Child Fatality Report

Report Identification Number: SV-18-013

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

Issue Date: Jun 27, 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: Dutchess
Gender: Female
Date of Death: 02/13/2018
Initial Date OCFS Notified: 02/13/2018

Presenting Information

An SCR report was received on 2/13/18, which alleged the SM was asleep in bed with the SC and woke to find the SC unresponsive and not breathing. The SM called 911 and the SC was later pronounced deceased. The SC was an otherwise healthy child.

Executive Summary

This report concerns of the death of the 2-month-old female SC. Dutchess County Department of Community and Family Services (DCDCFS) received an SCR report on 2/13/18 regarding the fatality. The report alleged the SM was co-sleeping in a bed with the SC and woke to find the SC unresponsive and lifeless. The SC was an otherwise healthy child with no known medical conditions.

On the morning of 2/13/18 the SM, SC and SS (age 4) were all asleep in the SM's bed. The SM placed the SC next to her and positioned the SC on her stomach. The SM woke after a few hours to find the SC unresponsive and not breathing. The SS also woke in the midst of the event. The SM began CPR and immediately called 911. EMS promptly responded, but were unable to resuscitate the SC.

The ME performed an autopsy and concluded the manner and cause of death to be undetermined. The ME ruled out any trauma to the SC. LE investigated the circumstances of the fatality and did not pursue criminal charges against the SM.

DCDCFS spoke with all individuals who lived in the SC's home, including the SM, MGM, MGF and the 4yo SS. The father of the 4yo SS (BF2) was contacted and a visit was also conducted at his home to assess for safety. The BF of the SC did not reside in the SC's home, but he was interviewed several times. DCDCFS did not see the BF's two other children. These SS resided with their BM and DCDCFS did not inquire whether they had ever met the SC. The BF had regular visitation with the SS, but this often occurred outside of the SC's home. At the conclusion of the investigation the BF had moved into the home with the SM, SS, MGM and MGF. After DCDCFS had a conversation with the SM, she demonstrated an understanding of the importance of following safe sleep recommendations in the future. The SM had a clear understanding of how the SC's unsafe sleep environment may have contributed to her death.

DCDCFS found some credible evidence to substantiate the allegations of DOA/Fatality and IG against the SM, regarding the SC. DCDCFS concluded that the SM failed to exercise a minimum degree of care in providing proper guardianship to the SC. The SM had consumed alcohol the night prior to the SC's death, the SC was placed to sleep on a pillow top mattress, positioned on her stomach, and in the bed with the SS and SM. The presence of the identified risk factors created an unsafe sleep environment for the SC and resulted in her death.

DCDCFS offered the SM and BF burial assistance, MH counseling, substance abuse treatment, and counseling. DCDCFS appropriately consulted their legal department in regard to the SM's ability to adequately parent the SS. The SM was offered and accepted Preventive Services in conjunction with the other services she was seeking. The SM was cooperative and actively participating in recommended services, so the decision was made not to seek legal intervention. At the time of this writing, the SM and BF both attended MH counseling and the SM was actively involved in substance abuse treatment. DCDCFS also provided referrals for counseling for the SS, appropriate for his age. The SM and BF of the SS declined grief counseling for the SS after much discussion with adult counselors and the school. They took the referral information in the event that the SS needs counseling in the future.

PIP Requirement
DCDCFS will submit a PIP to the Spring Valley Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the LDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, LDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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

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:
DCDCFS gathered pertinent information throughout the investigation to make a determination.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The question in the elevated risk section of the RAP indicating there was a death of a child as the result of abuse or maltreatment by the caretaker was answered "No." The answer was not consistent with the determination made in the investigation.
Legal Reference:	18 NYCRR 432.2(d)
Action:	DCDCFS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/13/2018 **Time of Death:** Unknown

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

County where fatality incident occurred: Dutchess
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:

- ☒ 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
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ 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	Grandparent	No Role	Female	67 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	68 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Other Household 1	Father	No Role	Male	38 Year(s)
Other Household 2	Other Adult - Step-mother to SS	No Role	Female	30 Year(s)
Other Household 2	Other Adult - BF to SS	No Role	Male	29 Year(s)

LDSS Response

DCDCFS initiated their investigation into the death of the SC within 24 hours of receiving the SCR report. DCDCFS coordinated their efforts with LE. DCDCFS contacted the source of the report, conducted a CPS history check and notified the DA of the fatality. DCDCFS went to the home the same day the report was received. The SS was assessed to be safe and the MGM, MGF, SM and BF were interviewed.

