Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-18-066

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

Issue Date: May 17, 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: 1 month(s)
Jurisdiction: Dutchess
Gender: Female
Date of Death: 11/30/2018
Initial Date OCFS Notified: 12/04/2018

Presenting Information

An SCR report alleged that on 11/29/18, the mother awoke around 6AM when her wife woke for work. The child was in her mother's left arm, not breathing. The mother began CPR while her partner called 911. During CPR, the mother noticed blood coming from the child's nose/mouth area. The child was transported to Vassar Brother's then transferred via ambulance to Westchester Medical Center. The child remained on life support until it was medically recommended the child be withdrawn as the child's condition was irreversible; the mother agreed and the child was pronounced dead on 11/30/18 at 10:04PM.

Executive Summary

This fatality report concerns the death of a 1-month-old female child that occurred on 11/30/18. A report was made to the SCR on 11/29/18, with concerns the child had been found unresponsive by her mother while co-sleeping, on the same date. There were no surviving siblings or other children living in the home.

Dutchess County Department of Community & Family Services (DCDCFS) coordinated efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the medical examiner's report was pending at the time the investigation closed. The medical examiner was unable to provide preliminary autopsy results to DCDCFS.

The mother reported feeding the child on 11/29/18 around 3AM, then placing the child to sleep with her, on her back in her left arm. The mother awoke around 6AM and found the child "limp" and said she "didn't look alive" in her arm. The mother screamed and called 911; the wife waited outside for EMS to arrive. The mother tried CPR but when she did, blood came out of the child's nose. The child was transported to the hospital and diagnosed with hypoxic ischemic injury. The child was put on life support and the mother signed a "do not resuscitate (DNR)" order. The child died on 11/30/18 at 10:04PM in her mother's arms.

The mother and her wife admitted to regularly co-sleeping with the child in their full/queen sized bed. The women said a safe sleep packet was given to them upon discharge from the hospital after the child's birth. There was a bassinet and two Pack 'N Plays available for the child to sleep in, however, they chose to co-sleep with the child. The mother and her wife said they would place the child in the bassinet to sleep at times when they were both very tired.

DCDCFS obtained pictures of the home from NY State Police, as well as depositions given by the mother, wife, EMS, and doctors. DCDCFS completed interviews with the mother, wife, father, relatives, and medical professionals. No cause for the injury was determined during the investigation. An attending doctor said the mother's decision to remove life support was appropriate as the child's injury was irreversible.

On multiple occasions, DCDCFS offered services such as burial assistance and bereavement counseling to the mother, her wife, and the father of the child; they repeatedly declined services.

DCDCFS unfounded and closed the initial case on 1/25/19 as they were unable to obtain credible evidence to support the allegation of inadequate guardianship against the mother and her wife.

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?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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:
Casework activity was commensurate with a fatality during an open CPS 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: 11/30/2018 **Time of Death:** 10:04 PM

Date of fatal incident, if different than date of death: 11/29/2018
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

How long before incident was the child last seen by caretaker? 3 Hours

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	No Role	Female	1 Month(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Female	27 Year(s)
Other Household 1	Father	No Role	Male	36 Year(s)

LDSS Response

DCDCFS received an SCR report on 11/29/18 regarding the child being found unresponsive by her mother. The following day, 11/30/18, DCDCFS received notification the child had died. On 12/1/18, DCDCFS notified the Spring Valley Regional Office and emailed the required notification form for the death of a child in an open investigation.

DCDCFS interviewed the mother and her wife on 11/29/18, while the child was on life support. The CW provided the phone number for the county help line and said the county wanted to offer community resources, counseling, and any other assistance they may need. The mother and her wife did not have any requests for assistance at that time. The mother explained to the CW that the child was a good baby who was born premature, but was healthy and growing. The mother said she brought the child to her pediatrician for a regular checkup on 11/20/18. The mother said she told her pediatrician she had been co-sleeping with her child and that he did not advise against it. She said upon discharge, when the child was born, she received a packet about safe sleep and a nurse told her and the wife about the dangers of co-sleeping. The mother said sometimes when they were really tired, they would place the child in the bassinet. She said the child was not placed in the bassinet on that night because she had soiled the bassinet and it was not clean. The mother said the child was a normal baby who woke every 2-4 hours to feed; she was last fed at 3AM on 11/29/18. The mother got in bed, held the child in her left arm, and woke at 6AM to find the child limp in her arm and said the child did not look alive; she screamed and called 911. Her wife waited outside for EMS while the mother attempted CPR, but when she did, blood came out of the child's nose. The child was initially brought to Vassar Brothers Medical Center and later transported to Westchester Medical Center. The mother denied the child's father ever had any involvement in the child's life.

On 11/30/18, the CW spoke with the doctor in the pediatric intensive care unit and the doctor said the mother agreed to a DNR, which was medically appropriate considering the child's irreversible condition. The doctor said the child's diagnosis was hypoxic ischemic injury. The doctor later called the CW and said the child died at 10:04PM while in her mother's arms. The hospital offered the mother and her wife a room to stay in at the hospital that night, but they declined.

The CW interviewed the mother's stepfather and the wife's father; both were active in their lives and said they were good parents to the child and had no concerns.

On 12/2/18, the CW completed a home visit to interview the father of the child. The father confirmed he was not involved in the child's life and was not aware the child had been born. The father was offered services and given the phone number to the county help line. The father said he was already in counseling and planned to speak to his therapist regarding the child's death.

The CW obtained medical records, completed a CPS history check, spoke with law enforcement, medical professionals, sent notification letters to appropriate parties, and met with their legal department. The CW requested contact from the child's pediatrician which was not returned.

Throughout the investigation, DCDCFS met with and contacted the mother and her wife multiple times and offered services such as bereavement counseling and burial assistance. The family denied a need for services.

The autopsy was pending at the time of this writing. DCDCFS found no aggravating factors and therefore unsubstantiated the allegations of the initial report and unfounded the case on 1/25/19.

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 reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Dutchess County Department of Community & Family Services does not have an OCFS approved CFRT.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
DCDCFS did speak to staff at the pediatrician's office however contact from the pediatrician was not returned.

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 parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
Multiple services were offered and the family declined.

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? Yes
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

There was no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was 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