Child Fatality Report

Report Identification Number: AL-18-016

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

Issue Date: Dec 18, 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: 2 month(s)
Jurisdiction: Albany
Gender: Female
Date of Death: 07/24/2018
Initial Date OCFS Notified: 07/24/2018

Presenting Information

An SCR report was received on 7/24/18, that alleged the 10-week-old subject child passed away on that date, while in the care of the father. The father had fallen asleep in a recliner while holding the infant. The mother arrived home from work and saw the baby facing head first, with her face in the corner of the recliner, between the father and the chair. The mother attempted CPR, but was unable to resuscitate the baby. The baby had a bruise on her nose and suffocated due to her position. The mother had an unknown role.

Executive Summary

This report concerns the death of the 2-month-old female infant. Albany County Department for Children, Youth and Families (ACDCYF) received an SCR report regarding the fatality on 7/24/18. The infant was an otherwise healthy child and her death was considered suspicious. The infant had no surviving siblings and there were no other children residing in the home.

The father was caring for the child at the time of her death. The father fell asleep in a recliner with the baby while rocking her to sleep. The mother arrived home and found the baby face down in the chair, with her head covered by the father's arm. The father did not recall falling asleep with the baby and had not slept in nearly 24 hours. The father was awoken by the mother when she discovered him and the baby asleep in the chair. The mother called 911 and performed CPR until EMS arrived. EMS and the fire department took over CPR, and transported the baby to the ER. ER staff tried to resuscitate the infant, to no avail.

The ME performed an autopsy, but the report was not yet completed at the time of this writing. ACDCYF asked for a preliminary finding, but the ME was waiting on further testing to return.

LE's investigation was concluded with no criminal charges filed against the parents. LE did not suspect foul play in the death of the SC.

ACDCYF discovered the father's 13yo brother was visiting the home at the time of the incident. He had been at the paternal grandfather's home in Brooklyn, and on 7/24/18, he accompanied the parents to their house. After the baby's death the child returned to his mother's home in Florida, where he regularly resided. The child, his father and his mother were all spoken with and there were no concerns for the 13yo.

ACDCYF substantiated the allegations of inadequate guardianship, DOA/Fatality and laceration, bruises and welts against the father regarding the subject child. ACDCYF found some credible evidence that the father had not slept in over 24 hours at the time he was alone caring for the SC. As a result of his fatigue, the father fell asleep in a reclining chair with the baby and she was found face down in the chair with her nose and head covered by his arm. The child also had bruising to her nose, that was not previously present. ACDCYF found the father's actions placed the baby at risk of imminent harm.

ACDCYF offered the parents burial assistance and they declined. The parents were also offered referrals for grief counseling on multiple occasions. At the time of this writing the parents were in counseling and trying to work through the loss of their daughter. The parents moved in with the mother's father shorty after the baby's death and reported he was a large support to them during their bereavement.

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:
ACDCYF gathered sufficient documentation to conclude the investigation.

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 casework was commensurate with the case circumstances and it was appropriate to conclude 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: 07/24/2018 **Time of Death:** Unknown

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

County where fatality incident occurred: Albany
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:

- [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? 2 Hours
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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)

LDSS Response

After ACDCYF received an SCR report on 7/24/18, they contacted the source, informed the DA of the fatality and coordinated their efforts with LE. A CPS history check was done for the family, and no history was found. ACDCYF learned that the infant had no siblings and their were no other children residing in her home.

ACDCYF learned the father's 13yo brother was at the home when the incident occurred. The 13yo was playing video games in the child's bedroom and was wearing noise cancelling headphones when the commotion took place. The 13yo had no knowledge of what happened and was notified when LE and a relative arrived at the home after the parents and baby were already at the ER. The 13yo was interviewed over the telephone because he resided out of state with his mother. The child was assessed as safe and there were no concerns for his well being.

ACDCYF went to the family's home and spoke with the mother and father within 24 hours of being notified of the infant's passing. The parents explained they were visiting family in Brooklyn, and had returned home at about 1AM on 7/24/18. The father then left for work at about 2:30AM. The mother fed the baby at 2AM and the baby fell asleep and was placed in her portable crib. The mother also went to sleep. The mother and infant woke again at 9AM and the mother fed the baby. The baby fell back asleep and was again placed in her crib. The mother did some household chores and laid in bed in and out of sleep, until noon. The father arrived home from work and the mother woke to him making breakfast. The mother woke the baby at 1PM, changed her and fed her. The mother left for work around 1:40PM and the father was caring for the infant. The father had been awake since 11AM on 7/23/18 when they prepared to leave for the trip to Brooklyn.

The father explained the baby was on her play mat and he was in the room watching her, and also the television. The father

said she was playing on her mat for about 2 hours;he then changed her and held her while sitting in the recliner in the living room. The father sent the mother a text message at 3PM to ask when the baby last ate and was changed. At 4PM he gave her a bottle. The mother and father spoke again through text at 4:39PM, after the baby finished eating. The father then began to rock the baby to sleep in his arms, while sitting in a recliner. The father reported falling asleep and waking to the mother yelling.

The mother stated she had continued to text the father after they last spoke, and she became nervous when he did not respond. The mother left work and arrived home at 7:30PM. She found the father sitting in the recliner, holding the baby close in his arm, with his elbow area covering her head, including her forehead and nose. The child's feet were visible and pointing up, while her head was not. The baby's head was down and in the recliner and the mother immediately pulled her out. She reported the baby's eyes were open , her lips were purple and she was lifeless. The mother said she also had a clear fluid coming from her nose and mouth. The father then took the baby into the hallway and called for help. The mother called 911 and then took the baby from the father and began CPR while he spoke to the operator. The first responders arrived and took over CPR. When the ambulance arrived the baby was taken to the ER and the parents followed.

Both parents denied any alcohol or drug use in the time leading up to the infant's death. Both parents also acknowledged receiving safe sleep education and had both a portable crib and crib for the baby.

The first responders were interviewed and reported no concerns of safety, abuse or maltreatment from what they observed at the home. The mother was performing CPR when they arrived. They took over CPR, but the baby had no heartbeat and her jaw was clenched, indicating she was gone. ACDCYF reviewed the baby's medical records and spoke to the pediatrician, there were no concerns regarding her care.

Official Manner and Cause of Death

Official Manner: Pending
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)?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
048513 - Deceased Child, Female, 2 Mons	048515 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
048513 - Deceased Child, Female, 2 Mons	048515 - Father, Male, 24 Year(s)	Lacerations / Bruises / Welts	Substantiated
048513 - Deceased Child, Female, 2 Mons	048515 - Father, Male, 24 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
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? Yes
Explain:
The parents were offered burial assistance and referrals for grief counseling.

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? 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 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.

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