Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-17-025

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

Issue Date: Nov 27, 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	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: Suffolk
Gender: Male
Date of Death: 07/11/2017
Initial Date OCFS Notified: 07/15/2017

Presenting Information

On July 11th, 2017, at approximately 1:30 AM while the SF was caring for the SC, the SF fell asleep in the recliner with the SC in his arms. When the SF awoke at 6:45 AM, he found the SC unresponsive and not breathing. The SF called 911 and EMS responded to the home. The SC was pronounced dead at 8:28 AM. The SC had no preexisting medical conditions and no visible injuries. The BM was asleep in the bedroom. The BM's role was listed with unknown role.

Executive Summary

An SCR report was received on 7/15/2017, regarding the death of the 1-month-old SC, which occurred on 7/11/2017. Suffolk County Department of Social Services (SCDSS) initiated an immediate investigation that included contact with the source and all other required contacts. The source was asked why the SCR had not been contacted sooner, and the source stated there was no urgency, and the death was believed to be accidental. The source also stated there were no SS and no other chn in the home. SCR and criminal history checks were completed and reviewed, it was learned that SF and BM had no previous history with CPS or LE. There was no known history of drug or alcohol misuse by the SF or the BM.

In the first 24 hours of the investigation, SCDSS determined there were no SS and the SC was the SF and BM first and only child. SCDSS offered mental health and trauma services to the family. The SF and the BM shared caretaking responsibilities for the SC. It was learned that through interviews with the SF and the BM that they would take turns caring for the SC. The SF would be up with the SC while the BM went to sleep in the bedroom and the when the BM was caring for the SC the SF would sleep in the bedroom. Both the SF and SM told SCDSS and LE that he evening of 7/10/2017, the BM took a shower and went to bed. The SF said at 11:30 PM he fed the SC and fell asleep in the recliner in the living room, holding the SC. At 1:30 AM on 7/11/2017, the SF awoke to feed the baby again and fell back asleep after feeding with the SC. The SC was asleep on his chest. When the SF awoke at 6:45 AM and found the SC was unresponsive and not breathing. The SF called 911 and began CPR. EMS arrived along with LE. The ME was called the SC was taken from the home straight to the ME’s office. The SC did not go to the hospital.

An autopsy was performed by the ME on 7/11/17. The SC time of death was listed as 8:28 AM. The autopsy results were still pending at the time of the writing of this report. The ME stated that he found no injuries on the SC. The examination was indicative of body being in the face down position which was consistent with the SF’s explanation. There were no arrests made.

SCDSS Unsub the allegations of DOA/fatality and IG regarding the SF for the SC. There was no credible evidence to support the allegations. Interviews with, the SF and the BM it was determined that, the parents had been educated on sleep and the usual place of sleep for the SC was in the SC’s pack and play. The SF fell asleep while feeding the SC. There is no evidence that the SF's actions caused the death of the SC. There were no SS and the INV was UNF and closed. The SF and the BM were in private counseling.

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:
SCDSS gathered sufficient information to make a determination.

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:
There were no SS and the parents were in private counseling to deal with their grief over the loss of the SC.

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: 07/11/2017 **Time of Death:** 08:28 AM

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

County where fatality incident occurred:	Suffolk
Was 911 or local emergency number called?	Yes
Time of Call:	06:45 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? 5 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Deceased Child	Alleged Victim	Male	26 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	No Role	Female	39 Year(s)

LDSS Response

On 7/15/17, SCDSS received an SCR report alleging DOA/Fatality and IG against SF for the 1-month-old SC. SCDSS began an immediate INV and it was learned the SC had died on 7/11/2017. During the investigation SCDSS interviewed the source and interviewed all first responders. The SF and BM were interviewed and observed. All appropriate collateral contacts were made including, pediatrician, medical personnel, the ME and family members. SCR history check was completed and reviewed. Criminal history check was completed. SCDSS made inquiries with the SF and the BF regarding drug and alcohol use. The SF and the BM deny alcohol or substance misuse.

SCDSS determined there were no SS and no other chn in the household. SF and BM provided a time line for SCDSS regarding the events leading up to the SC death. The SF and the BM's statements to both LE and SCDSS were consistent. The SF and the BM stated that on the evening of 7/10/2017 at 11:30 PM, the BM took a shower and went to bed. The SF was in the recliner in the living room with the SC and feeding him. After feeding the SF was sitting with the SC in his arms. The SF dozed off and awoke around 1:30 AM, he fed the SC again. The SF admitted to falling asleep with the SC on his chest. When the SF awoke at 6:45 AM, he found the SC unresponsive and not breathing on his chest. The SF called 911 and EMS and LE arrived to the home. LE and EMS determined the SC was already deceased. The SF and the BM were told to call family to come and be with them. They called the MGM and MA who live close by. LE called the ME and when ME arrived they took the SC directly into the van. The ME and LE then conducted a reenactment with the SF and the BM. LE provided SCDSS with this information. The reenactment was consistent with the SF's statement to SCDSS.

SCDSS obtained releases for the SC's pediatrician and the BM's pre natal records. SCDSS Interviewed the pediatrician and determined the SC was an otherwise healthy child. The SC was recently changed to formula and had been consistently gaining weight since changing to formula. SCDSS observed the SC's room and the SC had a crib but the SC as reported by the parents had not yet slept in the crib. The parents had been educated on safe sleep practices, and reported the usual place of sleep for the SC was the pack and play. SCDSS offered bereavement referral to the SF and the BM. On follow up visit to the home SCDSS brought the SF and the BM additional referrals for MH providers in the area. The SF disclosed he was currently seeing a psychiatrist but declined to sign a release. The SF was in counseling to deal with the trauma of losing the SC. Both the SF and the BM stated they were also attending a group to deal with their grief.

The autopsy results were still pending at the time of the writing of this report. SCDSS did speak with the ME and the death is believed to be accidental. There were no injuries and no evidence of maltreatment to the SC. LE had made no arrests and told SCDSS that they also believed death to be accidental.

SCDSS appropriately Unsub the allegations of DOA/fatality against the SF for the SC. There was no credible evidence to support the allegations. Through interviews and INV, it was learned that the SF and the BM took turns with the SC's care. The SF fell asleep with the SC in his arms. The SF awoke and found the SC unresponsive. There was no credible evidence that the SF's actions caused the SC death and it was determined to be accidental. The SF and the BM had been educated on safe sleep practice and the SC's usual place of sleep was a pack and play. The parents were provided with bereavement referrals and the INV was UNF and closed. There were no SS.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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? No
Comments: SCDSS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039776 - Deceased Child, Male, 26 Days	039778 - Father, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated
039776 - Deceased Child, Male, 26 Days	039778 - Father, Male, 34 Year(s)	Inadequate Guardianship	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	Needed but 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:
No other services needed. The SF was seeing a psychiatrist due to the trauma of losing the SC. Both the SF and the BM were in group counseling to deal with their loss. SCDSS did bring additional referrals for the SF and the BM.

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 household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS offered referrals to bereavement services, as well as other mental health referrals for all family members. The SF was seeing a psychiatrist due to the trauma of losing the SC. Both the SF and the BM were in group counseling to deal with their loss.

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 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

There was no child protective history.

Known CPS History Outside of NYS

There is no known history outside of New York State.

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

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