Child Fatality Report

Report Identification Number: SY-19-041

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: 2 month(s)
Jurisdiction: Jefferson
Gender: Male
Date of Death: 08/03/2019
Initial Date OCFS Notified: 08/05/2019

Presenting Information

On 8/5/19, an SCR report was received regarding the death of the infant. The report stated on the morning of 7/30/19, the mother was breast feeding the infant and realized he was not latching and was blue in color. The mother called 911 and EMS arrived and transported the infant to the ER. The infant was then transferred to another hospital for further evaluation. The infant arrived at the hospital in cardiac arrest and was intubated. It was determined the infant had no brain activity. There were no signs of physical injury on the infant and no indication he had been shaken. On 8/2/19, the death of the infant was pronounced.

Executive Summary

This report concerns the death of the 2-month-old male infant. The infant and mother resided alone in the home and the infant had no siblings. On 7/29/19, Jefferson County Department of Social Services (JCDSS) received an SCR report regarding the critical condition of the infant. The infant was home with his mother and at about 8:00PM the mother contacted 911 to report the infant was unresponsive. The infant did not have any known life threatening health conditions. On 8/5/19, a subsequent SCR report was received by JCDSS regarding the death of the infant on 8/3/19. The report indicated there were no signs of physical injury to the infant, nor an indication he had been shaken. The mother did not have a plausible explanation for the infants critical condition and ultimate death, and therefore the incident and death were suspicious.

JCDSS learned the mother had been feeding the infant and then noticed he was unresponsive. The mother gave several versions of these events to law enforcement and medical personnel, so it is not clear exactly what occurred before the mother contacted 911. When first responders arrived they found the mother performing CPR and took over. The infant was taken to the ER and presented in cardiac arrest. The infant was transferred to another hospital for specialized care shortly thereafter. Several tests were performed and the infant was kept alive with medical equipment. The prognosis for the infant was poor and life sustaining measures were removed on 8/3/19.

The ME was notified and performed an autopsy. The final autopsy report listed the cause of death as undetermined and the manner of death as sudden unexplained infant death.

JCDSS coordinated their investigation closely with LE and shared information gathered. LE initially spoke with the mother and then denied further requests for an interview without an attorney present. LE was awaiting the final autopsy results and will likely be closing their case without criminal charges.

The mother was very uncooperative with the CPS investigation and would not speak with JCDSS without an attorney present, despite numerous efforts to engage her. JCDSS offered to accommodate the mother's request. The mother ultimately told JCDSS she refused to seek counsel unless she was criminally charged. JCDSS spoke with the father, the maternal relatives, first responders, LE and multiple medical personnel in addition to reviewing the infants birth, pediatrician and emergency treatment records. JCDSS worked diligently to gather and document information from these sources in an effort to piece together the events that led to the infant's death, despite the mother's reluctance to speak with them. JCDSS verbally offered the mother counseling and grief services and followed up by mailing these referrals to her. JCDSS completed and documented all casework activity in a timely manner and were forthcoming in their response to OCFS' request for records.

JCDSS appropriately unsubstantiated the allegation of DOA/Fatality against the mother regarding the infant as no causal connection could be made between the cause of death and the mother's actions or inactions. The allegation of IG was substantiated against the mother as JCDSS found evidence that the mother delayed in seeking medical connection for the infant after discovering he was unresponsive. The CPS investigation was indicated and closed and no further services were provided because there were no surviving children.

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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **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:
The investigation had not yet been concluded at the time of this writing.

