Child Fatality Report

Report Identification Number: NY-16-095

Prepared by: New York City Regional Office

Issue Date: May 30, 2017 **(Report was reissued on: May 30, 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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 9 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 09/05/2016
Initial Date OCFS Notified: 09/05/2016

Presenting Information

The SCR registered a report alleging that on 9/25/16, at around 4:00 A.M., the mother breastfed the nine-month-old SC and put him to sleep on the bed with her and the father. At approximately 7:25 A.M., the parents found the SC unresponsive and immediately called 911. Emergency Medical Services transported the SC's body to Wyckoff Heights Medical Center where the SC was pronounced dead at 7:41 A.M. The report stated the SC had no known preexisting medical conditions; therefore, the death was considered suspicious.

Executive Summary

The SC was 9 months old at the time of his death. As of 3/21/17, the ME has not issued an autopsy report or provided a preliminary cause and manner of death.

The family had no CPS history with the SCR or ACS. The SC was the parents only child.

On 9/5/16, the SCR registered a report with allegations of DOA/Fatality and Inadequate Guardianship of the SC by the parents.

According to the parents and other family members, the mother breastfed the SC at about 4:00 A.M. and then placed him to sleep on the bed in between her and the father. The father woke up at approximately 7:25 A.M. and noticed the SC was unresponsive. The father said he woke the mother up; went down to the PGPs home and the PGF called 911. The SC was transported by EMS to Wyckoff Medical Center. The SC arrived at 7:32 A.M. and was pronounced dead at 7:41 A.M. The SC's temperature upon arrival was 94.2 degrees Fahrenheit and rigor mortis had begun.

ACS assessed the family's home and found it clean and organized with provisions for the SC.

The NYPD, ADA, and the ME responded to the home and based on the preliminary investigation there was no criminality associated with the SC's death. Days after the SC's death, the PGF died. The parents requested that ACS not contact them; therefore, visits have been discontinued as there are no other children in the home.

The investigation remains open pending the results of the autopsy.

As of 5/30/17, ACS has not yet made a determination.

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?** Unable to Determine

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

Explain:
N/A

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Unable to Determine
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
N/A

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: 09/05/2016 **Time of Death:** 07:42 AM

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: 07:20 AM
Did EMS to 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 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	Male	9 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	60 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	56 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)

LDSS Response

Following the fatality report, ACS contacted the NYPD, ADA, medical staff, the ME, and family members. Through the PGPs and collateral contacts, ACS learned there were no surviving children in the home.

The NYPD informed ACS that the ADA, the homicide detectives, and the ME conducted a preliminary investigation. There was no criminality found concerning the SC's death. According to the NYPD, the parents reported they placed the SC between them and apparently the child was suffocated between the sheets. The ME has not confirmed the SC was suffocated.

The attending physician from Wyckoff Medical Center indicated the family arrived at the ER at 7:32 A.M. by ambulance and the NYPD. The physician stated the SC was wrapped in a blanket.

The NYPD informed ACS that an autopsy was completed and the SC appeared well cared for by the parents. However, the result of the autopsy was pending.

On 9/6/16, ACS attempted to visit the parents at the case address; however, met the PGPs outside the home. The PGPs noted the mother was asleep and the father was out of the home. The PGF said that at the time of the incident, the father ran downstairs from his apartment screaming the SC was not breathing. The PGF said he (PGF) immediately called 911 for assistance and was instructed by the operator on how to perform CPR. The PGF stated the SC had a crib, but on the day of the incident the parents placed the SC to sleep with them. The PGPs did not know whether this was the parents' usual practice. The PGM reported the SC was a healthy child. Based on the case documentation, it is not clear whether the parents received information on safe sleep practices.

According to the case documentation, the family was distraught over the deaths of the SC and the PGF who died about a month after the SC. ACS made several attempts to interview the parents; however, it did not appear the father and other family members were agreeable to an interview. During this investigation, the father was occupied with making arrangements for the funerals of the SC and the PGF.

On 10/27/16, after several efforts by ACS, the mother agreed to an interview at the case address. ACS documented the mother was of slim build and was 5' and 5" tall. There was no estimated weight for the mother.

According to the mother, on 9/4/16, she and the father left the SC with the PGPs and went to a party. The mother said they had not been to a party in a while and they both were intoxicated by the time they returned home. There were no details about the amount of alcohol the parents consumed. The mother said they picked up the SC from the PGPs and she breast fed him at about 4:00 A.M. The mother said the SC did not like sleeping in the crib, therefore she placed him to sleep on the bed with her and the father. The mother said she did not recall anything after this. The mother said the father woke up at about 7:00 A.M. with a loud scream because the SC was not breathing. She said the father ran downstairs to the PGPs home and placed the SC on the table. The mother said she did not know who called 911, but noted the operator was providing instructions to the father to administer CPR.

The mother reported the SC was happy and healthy. She said that both she and the father missed the SC. She said she and the father went on a mountain climbing trip to start healing from the loss of the SC.

Despite ACS' numerous efforts, they were unable to conduct an interview with the father concerning the events leading to the SC's death. ACS did not document and estimate of the father's height and weight.

As of 5/30/17 ACS has not yet made a determination on 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 investigation adhere 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 NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
030966 - Deceased Child, Male, 9 Month(s)	030962 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Pending
030966 - Deceased Child, Male, 9 Month(s)	030962 - Mother, Female, 28 Year(s)	DOA / Fatality	Pending
030966 - Deceased Child, Male, 9 Month(s)	030963 - Father, Male, 28 Year(s)	DOA / Fatality	Pending
030966 - Deceased Child, Male, 9	030963 - Father, Male, 28 Year(s)	Inadequate	Pending

Month(s)		Guardianship	

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?	☒	☐	☐	☐

Additional information:
21. ACS made efforts to interview both subjects; however, the father did not make himself available.

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 Unavaliable	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:
N/A

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs related to the fatality.

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 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 family has no CPS History.

Known CPS History Outside of NYS

The family has no known CPS history outside .

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

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:	OCFS is recommending that ACS Supervisory Team review with the Specialists the CONNECTIONS' Step-by-Step Guide: Training for CPS Workers (rev 3/1/07) page 204, which addresses Safety Assessments, and to review the Safety Assessments submitted for this report. Staff must be reminded that when there are no surviving siblings and/or minor children in the home, the Specialist must select "no surviving siblings" in the Investigation Conclusion window of the CONNECTIONS database at the beginning of the investigation to prevent the CONNECTIONS system from generating the Safety Assessments and Risk Assessment Profile.

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