Child Fatality Report

Report Identification Number: NY-17-062

Prepared by: New York City Regional Office

Issue Date: Dec 11, 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: 26 day(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 06/24/2017
Initial Date OCFS Notified: 06/24/2017

Presenting Information

The 6/24/17 report alleged that the 3-week-old SC and her sibling lived with the SM and SF. On 6/24/17, both CHN were at home in their parents' care. The SM fed the SC at about 1:00 AM on 6/24/17, and then put the SC in the bassinet to sleep. At around 3:00 AM, the SF checked the SC who was resting and breathing peacefully. At about 6:00 AM, the SF again checked the SC and found her unresponsive. The SC did not appear to have any visible injuries. The SC died while in her parents' care. The SC was an otherwise healthy CH, thus making the sudden death suspicious.

Executive Summary

The 3-week-old female infant (SC) died on 6/24/17. The autopsy listed the cause of death as Undetermined (bed sharing with parents in adult bed with soft bedding) and the manner of death as Undetermined.

The allegations of the 6/24/17 report were DOA/Fatality and IG of the SC by the parents.

ACS learned that the SM fed the SC before she went to sleep between 12:30 AM-1:00 AM on 6/24/17. SM gave the SC medication for a medical condition, and then burped her before she put the SC to sleep. The SF heard the SC cry about 3:00 AM and then the parents burped the SC. The SF said he went to sleep at about 3:30 AM and between 4:00 AM-4:30 AM, he heard the SC cry again. He took her out of her bassinet, and placed her in the middle of the bed between himself and the SM. He said he awoke around dawn and he tapped the SC, but she did not move. He saw the SC on her back with her arm lifted higher than her head and her hand balled up into a fist. He said she was not breathing. The SF woke the SM, and she began to give mouth to mouth resuscitation. The SM called 911 as the SF tried to give CPR. EMS arrived and the SC was transported to the hospital. The SM said the SC was born premature at 34 weeks. She also said the SC slept in a bassinet every day. The 3-year-old CH was in the home at the time of the incident.

During the investigation, ACS opened a Family Service Stage (FSS) on 8/24/17 and closed it on 9/25/17. On 8/25/17, a Child Safety Conference occurred. The parents agreed to submit to a drug test. On 9/8/17, ACS received the results of the SM's drug test and it was negative. ACS did not state whether the SF took a drug test.

On 6/26/17, the ME said the SC had bleeding under the scalp, and broken ribs. The broken ribs were likely the result of the chest compressions. The ME believed that the co-sleeping was a factor, but had requested additional tests. Later, the ME informed ACS that the manner of death was ruled Undetermined and the cause of death was Bed Sharing. The ME said co-sleeping was unfortunately the cause.

On 6/27/17, the family Dr. said the SM was an excellent mother and was current with the CHN's medical appointments. The 3-year-old CH had a pre-existing medical condition.

On 9/28/17, ACS mailed a listing of resources where the family could attend bereavement counseling/support groups.

The 6/25/17 safety assessment was inadequate as it focused on the SC and not the surviving half-sibling. ACS listed the parents' inability/unwillingness to provide adequate care and/or protection of the CH, and the SC's vulnerability as safety factors that placed the CH in danger of harm although there were no safety factors that presented an immediate or impending danger. The 10/17/17 safety assessment was inadequate as the comments did not support the selected safety factor. The comments in the safety assessments reflected the 3-year-old CH was doing well in the home.

On 10/17/17, ACS IND the report on the basis that the ME listed the manner of death as undetermined but the cause of death as bed sharing. ACS explained that the SF placed the SC between himself and the SM knowing that this sleep arrangement placed the SC at risk of harm. The SM had knowledge of the risks of placing the SC in bed with them and still allowed the SC to sleep alongside the parents. The SC was found unresponsive and then later pronounced dead at the hospital. The SC had her own bassinet to sleep. The SM was informed about safe sleep and the risks of co-sleeping, and still allowed the SC to co-sleep between herself and the SF. The ME determined that the cause of death was bed sharing.

