Child Fatality Report

Report Identification Number: NY-17-038

Prepared by: New York City Regional Office

Issue Date: Nov 02, 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	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: 1 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 04/23/2017
Initial Date OCFS Notified: 04/23/2017

Presenting Information

The 4/23/17 report alleged that on either 4/20/17 or 4/21/17, the SM propped the SC up on a pillow on the bed. The SC fell off the bed onto the wooden floor. The SF was aware. Neither parent sought medical attention for the SC at the time. On 4/23/17 at 4:00 AM, the SC, who was sleeping in a Rock & Play, woke up. The SF gave the SC a pacifier, rocked the SC to sleep and put the SC in the Rock & Play. At 10:00 AM, the SF woke up and noticed the SC was not crying or breathing, and 911 was called. EMS gave the parents instructions for applying CPR to the SC. When EMS arrived in the home, the SC was deceased. The SC had a small amount of blood coming from the nose. The SC was in rigor mortis with stiff arms and legs.

Executive Summary

The 1-month-old male child (SC) died on 4/23/17. The autopsy listed the cause of death as undetermined and the manner of death was natural.

The allegations of the 10/27/16 report were DOA/Fatality, IG, and LMC of the SC by the parents. There were no surviving CHN in the household.

ACS learned that on 4/22/17, at about 11:00 PM the parents fed the SC, took him to a neighbor's home and then went to a party. The neighbor fed the SC the formula that was provided by the parents. Following the party, the SM returned home and the SF went to get the SC at the neighbor's home. The SF said he picked up the SC from the neighbor at 2:00 AM on 4/23/17. According to the SM, they returned at 3:00 AM or 3:30 AM on 4/23/17. The SF noted the SC had been a little fussy at 4:00 AM but the SC did not wake up until 7:00 AM. He said he consoled the SC by giving him his pacifier. He was in the living room on the daybed and the SC was next to him, while the SM was in the bedroom. The SC was swaddled. The SF said that at 10:00 AM, the SC's head seemed to have turned and he seemed to be on his back. The SF felt something was wrong as he did not hear any sound from the SC, so he took the SC to the SM in the bedroom and then called 911 for assistance. EMS responded and transported the SC to the hospital. ACS documentation did not reflect that EMS was interviewed pertaining to their observations of the family and home conditions.

The SF reported that the SC slept in the bassinet every night. The SF clarified that the SC slept in a Rock and Play. LE took the Rock and Play as part of the police investigation. The SF said the SC was not placed on his stomach, and was always placed on his back in his bassinet to sleep.

On 5/17/17, the female neighbor reported she had babysat once. She did not have any concerns regarding the SC or the parents. Later, ACS spoke with a male neighbor who said he only babysat the SC once. He said that on 4/22/17, the SC came to his home after 11:00 PM. He did not notice anything unusual. The SC was asleep in his bassinet rocker and there were no concerns. The SC woke an hour after the parents left. He gave the SC his bottle, burped and rocked him, and placed him in his rocker to sleep. The SC awoke a few times when his music timer went off. The SF arrived at about 3:00 AM to pick up the SC. The SF seemed fine. He said the parents had called about the SC throughout the time he was babysitting.

On 8/10/17, the ME informed ACS that the cause of death was listed as undetermined and the manner as natural. The ME said all the testing was post mortem and the results were negative. The ME did not know the cause of death, but found there were no suspicious injuries on the SC.

The Family Court Legal Service (FCLS) provided a legal consultation. According to FCLS, there was no indication that the parents' actions caused or contributed to the SC's death. The ME's Office had determined that the cause of death was natural. There were no suspicious injuries on the SC and all the test results were negative. The parents were appropriate in following up with routine pediatric appointments. The parents responded appropriately in immediately calling 911 when they observed the SC was not breathing.

On 8/21/17, ACS UNF the report. The decision was based on the ME findings that the cause of death was listed as undetermined and the manner as natural. The ME stated all the testing was post mortem and the test results were negative. The ME did not know the cause of death, but said there were no suspicious injuries.

