Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-18-090

Prepared by: New York City Regional Office

Issue Date: Feb 22, 2019

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: New York
Gender: Female
Date of Death: 09/13/2018
Initial Date OCFS Notified: 09/13/2018

Presenting Information

On 9/13/18, the SCR registered a report that alleged the SM put the twenty-six-day-old SC to sleep and three hours later the SM noticed the SC was not breathing. EMS was notified at approximately 3:00 AM. LE and EMS responded to the home and transported the SC to Columbia Presbyterian Hospital where she was pronounced dead due to unknown reasons. The allegations of the report were DOA\Fatality and IG of the SC by the SM.

On 9/14/18, the SCR registered a subsequent report that alleged the same information. The report added that the SC arrived at the hospital in cardiac arrest and medical staff were unable to resuscitate. She was pronounced dead at 3:27 PM on 9/13/18. The narrative also alleged the SC had no pre-existing medical conditions and no visible injuries were found on her body. There was no explanation for the SC's death. The allegations of the subsequent report were DOA\Fatality and IG of the SC by the parents.

Executive Summary

The SCR registered two reports on 9/13 and 9/14/18, regarding the death of the twenty-six-day-old female SC that occurred while in the care of her parents. Both reports alleged the SC was found unresponsive in her Pack and Play and the cause of her death was unknown. The report also alleged the SC did not have any pre-existing medical conditions and the parents were named the subjects of the reports.

Following the receipt of the 9/13/18 report, an ACS Specialist visited Columbia Presbyterian Hospital and obtained information regarding the SC. ACS learned the SM had fed and changed the SC at 8:00 AM and then at noon and placed her to sleep facing up in her Pack and Play. At approximately 3:00 PM, the SM attempted to wake the SC and found her face up, cold and unresponsive. The SM alerted the family and 911 was summoned. EMS first responded to the case address and transported the SC to the ER where she was pronounced dead at 3:27 PM. There were no other children in the home.

On 9/13/18, ACS learned from the Dr., ME and LE, that the SC was found with no signs of neglect or maltreatment. ACS also learned from the ME that the SC was born with “a lot of complications;” however, the SC was discharged from the hospital on 8/30/18. LE reported they found no criminality.

On 9/13/18, ACS interviewed the SM and her account of the incident was consistent with the information reported the DR., ME and LE. The SM added that she had a high-risk pregnancy that caused the SC to be tested for various conditions at birth; however, those tests results were pending. She was referred to a pediatrician who would give her the results to the tests. The SM explained she took the SC to an appointment on 8/22/18; however, she could not recall the address. She described the clinic and reported she was not comfortable with the clinic as it was located in an apartment building and they charged her a fee for the visit because she did not have medical insurance for the SC. The SM expressed that at the time, she did not have the money to pay for the visit; she became frustrated and left the clinic before the SC was seen by the pediatrician. The parents reported the SC drank four ounces of formula every three to four hours; she showed no sign of illness.

The SF, PGM and PU was also interviewed by the ACS Specialist and there were no discrepancies in their accounts of the incident. ACS learned that the SC was the parents’ only child. The SF reported that he and the SM were the only caregivers to the child. The BF reported that he is currently in treatment and that he is consistent with his medication. He

added that the medication does not impede his ability to provide adequate care to the SC. The PGM and PU had no concerns regarding the care the parents gave to the SC and that the family will provide support to help the parents. The parents declined services.

On 9/14/18, the ACS Specialist received information from the pediatrician with whom the SC had the follow-up appointment. The pediatrician reported that their record indicated the SM did call and an appointment was scheduled; however, they had no record that the SC was seen. The pediatrician added that the SC would have been seen without medical insurance.

The ME listed the cause of the SC's death Sudden Unexpected Death in Infancy and the manner natural. ACS has not yet determined the allegations at the time this report was issued.

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?** 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:
Investigation has not been determined.

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 determined the allegations to the time this report was issued.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	There are gaps in documentation in this investigation and there has been no new entries in the progress notes ` since 12/4/18.
Legal Reference:	18 NYCRR 428.5

Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Fatality Report was not completed for this investigation.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-day Safety Assessment was not completed for this investigation.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/13/2018 **Time of Death:** 03:27 PM

Time of fatal incident, if different than time of death: 03:00 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 03:00 AM
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? 2 Hours
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	Aunt/Uncle	No Role	Male	37 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	26 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	64 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)

LDSS Response

The twenty-six-day-old female infant (SC) died on 9/13/18. The SCR report narrative alleged that the SC was found unresponsive in her Pack and Play where she slept. EMS was summoned and they transported the SC to the hospital where she was pronounced dead. The parents were named the subjects of the report with allegations of DOA/fatality and IG of the SC because the SC died of unknown reasons.

