Child Fatality Report

Report Identification Number: SV-17-029

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		

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 07/23/2017
Initial Date OCFS Notified: 07/23/2017

Presenting Information

An SCR report registered on 7/23/2017 alleged on that morning, the BF awoke at approximately 5:00 AM and found his 3-month-old daughter (the SC) not breathing and unresponsive. The SC had been lying next to the BF in the same bed which was where the SC slept every night. The BF drove the SC to the hospital and was able to flag down an ambulance. The SC was pronounced dead upon arrival to the hospital. The cause of death was unknown at the time of the SCR report was made. The BM was at work during this time and the uncle was sleeping; both the BM and uncle had unknown roles with respect to the death.

Executive Summary

On 7/23/2017, the SCR received a report regarding the death of the 3-month-old female SC, who died due to unknown circumstances after allegedly sharing a sleeping environment with the SF. Suffolk County Department of Social Services (SCDSS) immediately responded by contacting the source of the report and making a home visit.

Though interviews were conducted separately, SCDSS collaborated with LE and contacted medical collateral contacts in an effort to learn information upon which to determine the report. SCDSS spoke with both parents, as well as the PU and his wife who lived in the downstairs portion of the home. SCDSS learned it was the parents' regular practice to share their bed with the SC, despite having a bassinet and crib available in the home. Though the parents claimed the SC never slept in it, the crib contained bumpers, a crib comforter, and hanging netting atop the crib. SCDSS reviewed safe sleep recommendations with the parents. The SF, who was the last person to see the SC alive, reported he last fed the SC at 1:00 AM and when she fell asleep, he placed her in the center of the adult bed with one pillow on one side of her, while he slept on the other side. The exact details of how the SC was positioned when put to bed, in addition to exactly how the SC was found, remained unknown. SCDSS did not include these questions in the initial 24-hour interview, and when efforts were made to re-interview the parents to gain more detailed information, the parents refused to further discuss anything related to the fatality. The BM had been at work at the time of the incident. SCDSS learned there were no SS or other children in the home.

SF responded to the events by hitting the SC's chest (as he did not know how to perform CPR) and alerted the PU for help. SF decided driving to the hospital would be faster than calling 911 and awaiting a response. PU drove and SF rode in the back, trying to revive the SC. While en route, the men flagged down a passing ambulance. The EMS workers on board attempted CPR to no avail, and transported the SC to the hospital where she was then pronounced deceased after further attempts to revive. Hospital records noted the SC suffered cardiac arrest.

The final autopsy report was not completed at the time the investigation closed or the time this fatality report was written; however, SCDSS contacted the ME who performed the autopsy and the ME reported there were no findings of abuse or trauma. The final autopsy report was pending toxicology results. There were no arrests related to the fatality, as LE reported finding no criminality in the matter. Pediatrician records and documentation from the SC's birth hospital did not indicate any prior illnesses which could account for her death, though it was noted the parents were counseled about not allowing a newborn to share a bed with other adults or older children.

Due to preliminary findings that showed no signs of abuse or maltreatment of SC, and based on the lack of information that could be obtained surrounding SC's death, SCDSS unsubstantiated the allegations against the SF. SCDSS thoroughly

reviewed the case among supervisors and administrators before making the decision to close the investigation. On more than one occasion, services were offered to the family in response to the fatality and were strongly encouraged.

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:
Casework activity was commensurate with case circumstances and safety assessments accurately reflected no safety concerns due to there being 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.

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: 07/23/2017 **Time of Death:** 06:05 AM

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

County where fatality incident occurred: Suffolk

Was 911 or local emergency number called? No

Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- [x] 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? 4 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was:

- [ ] Drug Impaired
- [ ] Alcohol Impaired
- [ ] Distracted
- [ ] Impaired by disability
- [ ] Absent
- [x] 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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	31 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	31 Year(s)

LDSS Response

Immediately upon receipt of the SCR report, SCDSS spoke with the source then went to the home where the incident took place. LE had been to the home prior to the CW's arrival, but were not present at the time of CW's visit. SCDSS interviewed the adults residing in the home, with the exception of the PU's wife who did not speak English; an interview was facilitated on a later date with a Spanish-speaking CW.