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

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:
NA

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/23/2017 **Time of Death:** 10:20 AM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 10:06 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)

LDSS Response

On 4/23/17, ACS interviewed hospital staff about the SC's death. According to the hospital staff's account, on 4/22/17 at about 3:00 P.M., the SM propped the SC on the bed, she turned her back for a moment, at that time, the SC fell off the bed. The parents were still in the room, and the SF picked up the SC from the wood floor after he heard the SC fall. The SF examined him for marks and bruises. The SF did not believe there was any concern to seek medical attention as the SC did not exhibit change with his behavior.

The hospital Dr. said the SC was severely underweight. At the time of his death the SC was 9 pounds 1 ounce. The SC started formula on 4/19/17 as the parents said the SC had seemed hungry and fussy. The Dr. said the SM fed the SC 5 to 6 times a day. The Dr. did not ask the parents whether they were aware that the SC was underweight. The Dr. was aware that on 4/22/17, at 3:00 PM the SC fell off the bed. The parents explained that the SC was on a pillow and slid off.

The family's Dr. had examined the SC on 3/31/17. The Dr. said there were no concerns regarding the SC.

On 4/25/17, the parents were interviewed. The SF said the SC was born healthy at 8 pounds. The SC was seen by the family Dr. and the SC was 9 pounds at the time of the visit. During the visit with the Dr., they were told that they could supplement the SC's meals with formula as well. He did not have any concerns pertaining to the SC's weight. There were no concerns at the time of the Dr. visit on 3/31/17. When asked about the SC falling from the bed to the floor, the SF

acknowledged that on 4/22/17, at about 4:00 PM-5:00 PM. The SM had the SC on a pillow and he was upright against it. He heard a thud on the hardwood floors. He picked up the SC. The SC cried a little and there were no marks or bruises.

Regarding the incident pertaining to the fatality, the parents went out on the night of 4/22/17. The SC was babysat by a neighbor. The SF said the neighbor fed the SC at 12:00 AM on 4/23/17. The SF picked up the SC from the neighbor at about 2:00 AM. The SF said the SC awoke at 7:00 AM and consoled him by giving him his pacifier. The SF was in the living room on a daybed and the SC was next to him; the SM was in the bedroom. He said at 10:00 AM the SC's head seemed to be turned. He did not hear any noise and went to the SM.

The SM said the SC always slept in the Rock and Play on his back and was not placed in the bed to sleep. The SM said she used formula as the SC was being fussy and had gas. She felt the formula helped. She said that on 4/19/17 she introduced one bottle of formula. On 4/22/17, she gave him 2-3 bottles as he seemed hungry.

On 5/10/17, the ME Investigator (MEI) told ACS that the SC seemed well cared for. The MEI conducted a re-enactment of what occurred when the parents found the SC and when the SC fell off the bed. There was no evidence of co-sleeping in the case circumstances as the SC slept in what seemed to be a reclined swing with an electrical component. LE had taken the Rock and Play as part of police investigation. The SC had been wrapped in a swaddled blanket that seemed white and fuzzy with arm holes. There was dry blood and foam near the SC's nostrils.

Official Manner and Cause of Death

Official Manner: Natural
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 investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
040821 - Deceased Child, Male, 1 Mons	040822 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
040821 - Deceased Child, Male, 1 Mons	040823 - Father, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
040821 - Deceased Child, Male, 1 Mons	040823 - Father, Male, 36 Year(s)	Lack of Medical Care	Unsubstantiated
040821 - Deceased Child, Male, 1 Mons	040822 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
040821 - Deceased Child, Male, 1 Mons	040822 - Mother, Female, 36 Year(s)	Lack of Medical Care	Unsubstantiated

040821 - Deceased Child, Male, 1 Mons	040823 - Father, Male, 36 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
ACS attempted visits to the home but was unsuccessful in acquiring access. The documentation did not reflect that EMS was interviewed pertaining to their observations of the family.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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	☐	☒	☐	☐	☐	☐	☐
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 family was referred to Community Based Services. Information obtained from ACS indicated burial assistance was not offered.

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 CHN in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS offered bereavement counseling and referred the parents to Community Based 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? N/A
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

The parents were not known to the SCR or ACS.

Known CPS History Outside of NYS

There was no known history outside of NYS.

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