Child Fatality Report

Report Identification Number: NY-18-062

Prepared by: New York City Regional Office

Issue Date: Dec 10, 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: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 06/13/2018
Initial Date OCFS Notified: 06/13/2018

Presenting Information

On 6/12/18, the one-month-old male, two and eleven-year-old siblings co-slept in the bed with their parents. Between 10:00 PM and 11:00 PM on the same night was the last time the SC was seen alive by the parents.

On 6/13/18, the parents found the SC unresponsive and immediately called 911. EMS responded and discovered the SC in the parents bed. The SC was transported to Brookdale Hospital where he was pronounced dead at 5:48 AM. The SC had no pre-existing conditions nor did he appear to have any injuries. The SC had a bed of his own; however, it was cluttered with items and not fit for sleeping. The reported allegations were DOA/fatality and IG of the SC by the parents.

Executive Summary

The SCR registered a report regarding the one-month-old male infant who died on 6/13/18 at 5:48 AM. The allegations of the report were DOA/Fatality and IG of the SC by the parents. The report alleged the SC had no pre-existing health conditions; however, the parents were co-sleeping with the child. The parents have two surviving siblings who reside with them. This family had no prior ACS involvement.

Following the receipt of the report, an ACS Brooklyn Field Office Specialist contacted Brookdale Hospital and obtained information regarding the incident. ACS learned the family ate dinner together at 9:00 PM and at 9:30 the SM fed and burped the SC and the child appeared well. The SF went to bed and the two-year-old child followed. The SM laid on the bed with the SF and two-year-old SS with the SC cradled in her arms and she unintentionally fell asleep. The alarm woke her at approximately 5:00 AM and she discovered the SC unresponsive. The SM called 911 and an EMS ambulance transported the SC to the hospital where he was pronounced dead at 5:48 AM.

On 6/13/18, ACS learned from LE and the ME investigator that the SC was found with no signs of maltreatment or abuse. However, it was confirmed that the parents slept with the SC in their bed. The following day ACS was informed the ME's findings listed the cause and manner of death undetermined (prone sleeping in an adult bed). LE found no criminality and closed their case.

On 6/13/18, the Specialist interviewed the parents separately and their accounts were consistent with each other and the account given to LE. The SM explained she was exhausted and fell asleep before she placed the SC in his "co-sleeper" as usual. A bassinet was in the bedroom. The SF reported he heard the ambulance and ran outside with the SC in his arms. The parents clarified that the eleven-year-old slept in his bed and was awakened by the commotion. They also explained that the two-year-old slept with them because there was no space for another bed. The parents reported the SC's last visit to the pediatrician occurred on 5/24/18 and he had no medical conditions. The parents denied drug or alcohol use, or mental health conditions. The SM disclosed that the eleven-year-old had witnessed DV in a previous relationship that caused him to be protective of her. The parents denied they received safe sleep training from the hospital, ACS counseled them and provided a bed for the two-year-old.

On 6/14/18, the family was interviewed at the Child Advocacy Center and the information gathered was consistent with what the parents stated had occurred. There were no disclosures regarding the safety of the siblings, and no arrest was made. There was no concern regarding the siblings' safety.

On 6/13, 6/14 and 6/15, ACS used an interpreter to interview the paternal and maternal grandparents and they had no concerns regarding the parents care and love for the children. ACS also interviewed the biological father of the eleven-year-old sibling and he reported the SM is a great mother. There was a lot of family support. ACS contacted neighbors and the landlord who expressed the parents were excellent parents. ACS contacted the SS's school and found his performance and attendance average.

On 6/18/18, ACS consulted with FCLS with the intent to file an Article 10 Neglect petition against the parents to seek supervision; however, FCLS informed ACS there was no basis to file the petition. ACS referred the family to counseling which they accepted and referred the two-year-old to daycare.

On 6/20/18, ACS received information from the pediatrician that confirmed the children's immunization were current and there were no medical conditions.

Since 6/13/18, ACS made weekly home visits and telephone contacts to assess and assist the family. The family has been engaged in services that reflected improvement. On 10/18/18, ACS substantiated the DOA/Fatality and IG allegations regarding the 6/13/18 report.

