Child Fatality Report

Report Identification Number: SV-17-059

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

Issue Date: May 29, 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: 3 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 12/24/2017
Initial Date OCFS Notified: 12/25/2017

Presenting Information

On 12/24/2017, EMS was called to the home at about 11:40AM for concerns of the SC choking. When EMS arrived, the SC was in late stages of death with stiff joints. The SC's skin was blue. The SC had vomit with blood on the front of his clothing. The SC had no pre-existing medical conditions. The SC was an otherwise healthy child. The SC was subsequently pronounced dead. The SF fed the SC before he left the home at 7AM. The SM called 911 at 11:40AM. The SC might have been dead for some time based on the condition that the SC's body was found in before the 911 call was made.

Executive Summary

An SCR report was received on 12/25/2017, with allegations of DOA/fatality and IG against the SF and the SM regarding the death of the three-month-old SC. The death of the SC occurred on 12/24/2017 but was not reported until 12/25/2017. Westchester County Department of Social Services (WCDSS) initiated an immediate investigation that included contact with the source. SCR and criminal history checks were completed. WCDSS questioned the SF and the SM about drug or alcohol misuse. The parents denied any drug or alcohol misuse.

In the first 24 hours of the investigation, WCDSS determined there were no SS. WCDSS went to the home and interviewed the parents. The SM said she had fed the SC at 6:00AM. The SF and the SM reported that the SF awoke for work on the morning of 12/24/2017, and inadvertently woke the SC. The SF stated before leaving for work at 7:40AM, he placed the SC in the bed with the SM. The SF and the SM reported that the SF had not fed the SC. The SM waited for the SC to fall back to sleep and then placed him back in his bassinet at 8:00AM. The SM placed the SC on his stomach with his face turned outward. The SM went back to bed and when she awoke she went to check on the SC and he was unresponsive. The SM said this was about 11:40AM. She attempted CPR but was not trained. The SM called 911 but due to a language barrier the 911 operator had not understood her. The SM called the SF and told him to call 911. The SM dressed quickly and was heading out of the apartment when LE arrived. The SM stated EMS arrived and transported the SC to the hospital and he was pronounced dead at 12:44PM.

WCDSS offered bereavement referrals and funeral assistance to the SF and the SM. WCDSS observed the home environment of the SC and the bassinet. There were no objects or blankets in the bassinet. The SM stated she had been instructed to place the SC face up when sleeping but due to the SC’s reflux she was fearful he would choke and had begun placing him on his stomach to sleep.

The final autopsy report was pending at the time of the writing of this report. The cause and manner of death were still pending. There were no signs of trauma to the SC and there was no causal connection between the SC sleeping on her stomach and the death. There were no arrests.

The allegations of DOA/Fatality were Unsub for the SM and the SF. There was no credible evidence to support the allegations that the parents caused the death of the SC. Based on interviews and pictures received from LE, the bassinet was observed to be free from any objects or blankets on the day of the SC’s death. WCDSS received and reviewed all medical records pertaining to the care of the SC and the parents provided more than a minimum degree of care. The case was UNF and closed.

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:
There were no SS and WCDSS offered appropriate services to the family prior to closing the investigation.

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: 12/24/2017 **Time of Death:** 12:44 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: 11:40 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? 3 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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

WCDSS conducted a joint investigation with LE. WCDSS received an SCR report on 12/25/2017 about the death of the SC. WCDSS learned through contact with LE and medical staff at the hospital that the SC died on 12/24/2017. LE and the attending physician confirmed that there were no SS. WCDSS conducted interviews with the SF and the SM on 12/26/2017, at their home in their native langauge. At the time of the home visit, WCDSS confirmed with the parents that were no SS and the SC was their only child. The SF reported that he had awoke the morning of 12/24/2017 at about 7:00AM to get ready for work. The SF stated he had inadvertently woke the SC. The SF said before he left for work he picked the SC up from his bassinet and put him on the bed with the SM. The SF then left for work, this was about 7:40AM. The SF stated he had not fed the SC before he left.

The SM reported that she had fed the SC at 6:00AM and had put him back down to sleep in his bassinet. The SM said after the SF placed the SC on the bed, she got up and placed the SC back to sleep in his bassinet. The SM was not sure of the time but believed it was about 8:00AM. The SM stated she placed the SC on his stomach. The SM explained the SC had reflux and would often choke on his formula and spit up. The SM placed the SC on his stomach. The SM sated the SC's face was turned to the side but could not remember which direction. The SM stated she awoke about 11:40AM and found the SC unresponsive in his bassinet. The SM stated she attempted CPR but she had no training. The SM stated she then called 911 but the operator had difficulty understanding her so she hung up. The SM called the SF and told him to call 911. The SM said she quickly got dressed and began to walk out of the apartment, when LE arrived. The SM stated EMS arrived and took the SC to the hospital. WCDSS appropriately asked the SM about safe sleep. The SM reported although she had been instructed to place the SC face up, she was afraid to because the SC would often choke. The SM said she began placing him on his stomach with his face turned outward, thinking this would keep the SC from choking.

WCDSS offered referrals to the parents for bereavement counseling and assistance with funeral costs. WCDSS observed that the SM was very distraught and provided the SM with the phone number for the mobile crisis team if needed. WCDSS questioned the parents about drug and alcohol use and the parents denied any drug or alcohol misuse. WCDSS observed the bassinet and there were no toys or blankets in the bassinet.

WCDSS spoke with all first responders and observed pictures of the home and the bassinet on the day of the incident. The home was clean and there were no safety concerns. The bassinet was free from any objects or blankets. WCDSS conducted an SCR and criminal history check.

WCDSS obtained and reviewed all medical records pertaining to the death of the SC as well as the SC's care. There were no concerns for the care of the SC by the parents. WCDSS continued to offer support and services throughout their case involvement.

ME's preliminary findings were there was no known causal connection between the SC sleeping on her stomach and her death. The cause and manner of death were pending and the final autopsy report was pending at the time of the writing of this report.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046190 - Deceased Child, Male, 3 Mons	046192 - Father, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
046190 - Deceased Child, Male, 3 Mons	046191 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
046190 - Deceased Child, Male, 3 Mons	046191 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
046190 - Deceased Child, Male, 3 Mons	046192 - Father, Male, 26 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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? No
Explain:
There were no SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS offered bereavement services and assistance with funeral expenses.

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

There was no history three years prior to the fatality.

Known CPS History Outside of NYS

There was no known 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