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: 08/03/2019 **Time of Death:** 06:50 PM

Date of fatal incident, if different than date of death: 07/29/2019

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

County where fatality incident occurred: Jefferson

Was 911 or local emergency number called? Yes

Child Fatality Report

Time of Call: 08:01 PM
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
At time of incident supervisor was: Unknown if they were 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	Male	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Other Household 1	Father	No Role	Male	35 Year(s)

LDSS Response

JCDSS had been investigating the incident that led to the death of the infant since 7/29/2019, when they received the initial SCR report. On 8/4/2019, JCDSS received another SCR report regarding the death of the infant and continued their investigation. JCDSS coordinated their efforts with LE as the mother was unwilling to cooperate with CPS. JCDSS conducted a CPS history review and notified the DA of the infant's death. There were no surviving siblings and JCDSS confirmed no other children resided in the home.

JCDSS attempted to speak with the mother numerous times during the investigation and she was uncooperative. JCDSS spoke with the maternal grandfather and uncle at the hospital and they stated that the mother wanted an attorney present when speaking to JCDSS, although the mother had not retained legal counsel. Neither individual shared any information regarding the incident.

JCDSS spoke to medical staff at the initial hospital where the infant was taken, as well as the hospital he was later transferred to for ongoing life support. JCDSS also reviewed medical records for the infant. JCDSS learned on 7/29/19, the mother called 911 at 8:01PM, and LE and EMS responded to the home at 8:16PM. The mother performed CPR until EMS arrived and took over. The infant was transported to the hospital via ambulance and arrived at 8:18PM. The mother told hospital staff she put the infant in the crib at 7:35PM. The nurse told JCDSS that the infant went without oxygen for at least an hour according to that timeline of events. When the infant arrived at the hospital he was intubated and was having seizure activity. The infants pupils were fixed and he had no response to pain. ER staff performed numerous medical tests and the results of the tests were unfavorable and indicated a poor prognosis for the infant. The infant was noted to have a severe anoxic brain injury. On 8/2/19, the infant was declared brain dead and remained on life sustaining equipment pending possible organ donation. On 8/3/19, the father declined organ donation and all life sustaining care was withdrawn.

JCDSS contacted the state of Virginia to make a visit to the father. CPS in Virginia interviewed the father and JCDSS also spoke with him on the phone. The father stated he last saw the infant 3 weeks ago, when the mother took the infant to New York. He stated they argued frequently and the mother was controlling. He told JCDSS she had untreated mental health issues and alluded that she may have smothered the infant. The father was incarcerated for an unrelated probation violation during the CPS investigation and JCDSS spoke with his probation officer (PO). The PO reported the father had a history of drug use and threats.

LE shared information with JCDSS after interviewing the mother. LE informed JCDSS the mother gave conflicting stories about the time frame before she found the infant unresponsive. The mother told the responding law enforcement officer that she breast fed the infant and as she put him down in the crib he went limp and told ER staff that she fed the infant, placed him in the crib and later found him unresponsive. The social worker at the hospital where the infant was transferred stated the mother reported after breast feeding the infant she had to pull him from her breast and that is when she discovered he was unresponsive. LE thought the infant's death may be related to a unsafe sleep situation. A "pillow nest" was seen in the home and LE believed that is where the infant may have been sleeping. LE also told JCDSS that they believed the mother may have fallen asleep and woke up to find the infant unresponsive, but she continued with her normal routine before calling for help. JCDSS learned that at 7:54PM on 7/29/19, the mother sent a picture of the infant to a friend and noticed he was blue in color. The mother then called 911, seven minutes later.

JCDSS mailed referrals for grief counseling services to the mother as she would not meet with them.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a 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)? 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
051765 - Deceased Child, Male, 2 Mons	051766 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
051765 - Deceased Child, Male, 2 Mons	051766 - Mother, Female, 32 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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was given referrals for grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? No
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

An SCR report against the mother from 2014, was indicated as there was evidence found that she used physical discipline to reprimand children she was caring for while operating a day care in her home. The mother left marks on some of the children and admitted to hitting them. The mother was arrested and the daycare was closed.

Known CPS History Outside of NYS

There is no known CPS History outside of New York State. The family had previously resided in the State of Virginia and JCDSS contacted Virginia to inquire about CPS history there.

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