NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-105 **Prepared by: New York City Regional Office**

Issue Date: 4/19/2016

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
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: 10 month(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 12/25/2015
Initial Date OCFS Notified: 12/25/2015

Presenting Information

On 12/25/15, the SCR registered a report alleging that at 5:30 A.M the mother awoke to feed the SC and then placed him to sleep with her on an air mattress. The mother then awoke at 7:15 A.M. and found the SC unresponsive. The report also alleged that the mother had accidentally smothered the SC. The report indicated the mother attempted CPR and a family member called 911. EMS responded to the home and transported the SC to the hospital where he was pronounced dead at 8:06 A.M. The report noted that the SC had a pre-existing medical condition, but it did not appear that this contributed to the SC's death.

The report stated that the mother resided in Florida and was visiting relatives in Staten Island for the holidays.

Executive Summary

The SC was 10 months old at the time of his death. The ME listed the cause of death as undetermined (co-sleeping) and the manner of death undetermined.

The mother and SC resided in Florida, but came to New York on 12/3/15 to visit maternal relatives whom the mother had not seen in 14 years. The mother had another child in Florida who was in the legal custody of the MGM. The SC's father was not involved in his life.

On 12/25/15, the SCR registered a report with allegations of DOA/Fatality and Inadequate Guardianship of the SC by the mother. According to ACS' investigation, the mother indicated that she attended a Christmas Eve gathering at the home of the maternal great cousin (MGC) who was a kinship foster parent of two children. The MGC gave the mother a twin size air mattress and a pack-n-play for the SC as they had been staying in her home for a few days.

On 12/25/15, at 5:30 A.M., the mother awoke to feed the SC. Following the feeding, the mother placed the SC to sleep with her on the mattress. The position in which she placed the child was not documented. There was no documentation regarding other items that were placed on the bed. At about 7:00 A.M., the mother woke up again, and found the SC face up and unresponsive. The mother attempted CPR and yelled out to her relatives who called 911.

EMS responded to the case address and transported the SC to Staten Island University Hospital (SIUH) where they arrived at 7:45 A.M. The maternal great aunt (MGA) followed in her car with the mother. The attending physician indicated that efforts to resuscitate the SC failed and he was pronounced dead at 8:06 A.M. The SC showed no external signs of trauma. The NYPD found there was no criminality involved in the SC's death.

The foster children were deemed safe in the care of the MGC who was their foster mother.

Days after the SC's death, the MGM came to New York for the mother and arranged to have the SC's body transported to Florida for the burial. The mother decided that she would not return to New York and had no further involvement with ACS' investigation.

The ME stated that because the SC was co-sleeping with the mother, the possibility of an "overlay" could not be ruled out.

On 3/30/16, ACS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship. ACS documented that although the ME noted the possibility of an overlay due to the mother co-sleeping with the SC on a twin size mattress, the ME could not "prove" this caused the SC's death. ACS documented a narrative of the investigation to support the decision of Inadequate Guardianship as opposed to the reason for their decision to unsubstantiate this allegation.

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?** No

Explain:
N/A

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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 24 Hour Assessment
Summary:	The safety decision number 2 noted there were some safety factors; however, none was documented in the investigation. Also the assessment was approved on 12/27/15.
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.
Issue:	Appropriateness of allegation determination
Summary:	ACS unfounded the report because the ME could not "prove" the cause of death was due to an overlay. However, did not consider that this possibility was not ruled out and that the mother placed the SC at risk of harm by co-sleeping with him.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The progress notes of the three field offices assigned to this investigation noted a discrepancy with the whereabouts of the foster children at the time of the incident and this matter was not clarified. The SIFO had the primary role in this case.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2
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 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: 12/25/2015 **Time of Death:** 08:06 AM

County where fatality incident occurred: RICHMOND
Was 911 or local emergency number called? Yes
Time of Call: 07:26 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 2 Hours

Is the caretaker listed in the Household Composition? Yes - Caregiver 1

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Other Household 1	Deceased Child	Alleged Victim	Male	10 Month(s)
Other Household 1	Mother	Alleged Perpetrator	Female	25 Year(s)
Other Household 1	Sibling	No Role	Female	4 Year(s)

LDSS Response

ECS initiated the investigation and later the primary role was assigned to the Staten Island Field Office (SIFO). A secondary role was assigned to OSI, as the case address was a foster home. The case address was a one family home with three levels.

The BM and 10-month-old SC stayed at different relatives' homes during the time they were in New York. At the time of the SC's death, the mother had been staying at the case address for a few days; this included the Christmas holidays.

The BM, the MGA and 2 MGCs, one of whom was the foster parent (FP), reported the SC appeared fine on 12/24/15. The family took the SC to the mall and then returned to the home to prepare for a gathering where they exchanged gifts at midnight. After the guests left the home, the MGA and the other MGC stayed at the case address overnight. The MGA and the MGC (FP) slept on the upper levels. The other MGC slept on the living room floor on one side of the playpen where the SC slept and her child slept on the couch. The mother slept on an air mattress that was placed at the other side of the playpen.