The SF was the last person to see the SC alive, as the BM was at work at the time. The 3 had resided together, and the SC was the only child. The PU and his wife lived below, in a separate section of the home. SF told SCDSS he last saw the SC alive when he fed her a bottle at 1:00 AM. She fell asleep in his arms. He placed her in the center of the adult bed and put a pillow on the left side of the bed. SF got in bed on the right side and went to sleep. SF reported he awoke at 5:00 AM and found it strange the SC had not awoken in between those times to eat as she typically did. At that time, he realized the SC was not breathing. SF reported he did not know CPR but had heard from BM if there was an issue to hit the infant on the chest. SF stated he hit the SC on the chest with no result so he ran downstairs to the PU's apartment. He woke the PU, who suggested they call 911, but SF felt it would take too long. The 3 of them then got in the car to drive to the hospital. While driving, they flagged down a passing ambulance. EMS attempted CPR but when unsuccessful, they transported them to the hospital. SCDSS later contacted the hospital and learned the SC was unresponsive upon arrival and pronounced deceased

by an attending physician. PU corroborated the account regarding his alert of the SC's condition and their response.

BM and SF both reported it was typical practice to sleep with the SC in their bed. SCDSS observed a bassinet with baby items in it, and a crib that contained bumpers, a crib comforter, and hanging netting that covered it. The parents reported the SC typically took naps in the bassinet but had never slept in the crib. BM explained sleeping with the SC in their bed made it easier to breast feed, and SC always slept with them at night. SCDSS went over safe sleep recommendations with the parents.

SCDSS exchanged information with LE, and learned LE found no criminality with regard to the fatality. LE planned to keep their investigation open pending the final autopsy report.

There were several unanswered questions that if asked, could have led to information upon which to make a better-informed determination. Such questions include but are not limited to: position in which SC was found; position in which SC was placed to sleep; what, if any, items were found obstructing SC's airway; possible parental impairment; and, any other environmental details. Though these questions were not asked in the initial interviews, the CW attempted several follow-up interviews to which the parents continuously refused. Though they maintained contact and allowed the CW into the home, they refused to further discuss the incident; therefore, without an explanation or a definitive cause of death from the ME, much remained unknown regarding cause and circumstances of the death.

SCDSS contacted collaterals and learned the pediatrician had no prior concerns for the SC or her care. SCDSS gathered information from the hospital, and disclosures from the SF to hospital staff were consistent with that which he had reported to SCDSS. Hospital records confirmed the SC suffered cardiac arrest and was pronounced deceased shortly after arrival.

SCDSS offered fatality-focused services and concluded the investigation after having completed all safety and risk assessments timely and accurately.

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?No
Comments: There is no OCFS approved Child Fatality Review Team in Suffolk County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042241 - Deceased Child, Female, 3 Month(s)	042202 - Father, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
042241 - Deceased Child, Female, 3 Month(s)	042202 - Father, Male, 23 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	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	☐	☐	☐	☐	☐	☒	☐

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 children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were referred for grief counseling but did not appear to have received any services while the case 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 fetal alcohol effects or syndrome

☒ With neither of the issues listed noted in case record

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 known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

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

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

Action:	Though SCDSS appropriately responded and conducted interviews immediately upon receiving the report, key information was not obtained at that time. The information not obtained directly had to do with the fatality, such as positioning of how the SC was placed to sleep and how the SC was found when unresponsive. Such information would have been beneficial to an accurate determination. Though diligent efforts were made to follow up on this information on later dates, the parents refused to discuss details of the fatality. It is recommended that SCDSS make efforts to gather as much detailed information as possible in the first contact with the family in cases of child fatality investigations, in the event that information is unable to be obtained at a later time.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No