ACS contacted the NYPD, medical staff from the ER, and the SC's pediatrician. None had concerns about the level of care the SC received from the parents or their account concerning the events leading up to the SC's death.

On 6/16/16, ACS made a visit to the case address and found NYPD detectives and the ME's investigator conducting a death scene investigation. The Specialist observed a folded knitted blanket and a receiving blanket laid flat in the basinet. These were the only items in the bassinet and they were confiscated by the NYPD.

ACS did not observe any safety hazards in the home. ACS found that the surviving children who resided with the SC did not have adequate sleeping arrangements. ACS provided a bunkbed for the minor children. The sleeping arrangement for the adults in the home was not clear.

The mother reported the SC was asleep in her bassinet and woke up crying at 3:00 A.M. The mother said she picked up the SC and attempted to breastfeed the child but the child refused the feeding and continued to "scream." The mother said she held the SC to console her and within a few minutes the child fell asleep. The mother then placed the SC back in the bassinet and then said her prayers. The mother said that the SC woke up again crying, but she was unable to console the child. Therefore, the mother consulted with the father and they decided to take the SC to the hospital.

The father corroborated the mother's account and noted that the family was fasting and praying for the month in celebration of a religious holiday. The father said the SC was fine on 6/15/16. According to the father, the family went to sleep at approximately 12:00 A.M. and at approximately 3:00 A.M., on 6/16/16 the family woke up to have something to eat. The father noted that the SC woke up crying and after the mother attended to the SC and placed her (SC) in the bassinet, the mother prepared a meal for the family. However, at approximately 3:45 A.M., after prayer the SC began to cry again and they decided to have their adult son drive them to the hospital. The father said he and the mother sat in the backseat of the car with the SC. The father noted he held the SC and the SC stopped crying; therefore, he and the mother thought the SC had fallen asleep. However, when they arrived at the hospital the SC was unresponsive.

The father explained they did not take the SC to Kings County Hospital which was closer to the home because the SC was born at Brooklyn Hospital and this was where she continued to receive her medical care. In addition, they did not call 911 because sometimes EMS delayed in responding. The father said Brooklyn Hospital was a 15 minute ride from their home.

The adult cousin and male sibling corroborated the parents account. However, the adult female sibling and the two minor siblings who resided in the home noted that they were asleep when the parents left to the hospital with the SC.

According to medical staff from Brooklyn Hospital, the parents arrived at the ER at 4:32 A.M. on 6/16/16 in the family's vehicle. The doctor stated that the triage nurse noticed the SC was pulseless and limp. The nurse brought the SC to the attention of the doctors and the medical staff started resuscitation efforts immediately until 5:12 A.M. when the SC was pronounced dead.

ACS contacted the surviving siblings, pediatrician and school guidance counselors and there were no concerns about the care the children were receiving.

On 8/15/16, ACS unfounded the report.

Official Manner and Cause of Death

Official Manner: Undetermined
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: 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
029547 - Deceased Child, , 2 Mons	031841 - Mother, Female, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
029547 - Deceased Child, , 2 Mons	031841 - Mother, Female, 42 Year(s)	DOA / Fatality	Unsubstantiated
029547 - Deceased Child, , 2 Mons	029549 - Father, Male, 44 Year(s)	Inadequate Guardianship	Unsubstantiated
029547 - Deceased Child, , 2 Mons	029549 - Father, Male, 44 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 or 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: Family was offered PPRS, but refused.							
Additional information, if necessary: N/A							

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? N/A
Explain:
There were no immediate needs.

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.

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
☐ Had heavy alcohol use
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Used illicit drugs
☒ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

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

The family had no CPS history.

Known CPS History Outside of NYS

The family had no known CPS history outside of NYS.

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.

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