Child Fatality Report

Report Identification Number: NY-18-011

Prepared by: New York City Regional Office

Issue Date: Jul 16, 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: Bronx
Gender: Female
Date of Death: 02/03/2018
Initial Date OCFS Notified: 02/06/2018

Presenting Information

On 1/31/18, while in the care of the SF, the otherwise healthy four-month-old SC was placed on a bed with two pillows while the SF worked on his computer in the same room. The SF turned around and found the SC to appear "blue" in color. The SC 's aunt, who was also in the home at the time, initiated CPR on the SC and called 911. The SC was taken to the hospital and arrived at 4:35 PM. The SC was placed on life support in the Intensive Care Unit. She was pronounced dead on 2/3/18 at 11:15 AM. The SF provided conflicting information regarding the length of time the SC was last seen alive and where she was found unresponsive. The cause of the death of the SC is unknown. The report alleged DOA/Fatality and IG of the SC by the SF.

Executive Summary

On 2/7/18 at 1:30 PM, the three-month-old female SC died after being taken off life support she had been on for four days. The ME has not issued the autopsy report and ACS has not yet made determinations on the 1/31/18 or 2/6/18 reports. ACS visited the hospital and learned that the SC was left in the care of the SF while the BM was at work from 9:00 AM to 5:00 PM on weekdays. The SF reported he works from home while caring for the SC.

The SF reported he placed the SC on the parents bed in a “Boppy pillow,” and propped the bottle with a rolled blanket. The SC fed while he worked on the computer. The SC finished her bottle which the SF removed then he continued working on the computer. The SF stated the SC was fine at this time. Sometime later, the SF turned around and found the SC raveled in the blanket, face down, pale and cold. He ran upstairs to the MGA who initiated CPR until EMS arrived and transported the SC to Montefiore Children’s Hospital where she was listed in critical condition and placed on life support.

The SF denied leaving the SC home alone and the BM reported she provides care to the SC when is not working. The Specialist learned there was a discrepancy in the amount of time between when the SF said he checked the SC and when he reported he found her unresponsive in her bassinet. The physician reported that due to her condition, the SC had been without oxygen for approximately thirty minutes.

LE reported the SF admitted to smoking marijuana but hadn't used any on the day of the incident. LE informed ACS they found no criminality. The parents have no other children.

According to ACS, the ME has not issued an autopsy report. ACS has not made a determination on the 1/31/18 or the 2/06/18 report to the date this report was issued on 7/6/18.

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?** N/A

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?** N/A

Was the decision to close the case appropriate? N/A
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:
ACS has not yet made a determination.

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: 02/03/2018 **Time of Death:** 11:15 AM

Date of fatal incident, if different than date of death: 01/31/2018
Time of fatal incident, if different than time of death: 04:00 PM

County where fatality incident occurred: Bronx
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? 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? 30 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

☐ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☐ Asleep

☒ Distracted
☐ Impaired by disability
☐ 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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	No Role	Female	24 Year(s)

LDSS Response

On 1/31/18, the SCR registered a report of a three-month-old female infant SC who went into cardiac arrest while in the father's care at home. The SF, could not provide a plausible explanation for the SC's death. ACS initiated an investigation by contacting Montefiore Children's Hospital Pediatric Intensive Care Unit, and learned that the SC was placed on a life support system and that she was at home with the SF while the BM went to work. There were no other children in the home.

On the same date, the Specialist interviewed the parents and learned the SC usually slept face down and she could turn over without assistance. The parents reported that despite safe sleep training, they would bed share with the SC so she would not cry. The Specialist noted the bassinet was filled with items. The BM stated she works full time during the day and the SF worked from home while caring for the SC. The BM reported she would feed the SC twice at night and again in the morning prior to leaving for work. She also told ACS she provided all of the care taking responsibilities for the SC when she was not at work. The BM reported she changed her job to be able to spend more time with the SC.

According to the SF, he would sleep until he heard the SC squirming, usually around 11:00 AM. He would then change and feed the SC and place her on the bed with a "Boppy" pillow and propped the bottle with a rolled blanket so she could feed from her bottle. When she finished he took the bottle and left her laying on the bed. He returned to work on the computer with his back to the SC and he listened to music with headphones. The SF stated when he did not hear the SC playing or cooing as she usually did he turned around to check her. The SF unraveled her from the blanket and found her face down, pale and cold. The SF stated that at the time of the incident, his back was turned for approximately five minutes then later said it may have been twenty minutes. He also stated the SC was in her bassinet and later recanted. The SF ran upstairs with the SC to the MGA, who then called 911 for emergency medical assistance and initiated CPR. EMS arrived and transported the SC to the hospital. The SF stated his phone could not make calls and he was not aware he could have summoned 911 without the service. He admitted to smoking marijuana periodically and tested positive for a marijuana screening.

The BM reported that approximately 4:00 PM, she received a call from the MGA alerting her of the incident. She took a taxi to the hospital where she was informed of her daughter's medical condition.

On 2/2/18, the Specialist interviewed the MGA and she stated she was on the phone when she heard someone banging loudly on her door. She saw the SF with the SC screaming "she is not breathing." The MGA stated she immediately initiated CPR to which she was certified. She instructed the SF to call 911. EMS responded and transported the SC to the

hospital. According to the information received, the MGA was not a person legally responsible for the SC.

On 2/3/18 at 10:30 AM, the SC was declared brain dead. The physician explained the SC was found face down, wrapped in the blanket for approximately thirty minutes despite the BF's statement that it was five minutes; it appeared she suffocated.

On 2/6/18, the SCR registered a subsequent report alleging the death of the SC.The report alleged DOA/Fatality of the SC by the SF who was the sole caretaker at the time of the incident and because he gave conflicting information regarding the time and place the SC was found unconscious.

ACS learned from the pediatrician in the neonatal Unit that on 2/7/18 at 1:30 PM, the SC was taken off the ventilator. LE found no criminality and closed their case. ACS conducted an extensive search on the parents in two other states; however, it yielded no CPS history. The parents declined services and stopped communication with ACS.

ACS has not yet determined 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)?No
Comments: The ACS investigation adhered to previously approved protocols for 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
045781 - Deceased Child, Female, 4 Mons	045782 - Father, Male, 25 Year(s)	DOA / Fatality	Pending
045781 - Deceased Child, Female, 4 Mons	045782 - Father, Male, 25 Year(s)	Inadequate Guardianship	Pending

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 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 declined services offered by ACS.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
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

Child Fatality Report

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/31/2018	Deceased Child, Female, 3 Months	Aunt/Uncle, Female, 47 Years	Inadequate Guardianship	Pending	No
	Deceased Child, Female, 3 Months	Mother, Female, 25 Years	Inadequate Guardianship	Pending	
	Deceased Child, Female, 3 Months	Father, Male, 25 Years	Inadequate Guardianship	Pending	

Report Summary:
The three-month-old child resided in the home with her parents and PA. On 1/31/18, while in the care of the adults, the SC went into cardiac arrest. A plausible explanation was not provided by the adults, therefore, all are named alleged subjects in this matter.

Report Determination: Undetermined

OCFS Review Results:
ACS supervisor did not approve the determination on this case.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

The parents have no ACS 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.

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