On the following day, the SCR registered a subsequent report with similar information and the same allegations. The second report added that the SC had no pre-existing medical conditions and no visible injuries were found on the SC's body. The PGM and the PU, who also resided in the home and were present at the time of the incident, were not subjects of the report. There were no other children in the home.

On 9/13/18, ACS initiated the investigation by visiting Columbia Presbyterian Hospital Pediatric ER and gathered information. The Dr. reported the SM stated she fed the SC at 8:00 AM and again at 12:00 PM. The SC was fed a bottle every three to four hours. The SC fell asleep and the SM laid her on her back in the Pack and Play. The Pack and Play was located in the parents' bedroom and at the time of the incident, the parents were in another room doing chores. Three hours had past and the SC had not awoken or cried, the SM went to wake the SC and found her face up, cold and unresponsive. The SM initiated CPR (to which she was certified), while the SF summoned 911. EMS transported the SC and SM to the hospital where the SC was pronounced dead at 3:27 PM.

ACS contacted the ME investigator and LE concerning the death of the SC. The ME reported the SC was found with no signs of trauma and the autopsy was pending. LE conducted their investigation of the incident at the parents' home and found no criminality; there was no arrest.

The ME reported the SC was born with complications; however at the time of death, she appeared to have been well cared for. ACS obtained information from the hospital that was similar to the ME's report. ACS learned that at the time of discharge, some of the SC's tests results were pending and an appointment was given to the parents to see a Specialist on 8/22/18. ACS contacted the referred Specialist with whom the appointment was made and it was reported there was no record of the SC's visit.

On 9/13/18, ACS interviewed the parents separately at the case address and found no discrepancies in their accounts. They confirmed the report narrative and added that the SC displayed no symptoms of a medical condition. The parents explained that the SC ate on schedule, gained weight and expelled waste normally. The SM stated she did not allow anyone to take the SC out of their bedroom and that only she and the SF provided care to the SC. The SM explained that the PGM and the

PU had minimal contact with the SC.

The parents explained that the SM took the SC to the appointment on 8/22/18; however, the SM recalled only that the office was located in an apartment building. The SM stated she was asked to pay a fee for the visit because she had no medical insurance for the SC. The SM became frustrated and left the office before the SC was seen by the Dr. The SM reported she received prenatal care early in her second trimester. She had a high-risk pregnancy with complications and she was monitored closely by her Dr.

ACS documented that the home had appropriate accommodations for the SC. The parents denied drug use or DV and ACS found no sign of drug or alcohol use in the home. The PGM and the PU reported similar accounts of the incident and they had no concerns of the care given to the SC. On 9/13/18, ACS interviewed a neighbor who stated that the SM was a good mother.

The ME listed the cause of the SC's death Sudden Unexpected Death in Infancy and the manner natural. ACS has not yet determined the allegations to the time this report was issued.

Official Manner and Cause of Death

Official Manner: Natural
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)?No

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
049021 - Deceased Child, Female, 26 Days	049023 - Father, Male, 32 Year(s)	DOA / Fatality	Pending
049021 - Deceased Child, Female, 26 Days	049023 - Father, Male, 32 Year(s)	Inadequate Guardianship	Pending
049021 - Deceased Child, Female, 26 Days	049022 - Mother, Female, 27 Year(s)	DOA / Fatality	Pending
049021 - Deceased Child, Female, 26 Days	049022 - Mother, Female, 27 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?	☐	☒	☐	☐

Additional information:
The last documentation recorded in this investigation 12/4/18 and there were substantial gaps in entries prior to the lase entry.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS documentation did not reflect that the Specialist offered Burial sssistance or Family Planning to the parents.

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.

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 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

The SM was known to ACS as a child in four SCR reports dated 3/13/2006, 9/19/2007, 10/16/2008 and 5/12/2009. The MGM was named the subject in all of the reports. The allegation of the 2006 and 2007 reports were substantiated and the report was indicated for EdN due to chronic absenteeism and the MGM's lack of cooperation with the school. The 2008 and 2009 reports also had allegations of EdN which were unsubstantiated against the MGM. The MGM and SM engaged in the Person In Need of Supervision Diversion program and they received Purchased Preventive Rehabilitated Services in 2009.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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