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?** No

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 6/25/17 safety assessment was inadequate as the documentation focused on the SC and not the SS. ACS inappropriately listed the parents' inability/unwillingness to provide adequate care of the CH as a safety factor that placed the SS in danger.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations 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 attended and what was discussed.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The 10/17/17 safety assessment was inadequate as the comment did not support the safety factor. ACS listed safety factors although the associated comments stated the parents provided adequate care of the SS.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations 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 attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/24/2017 **Time of Death:** 06:45 AM

Time of fatal incident, if different than time of death: 05:30 AM

County where fatality incident occurred: Queens
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
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	Female	26 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

On 6/24/17, LE said the SF initially stated the SC was asleep in the bassinet, but later said the SC was in bed with him and the SM. The SM fed the SC at about 1:00 AM, the SF observed the SC at 3:00 AM, and when he awoke at about 6:00 AM he observed SC was not breathing. He performed CPR and then called 911. The death did not seem suspicious, and foul play was ruled out by the ME. Later, LE said the 3-year-old CH seemed well cared for. ACS learned there was suspicion that one of the parents rolled over on the SC. LE reported the ME said there were no visible signs of trauma inflicted. The SC had to be face down prone position. There were fractured ribs, but they were caused by CPR compressions to the SC by EMS.

On 6/24/17, ACS interviewed the SF who said he heard the SC cry about 3:00 AM, and then he fed and burped the SC. The SM also burped the SC. The SF said he went to sleep at about 3:30 AM and between 4:00 AM-4:30 AM, he heard the SC cry again. He took her out of her bassinet, and placed her in the middle of the bed between himself and the SM. He said he awoke around dawn and he tapped the SC, but she did not move. He observed the SC was on her back and she was not breathing. The SF woke the SM, and she began to give mouth to mouth resuscitation. The SM called 911 as the SF tried to give CPR. EMS arrived and transported the SC to the hospital. The SM said the SC was born premature at 34 weeks. She also said the SC slept in a bassinet. The parents denied substance abuse.

Later, ACS visited the home, engaged the parents and observed the parents' queen size bed and SC's "sleeper" referred to as the bassinet. The SM said the SC slept in the sleeper with a queen size pillow in it. ACS informed the SM that the sleeper was not considered a bassinet. The SM said the SC's crib was converted into a toddler bed for the 3-year-old CH. Regarding the events of 6/24/17, the SF said that he picked up the SC by the head and saw that her body was limp and then woke the SM. The SM said that around 5:00 AM or so, the SF woke her and told her the SC was not breathing.

ACS interviewed a neighbor who said he resided in the home for two years. He shared the kitchen with the family but stopped using it after he observed it was dirty. He said LE had come to the home several times as the parents argued. He observed the SC twice and she looked well.

On 7/13/17, ACS discussed domestic incident reports (DIR) with the SM. According to the SM, the parents had a misunderstanding and they did not believe it was going to lead to an arrest. Their parents visited the home and addressed the incident with them. ACS did not state whether the issues were resolved.

On 7/26/17, during a home visit the parents informed ACS that they each weighed 180 pounds. The SM said that while co-sleeping with them, the SC was placed on her back. The SM said she had a spiritual advisor who began to provide bereavement counseling to the parents. The parents were asked whether they were told about and saw the “Safe Sleep” video regarding the dangers regarding co-sleeping with babies. The SM said she was instructed in the hospital and provided documentation. She was given a DVD, but did not watch it. The SF did not see the video, but read the brochures.

On 9/28/17, the DC staff member said the 3-year-old continued to do well in DC.

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 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 the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041061 - Deceased Child, Female, 26 Days	041062 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
041061 - Deceased Child, Female, 26 Days	041062 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
041061 - Deceased Child, Female, 26 Days	041063 - Father, Male, 22 Year(s)	DOA / Fatality	Substantiated
041061 - Deceased Child, Female, 26 Days	041063 - Father, Male, 22 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?	☒	☐	☐	☐
Was there an adequate safety 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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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:
ACS made a referral for an Agency for Child Development (ACD) DC voucher for the 3-year-old CH. The parents agreed to submit to a drug test. On 9/8/17, ACS received the results of the SMs drug test and it was negative. The documentation did not reflect whether the SF took a drug test.

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:
ACS made a referral for an Agency for Child Development (ACD) DC voucher for the 3-year-old CH.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents agreed to submit to a drug test. On 9/8/17, ACS received the results of the SM's drug test and it was negative. The documentation did not reflect whether the SF took a drug test nor if any result of such test.

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?	Yes

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 and ACS as subjects in a SCR report.

Known CPS History Outside of NYS

There was no known CPS 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