At 5:30 A.M., the SC woke up and the BM went to the kitchen to prepare his formula. The MGC (FP) stated that when the SC woke up at 5:30 A.M. she went downstairs and saw the BM preparing the SC's formula and the SC was standing in the playpen. The MGC said she returned upstairs and did not see where the BM placed the SC to sleep after he was fed. The BM said she placed the SC by her side on the mattress. The BM was 5' and 9" tall and weighed 250 pounds; and the SC was 27 ½ " tall and weighed 18 pounds and 11 ounces. The position in which he was placed to sleep was not documented.

At 7:00 A.M., the BM woke up again with half of her body off the slightly deflated mattress and the SC on the mattress face up on his pillow, with his legs "cocked open." The BM said she noticed the SC's lips were slightly purple and when she picked up the SC from the mattress, his body was limp and he was not breathing. The BM indicated that she attempted CPR while relatives called 911. EMS responded to the case address and transported the SC to SIUH where he was

pronounced dead at 8:06 A.M. The SC showed no external signs of trauma.

The family denied that the BM drank any alcohol or used drugs during the event and noted that she was very attentive to the SC. The NYPD found there was no criminality involved concerning the SC's death.

The ME provided a verbal report noting that the cause and manner of death would be ruled as undetermined. The ME did not rule out the possibility of an "overlay", as the BM was co-sleeping with the SC on a twin size mattress.

The foster children were deemed safe in the care of the FP. Although neither the FP nor the foster children had a role in the fatality report, OSI made monthly visits to the case address from December 2015 through March 2016.

The MGM confirmed that she came to New York for the mother. The MGM indicated that the mother was a very good parent to the SC.

During the investigation, a discrepancy arose concerning the people who were present at the time of the incident. The information obtained by the SIFO from the MGA and the 2 MGCs, suggested that the foster children were present in the home on the morning of the incident along with the children of the visiting MGC and MGA and that the child of the MGC who was asleep on the couch was taken upstairs where all the children remained. The SIFO was informed that the children did not witness anything and were not aware of the SC's death. However, ECS and OSI were informed that the foster children were at a weekend visit with their father at the time of the incident. OSI contacted the foster children's case planner at the agency who confirmed the foster children were on a weekend visit with their father. The SIFO who had a primary role in the case did not explore this discrepancy further.

On 3/30/16, ACS unfounded the report.

Official Manner and Cause of Death

Official Manner: Undetermined
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 the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
023182 - Deceased Child, Male, 10	023183 - Mother, Female, 25	DOA / Fatality	Unsubstantiated

Month(s)	Year(s)		
023182 - Deceased Child, Male, 10 Month(s)	023183 - Mother, Female, 25 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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:

The mother returned to Florida days after the fatality and did not continue to cooperate with the investigation.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Mother returned to FL.

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:
The foster children in the home were not aware of the child's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The mother returned to FL days after the SC's death and refused any assistance for bereavement counseling.

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?	Yes
Was the child acutely ill during the two weeks before death?	No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

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 was known as a child in a SCR report dated 11/21/06 under the MGM's name. The allegation of the report was Inadequate Guardianship of the mother by the MGM.

The investigation revealed that the MGM came from FL and was temporarily residing with relatives while she waited to be eligible to enter the shelter system. In the meantime, the mother was having behavioral problems at school, not keeping curfew, smoking marijuana and had clinical issues. The MGM sought clinical services and a PINS for the mother. The mother was assigned a probation officer. However, the MGM planned on returning to FL.

On 2/1/07, the report was unfounded and referred to community-based services.

Known CPS History Outside of NYS

The mother was known to CPS in Florida involving her oldest child.

On 6/6/12, the mother was involved in a physical altercation with a former paramour who was not her child's father while

the child was in the home. A safety plan was developed for the mother to consider contact with the DV advocate's office for relocation money, a restraining order, informing neighbors, DV counseling, and a daycare for the child. The mother expressed that she wanted to relocate to NJ. The paramour was subsequently arrested. The mother refused daycare and other services.

On 12/14/12, a subsequent report was received after the mother became involved in a physical altercation with her brother. It was alleged that the mother would become violent when she used drugs. She admitted to using oxycodone on a daily basis. It was determined that the mother was unable to care for the child in a safe and nurturing manner and had refused all services. The child was placed in the care and custody of the MGM. The mother was ordered to vacate the home and was allowed supervised visits. The mother was offered drug treatment, anger management services,counseling, and a mental health evaluation. The mother did not comply with these services and on 1/ 8/13 the Circuit and County Courts in Florida granted temporary custody of the child to the MGM.

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