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?** 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?** No

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:

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Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The ME's report stated the cause and manner of death was undetermined. There were no aggravating factors such as drug or alcohol misuse involved in this case to support substantiating the DOA/Fatality.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS must submit a performance improvement 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 NYCRO of the date of the meeting, who will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/13/2018 **Time of Death:** 05:48 AM

Time of fatal incident, if different than time of death: 04:30 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 05:00 AM
Did EMS 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
How long before incident was the child last seen by caretaker? 5 Hours
At time of incident supervisor was:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)

LDSS Response

On 6/13/18, ACS' Brooklyn Field Office responded to the report registered by the SCR regarding the death of the two-month-old male by contacting LE to obtain information regarding the information. According to the case documentation, the allegations were DOA/Fatality and IG of the SC by the parents as the SC was found with no indication of abuse or neglect; however, the parents reported the SC slept with them. ACS case documentation reflected this family had no prior involvement with ACS.

ACS obtained information from LE who responded to a 911 call to the case address and reported that upon their arrival, they observed EMS in the process of administering CPR; they transported the SC to Brookdale Hospital. The ME investigator and LE reported the parent's reenactment confirmed the parents shared their full-size bed with the SC and the two-year-old sibling. The SM explained she unintentionally fell asleep as she laid on the bed cuddling the SC. She stated she attended school, and was on maternity leave from work due to the birth of the SC. The investigator reported the family slept horizontally and at 5:00 AM the alarm awoke the SM and she observed the SC face down and unresponsive. The SM's screams alerted the SF and he summoned 911. The operator instructed them to administer CPR until EMS arrived. The SC was transported to Brookdale Hospital where he was pronounced dead at 5:48 AM. The ME reported no signs of abuse or neglect were found on the SC and it was ruled an accidental death.

On 6/13/18, the family was immediately referred to the Brooklyn CAC and it was reported that their accounts were consistent with statements given to the first responders. The eleven-year-old made no disclosure of abuse or neglect; however, he and the parents sobbed uncontrollably.

On the same day the Specialist interviewed the parents who reported the SC showed no sign of illness or discomfort prior to his death. At the time of the discovery, the parents left the SS with the landlord and arranged for the maternal grandparents to pick them up. ACS found no evidence that the parents were under the influence of drugs or alcohol. The parents reported they had a lot of family support; they relocated to live with family. The eleven-year-old SS attended a new school and the two-year-old was enrolled into day care with ACS' assistance. The parents denied they received safe sleep training from the hospital. ACS case documentation did not reflect whether the Specialist queried the pediatrician regarding safe sleep instructions. The parents had a bassinet for the SC and it contained clothing at the time of the incident. The SM explained that she always used the co-sleeper to protect her child from harm and she unintentionally fell asleep that night due to exhaustion.

Throughout the investigation, the Specialist maintained weekly telephone contact along with home visits to assist the family. ACS provided a bed for the SS and referrals for services. The Specialist received information from the children's pediatrician that reflected the parents kept up with appointments and there were no reported concerns. The Specialist conducted interviews with family members and neighbors who reported the parents were great parents. The school staff had no concerns for the attention the SS received from the parents. On 10/10/18, ACS received a copy of the final autopsy report from the ME and it listed the cause and manner of death undetermined (prone sleeping in adult bed).

On 10/18/18, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the parents citing the ME's report.

ACS added that due to the unsafe sleep accommodations, the parents failed to provide a minimum degree of care and were cited as contributors to the SC's death.

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 ACS 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048083 - Deceased Child, Male, 2 Mons	048084 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
048083 - Deceased Child, Male, 2 Mons	048084 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
048083 - Deceased Child, Male, 2 Mons	048085 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
048083 - Deceased Child, Male, 2 Mons	048085 - Father, Male, 28 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

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 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	☒	☐	☐	☐
Explain: The family were enrolled in PPRS where they engaged in individual and family bereavement counseling.				

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 children were deemed safe in the parents care.				

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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The paternal grandparents allowed the family to reside with them until they can permanently relocate.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The eleven-year-old SS received monitoring through the school staff and he engaged in counseling with the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents engaged in counseling services and received support from their religious affiliation.

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 was no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was 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