

Report Identification Number: NY-16-084

Prepared by: New York City Regional Office

Issue Date: Mar 21, 2017

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: 20 day(s)

Jurisdiction: Bronx
Gender: Female

Date of Death: 08/15/2016
Initial Date OCFS Notified: 08/15/2016

Presenting Information

On 8/15/16, the SCR registered a report regarding the death of this twenty-day-old female SC. The narrative of the report stated in the morning of 8/15/16, the BM was sleeping with her twenty-day-old SC. While in bed with the SC, the BM woke up and found the SC unresponsive. The BM last saw the SC alive at 10:00 A.M. when she attempted to breast feed her. The SC did not have any pre-existing medical condition and was an otherwise healthy baby. The BM called the MGM who contacted a neighbor who called EMS. The SC was transported to the hospital by EMS at 12:09 P.M. and was pronounced dead at the hospital at 12:22 P.M. The SC's preliminary autopsy indicated the cause of death was cardiac arrest. There was no plausible explanation for the SC's sudden death. The report also stated the BF was at work at the time of the incident.

Executive Summary

This twenty-day-old female SC died on 8/15/15 while sleeping in a "king size bed with her BM. ACS' investigation revealed that on the night of 8/14/15, the SC was very fussy and refused to breast feed, defecate or urinate during the night. On the morning of the incident, the BM was tired and at 10:00 A.M. she placed the SC next to her in the bed to breast feed her. Both the BM and the SC fell asleep and when the BM awoke she found the SC unresponsive. The BM called the MGM on her cell phone and informed her the child was not responding. The MGM spoke with the BM then contacted a neighbor by telephone who called EMS. EMS responded to the home and transported the SC to the hospital. The hospital staff worked on the SC before she was pronounced dead at 12:22 P.M. According to the ME final determination, the SC's cause of death was undetermined. The ME's final manner of death was undetermined (bed sharing with adult). Although there were no surviving siblings or other minor children in the home, ACS did not provide the parents with information regarding "Safe Sleep."

On 8/15/16, the ACS Specialist initiated the investigation and made contacts with the family and other collaterals. The statements obtained from the family and the information provided by relevant collaterals revealed there were no evidence of foul play regarding the SC's death and the SC had been well cared for by the parents. There is no documentation that ACS discussed safe sleep or the dangers of co-sleeping with the BM.

On 1/29/17, ACS unsubstantiated the allegations of DOA/FATL and IG against the BM. ACS closed the case and referred the BM to Community Based Only services. The BM returned to the MGM's home and began counseling services and attending school. ACS documented the BM was doing well and there were no reported concerns. The family communicated only in Spanish, and at every casework contact, ACS utilized language services to engage family members.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**



- Safety assessment due at the time of determination? Yes

Determination:

- Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation? Yes, sufficient information was gathered to determine all allegations.
- Was the determination made by the district to unfound or indicate appropriate? Yes

Explain:

The case documentation did not reflect the Specialist inquired from the parents if they received "Safe Sleep" education. Also, the records did not indicate the Specialist provided the BF referrals for services to deal with the loss of his daughter.

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:

There were no surviving siblings or other minor children in the home.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS did not provide the parents with information regarding "Safe Sleep."
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform New York City Regional Office of the date of the meeting, who attended and what was discussed.
Issue:	Failure to Offer Services
Summary:	ACS failed to offer the BF services. The BF was also impacted by his daughter's death and should have been offered bereavement counseling services to deal with his loss.
Legal Reference:	SSL 424(10); NYCRR 428.6
Action:	The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform New York City Regional Office of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities



Incident Information

Date of Death: 08/15/2016

Time of Death: 12:22 PM

County where fatality incident occurred:

BRONX

Was 911 or local emergency number called?

Yes

Time of Call:

11:25 AM

Did EMS to respond to the scene?

Yes

At time of incident leading to death, had child used alcohol or drugs? No

Child's activity at time of incident:

Sleeping

Working

Driving / Vehicle occupant

Playing

Eating

Unknown

Other

Did child have supervision at time of incident leading to death? Yes

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		20 Day(s)
Deceased Child's Household	Father	No Role	Male	18 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)

LDSS Response

On 8/15/16, ACS initiated the investigation and visited the case address. The BM reported that she and the MGM had decided to take the SC to see a Dr. on the day of the incident. She stated at approximately 10:00 A.M., she noticed something was wrong with the SC. She contacted the MGM and reported her observation of the SC. The MGM, who was entering the building at the time, asked a neighbor to call 911, while she rushed to see BM and the SC.

The family members did not report any concerns regarding the care the parents provided the SC. They described the BM as over protective of the SC and was always good with the SC. The family requested assistance with the funeral expenses. During the visit, the Specialist observed a crib which was still in the plastic wrapping for the SC. The parents stated the crib was not assembled due to lack of space. The bedroom was very small and there was not enough space for the crib. The case records did not reflect the Specialist discussed "Safe Sleep" education with the family.



The Specialist then contacted the attending Dr. who reported that the SC did not have any signs of trauma to her body. According to the Dr., the SC's preliminary cause of death was cardiac arrest.

Later that same day, the assigned LE personnel reported that no arrest would be made pending the final autopsy.

Between 8/24/16 and 10/6/16, ACS made several casework contacts with the family and other relevant collaterals. There was no new information regarding the fatality. The BM was in receipt of services.

On 10/6/16, the BM's caseworker (CW) reported that the BM was in receipt of counseling services at Urban Health Care Center. The BM was doing well and had been attending school. The CW also provided the BM with information regarding employment opportunities.

On 1/13/17, the ME reported that the SC's cause of death was Undetermined. The manner of death was also Undetermined (bed sharing with adults).

On 1/29/17, ACS unsubstantiated the allegations of the report against the BM and closed the case. ACS referred the BM to Community Based Only services.

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 approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

Comments: There is no OCFS approved CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
030741 - Deceased Child, , 20 Days	030742 - Mother, Female, 18 Year(s)	DOA / Fatality	Unsubstantiated
030741 - Deceased Child, , 20 Days	030742 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Legal services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Homemaking Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Parenting Skills	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Domestic Violence Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Early Intervention	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Child Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Additional information, if necessary:

There are no surviving siblings or other children in the home. ACS did not attempt to engage the BF about services following the death of his child.

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 surviving siblings or other minor children in the home.

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

Explain:

The BM was provided with services; however, ACS did not provide the BF with 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 in NYS within three years prior to the fatality.

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

There is no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no CPS history outside of New York State.

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