Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-18-103

Prepared by: New York State Office of Children & Family Services

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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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 10/19/2018
Initial Date OCFS Notified: 10/19/2018

Presenting Information

The 10/19/18 SCR report alleged upon waking up from sharing a bed with the SC, the subject parents found the 1-month-old infant unresponsive and blue. The child died at 1:35 PM on 10/19/18. She was an otherwise healthy child that died while in the care of the parents. The grandparents, the aunts and an unknown named child had unknown roles.

Executive Summary

This report concerns the death of a 7-week-old female child, whose death was reported to the SCR on 10/19/2018. The baby was in mother and father's care at the time of her death. The investigation revealed both parents were in the same bed with the child when she became unresponsive. ACS investigated the circumstances of the fatality.

The fatality occurred in the parents' home, where they resided with two unrelated adults. ACS confirmed there were no other children living in the home, and the parents had no other children. The child was placed to sleep next to her mother, on her back, cradled in her arm; the father slept on the other side of the mother and away from the child, but was aware of where the child was sleeping. The parents awoke to find the child in the same position, unresponsive.

ACS spoke with the medical examiner, who revealed that after an autopsy, the cause of death was undetermined. ACS consulted the medical examiner about the circumstances of the fatality in an effort to elicit information about causation. The medical examiner concluded the toxicology results were negative and there were no suspicious injuries. ACS was informed the manner of death also remained undetermined for two reasons: The parents were bed-sharing with the infant; and, there were microscopic findings that the child had a virus of the airway. Since there was no evidence to confirm the cause of death was a result of bed-sharing, the allegation of DOA/Fatality was unsubstantiated. ACS learned from the family and collateral contacts such as family members, law enforcement, and medical staff that the parents took the child to the hospital and pediatrician when she was not feeling well. Further, when the child was found unresponsive, they took appropriate action by contacting emergency services.

ACS closed the investigation after determining the allegation of inadequate guardianship to be substantiated against the mother and father. This was based on the immediate danger of serious harm in which the mother and father placed the infant by the manner in which they shared the sleeping environment. It appeared there were unused safe alternative sleeping arrangements available in the home.

Law enforcement and ACS communicated often about details of the case. Based on documentation, it did not appear law enforcement filed any criminal charges. ACS offered grief counseling to the mother and father. A mental health referral was also made, though it did not appear any services were utilized while the case was open. ACS closed the case once the investigation was complete.

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 determination was appropriate and well-supported in documentation after a sufficient amount of information was gathered. The safety assessments and recorded decisions were appropriate given the circumstances, though they were not required as there were no surviving children.

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:
The decision to close the case was appropriate. There was an abundance of supervisory consultation in the documentation.

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: 10/19/2018 **Time of Death:** 01:35 PM

Time of fatal incident, if different than time of death: 12:30 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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
How long before incident was the child last seen by caretaker? 3 Hours
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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	83 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	24 Year(s)

LDSS Response

ACS initiated their investigation promptly by coordinating with LE and sharing information. In addition to LE, ACS contacted the source, hospital, district attorney, the parents, and the two unrelated household members. ACS reviewed CPS history which revealed that neither the parents nor child were known to the system as confirmed subjects or recipients of services as adults. These actions were completed on the date of the SCR report, and further contact with the family and collaterals continued throughout the length of the investigation.

The parents resided with an unrelated elderly woman and her adult daughter. ACS interviewed the two household members, and neither expressed any concerns for the parents' care of the infant. After speaking with collaterals who interviewed the parents in response to the incident, as well as speaking with the parents and household members, ACS learned the mother and father took a nap with the child in their bed at approximately 9 AM on 10/19/18. All were positioned on their backs, and the infant was described as cradled against the mother; the child was on the outside of the bed, not in between the parents. The mother woke around 12:30 PM and noticed the infant was not breathing. The mother alerted the father, then went to get help from the younger household member. The child was described as cold, pale, and with blue lips when found unresponsive. The household member immediately called 911 and was instructed to perform CPR – she reported she was CPR certified. EMS took over resuscitative efforts upon their arrival. The child was transported to the hospital, where continued life-saving efforts were unsuccessful. The child was then pronounced deceased.

On 10/9/18, the mother said she had planned on taking the child to the pediatrician that afternoon for her cold symptoms and an incident of vomiting earlier in the day; however, this doctor's visit did not take place due to the child passing away. She reported she was warned about the dangers of co-sleeping at the hospital after giving birth, but had not understood

why a child who could move and turn her head was not safe in bed with adults. The pediatrician expressed no concerns for the parents' care of the child, who had last been seen at the practice on 10/3/18. ACS asked the medical examiner about a causal connection between the unsafe sleep environment and the death, to which ACS learned that could not be definitively confirmed based on the way the child was found and the finding that the child also had a virus.

The mother denied using drugs during pregnancy when asked by ACS. Both parents denied current substance use, and no signs of additional areas of child welfare concern were observed or revealed in the interviews. A police officer who was a first responder reported observing no concerns the parents were the influence of anything. ACS facilitated drug tests for both parents a month after the SCR report, and all results were negative. The appropriate fatality-related services were offered, and the case was closed upon sufficiently gathering information to determine the investigation.

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 was initiated by the Instant Response Team, and later in the investigation, the CAC's Multi-Disciplinary Team Coordinator contacted the investigating unit to discuss the case. The investigation adhered to previously approved protocols for a 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
048254 - Deceased Child, Female, 1 Mons	049347 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
048254 - Deceased Child, Female, 1 Mons	049348 - Father, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
048254 - Deceased Child, Female, 1 Mons	049347 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
048254 - Deceased Child, Female, 1 Mons	049348 - Father, Male, 27 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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 siblings, nor were there other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Though a mental health referral was made and bereavement services were offered to the parents, it did not appear services were utilized while the investigation was open.

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

On 5/31/2011, the father was named as an alleged subject regarding his minor siblings. The allegations were CD/A, EN, IG, and PD/AM. Though the report was indicated against another family member, allegations against him were unsubstantiated.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

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