The SM, SS and SC resided in the home of the MGM and MGF. The SM reported that 2/12/18 was an uneventful day. The SS went to bed in his upstairs bedroom at 8:30PM and the SC was in the downstairs living area with the SM. The SM fed the SC at 12:00AM on 2/13/18 and the SC then went to sleep for the night. The SC, SM and SS woke between 6:30 and 7:00AM on 2/13/18 and the SM gave the SS breakfast. The SS told SM he did not feel well and the SM allowed him to stay home from school. At about 9:00AM the SM, SS and SC went downstairs and laid together in the SM's bed. The SS was watching cartoons at the bottom of the bed and fell asleep. The SM was on the left side of the bed and the SC was sleeping on her stomach directly next to her. The SM was educated on safe sleep practices, but had placed the SC on her stomach because she had been recently spitting up frequently. There were several portable cribs and a bassinet observed in the home for the SC to use. SM denied there were any pillows or blankets used by the SC. The SM woke again at 12:00PM and found the SC was blue in color. The SM took the SC to the changing table and began CPR while calling 911. The SS woke during the 911 call and was on the floor next to the SM watching her perform CPR.

The SM had 4 beers the night before the fatality and disclosed regular marijuana use. The SM reported she last used marijuana on 2/10/18 and LE found marijuana in the SM's living area. The SS and SC were with the MGM and MGF when the SM used drugs. The BF denied any drug or alcohol use. The SM and BF agreed to drug screening. The BF was negative for all substances, and the SM was positive for illicit drugs. The SM admitted to recreational drug use with her friends when she was out of the home and the MGM was supervising the SS and SC. The MGM was also aware of the drug use and confirmed she always had the children in these circumstances. The SM agreed to a substance abuse evaluation and enrolled in treatment.

The BF did not live with the SM and SC, but frequently stayed overnight. The BF had not spent the night before the fatality at the case address. At the time of the incident the BF was at work. The SM and MGM called the BF to tell him about the death of the SC.

The MGF was also in the home, but had no knowledge of what happened until EMS arrived. The MGF was in the upstairs of the home doing laundry when the SC was found unresponsive. The MGM was at work at the time of the incident. The SM called the MGM at about 12:45PM to tell her the SC was not breathing. The SC was transported to the ER, where the MGM was working. The SC was unable to be saved. The MGM and MGF denied any concerns with the parenting provided by the SM or BF.

The SS was interviewed, but was very distracted and unwilling to talk with DCDCFS for long. The SS told DCDCFS he and the SC were in the bed with the SM earlier in the day. The BF2 was notified and interviewed. He had no concerns for the care the SM provided to the SC or SS. He reported that he and the SM had an amicable relationship and were easily able to work out a shared custody agreement. The BF2's home was assessed and there were no concerns.

DCDCFS made several collateral contacts throughout the investigation, including EMS, the SS's school and medical staff. DCDCFS also reviewed medical records for the SC and SS. First responders reported the SM acted appropriately while they were at the home. There were no concerns of abuse or maltreatment noted by any of the collateral contacts.

Official Manner and Cause of Death

Official Manner: Undetermined
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? No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046302 - Deceased Child, Female, 2 Mons	046303 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
046302 - Deceased Child, Female, 2 Mons	046303 - Mother, Female, 30 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?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐

At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/07/2017	Sibling, Male, 8 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report was received alleging that the BF was screaming obscenities and making threats to the then 8yo and 6yo SS. The BF banged something repeatedly and the 8yo was hysterically crying and screaming, while holding his head as if in pain. The 6yo was not injured. Both the SS were afraid of the BF.

Report Determination: Unfounded | **Date of Determination:** 08/03/2017

Basis for Determination:
The BM of the SS and the BF denied the allegations. The BF admitted he yelled at the SS while they were in the car as they kept pestering him with a question. The SS denied that the BF was screaming at them, and that they were crying. The SS also denied fear of the BF. During the investigation the BF was criminally charged after a verbal and physical confrontation with the BM of the SS. The SS were not present during the incident. The BM received an OP against the BF, but this did not include the SS. The BM and BF shared joint custody of the SS.

OCFS Review Results:
The casework was commensurate with case circumstances. The BM, BF, and both SS were seen and interviewed multiple times. Safety and RAP assessments were completed timely and adequately. Appropriate collateral contacts were made.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/31/2016	Sibling, Male, 7 Years	Father, Male, 36 Years	Fractures	Unsubstantiated	No
	Sibling, Male, 5 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Other Adult - BM to SS, Female, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 7 Years	Other Adult - BM to SS, Female, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report was received alleging the BM and BF abused alcohol and drugs to the point of impairment, rendering

them unable to appropriately care for the two SS. The report further alleged the BF became violent when intoxicated and assaulted the BM in front of the SS. The BF became angry with the SS one year prior and twisted the child's arm while swinging him around, resulting in a fracture to the SS's arm.

Report Determination: Unfounded | **Date of Determination:** 05/04/2016

Basis for Determination:
Both the BM and BF denied any substance abuse or DV in the home. The BM and BF agreed to drug testing, and were negative for all drugs. The SS, BM and BF denied physical violence, but recalled a verbal argument the adults previously had after the BF had a car accident, causing damage to the car. The arm injury sustained by the SS one year prior was reported to be the result of the SS falling off the porch on his bike, and everyone denied the BF had anything to do with it.

OCFS Review Results:
Casework was commensurate with case circumstances. The SS, BM and BF were interviewed and collaterals contacted.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

There is no CPS history three years prior to the fatality in New York State.

Known CPS History Outside of NYS

There is no known 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