Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-102

Prepared by: New York City Regional Office

Issue Date: Feb 20, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 08/28/2019
Initial Date OCFS Notified: 08/28/2019

Presenting Information

The narrative of the report alleged that on 8/28/19, the 4-month-old SC, an otherwise healthy child, was in the care of the SF and the PGF. The SF placed the SC down on her chest on a regular bed for a nap, not in a crib. The bed was made with just a comforter flat on top of the bed. The two-year-old SS was in a crib in the same room. The SF went to a store for approximately 30 minutes while the PGF was home to watch the children. During this time, the SC was wearing a diaper only, and was left to sleep chest down on the bed for a period of at least 30 minutes. It was unknown if the PGF checked on the SC during this time. Upon the SF's return from the store, the SF discovered the SC was unresponsive. The SF performed CPR and instructed the PGF to notify emergency medical services, who responded to the home on or around 3:53 PM. The SC was pronounced deceased at 5:08 PM.

Executive Summary

On 8/29/19, the SCR registered a report regarding the death of the SC that occurred on 8/29/19, who was at home with her SF, SS and PGF. ACS Queens Field Office received information from LE that confirmed the death and initiated the investigation timely.

ACS learned that the SF provides care to the SC and the SS while the BM goes to work six days of the week. On the day of the incident, the SM was at work. The SF left the SC and SS asleep under the supervision of the PGF. The SC was placed prone on the adult bed and the SS was in her crib. The SF stated he left home at 3:00 PM and was gone for approximately thirty to forty-five minutes. Upon his return, he observed the SC had rolled over and was not in the space he left her on the bed. He found her unresponsive. He took her to the PGF’s room and the PGF summoned emergency medical assistance. The SC was transported to St. John’s Episcopal Hospital (SJEH) where she was pronounced dead at 5:08 PM on the same day.

ACS learned from the attending Dr at SJEH that they found no signs of maltreatment or abuse on the SC. The ME reported the autopsy report is pending. LE reported they removed the comforter from the bed on which the SC slept. They found no criminality and there was no arrest. The SS was deemed safe and left in the BM and MGM’s care. The family had a lot of support. The family was not known to the SCR or ACS prior to the SC’s demise.

ACS learned from the SF that although he was familiar with safe sleep practices, he opted to place the SC on her stomach to sleep at the advice of the children’s Dr. ACS learned from the BM that the Dr advised more tummy time for the SC; however, she was not aware the SF was placing the SC to sleep on her stomach. The parents reported that although the PGF used a walker or a wheelchair, he could monitor the children in their absence.

ACS learned from the Dr that the SC was last examined on 8/9/19, and she had no medical conditions. The SC and SS were up to date with their immunizations and the Dr reported no concerns for the care given by the parents.

The PGF told the Specialist he did not check on the children as they were asleep. The MGM reported the SF is a good father and son. The parents accepted PPRS and the SS was enrolled in daycare, where she receives speech therapy and is making progress.

ACS had not yet determined the allegations at the time this report was written.

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?** 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

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 had not yet determined the allegations when this report was issued.

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: 08/28/2019 **Time of Death:** 05:08 PM

Time of fatal incident, if different than time of death: 04:00 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 04:00 PM
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? 45 Minutes
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	Female	4 Month(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	26 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Male	64 Year(s)

LDSS Response

Following the receipt of the report on 8/28/19, the ACS Queens Field Office initiated an investigation within the required timeframe by contacting LE, ME and SJEH and obtained information regarding the incident. The staff confirmed the SC arrived via ambulance, was triaged at 4:20 PM and pronounced deceased at 5:08 PM. The Dr. reported the SC had no marks or bruises that indicated maltreatment or abuse. According to hospital records, the SC was born full term and she had no medical conditions. LE reported they responded to the case address at 3:57 PM and the SF appeared nervous, confused and in shock. LE found no criminal intent. The ME reported the autopsy report is pending.

On 8/29/19, the ACS Specialist visited the case address and interviewed the parents, PGF and MGM separately. The SF told the Specialist that BM fed the SC and SS at 8:00 AM before she left for work and they were well. The SF said he fed the SC between 1:00 and 2:00 PM and placed her to sleep at the head of the adult bed, prone and with her face turned to the side. He explained that he was aware of safe sleep; however, he placed the SC face down because her head appeared flat and the Dr advised to place her on her stomach. He explained he also placed the SC on the adult bed as opposed to her bassinet to make her accessible to the PGF. The PGF has limited mobility, however, he can hold and soothe the children in the absence of the parent. The SS was asleep in her crib in the same room as the SC. The SF reiterated the children were fine, they had no illness and the SC showed no signs of discomfort. The SF left the home at approximately 3:00 PM to run an errand. The PGF was in his bedroom adjacent to where the children slept. The SF reported upon his return and to his surprise, the SC was at the foot of the bed with her face down in the comforter, it appeared as if she had rolled over. The SF had seen the SC roll over once before. He picked up the SC and observed her lips appeared discolored and that she had been sweating, he then realized she was unresponsive. He ran into the PGF's room with her and the PGF called 911. The SF initiated CPR as instructed by the 911 operator. EMS and LE responded to the case address and continued resuscitation efforts.

The BM reported she left the children in the SF's care and they were doing well. At the last medical checkup, the Dr advised an increase of tummy time for the SC because the back of her head was flat; however, the BM was not aware the SF had been placing the SC to sleep on her stomach. She was aware the SF would leave the children in the care of the PGF, for a short time sometimes to run errands. The parents also denied DV, drug use or having any mental health conditions. The parents explained that the PGF could provide care despite his limitations. The home contained food and was deemed safe.

The MGM and PGF reported they had no concerns for the care the SF provided to the children. He was always attentive, interactive and loving. The PGF stated that during the SF's absence, he heard the SC fuss and then stop, so he assumed she fell back asleep; he did not check on her. He contacted the SF to ask for something from the store; but he did not tell the SF that the SC was fussing and had fallen back to sleep.

On 8/30/19, the pediatrician reported the SC's last visit occurred on 8/9/19, she was given a vaccine. Both children were up-to-date with their immunizations. The pediatrician reported Safe Sleep Training was provided to all parents and they do not advise parents to place children to sleep on their stomachs.

ACS held a CSC on 8/29/19, 9/5/19 and 9/18/19 and on 9/24/19, the parents accepted PPRS; they were on a wait list for some services. The SF tested positive for marijuana and enrolled in services.

On 11/1/19, the daycare staff reported the SS received speech therapy two times per week with positive results.

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)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052869 - Deceased Child, Female, 4 Mons	052870 - Father, Male, 26 Year(s)	DOA / Fatality	Pending
052869 - Deceased Child, Female, 4 Mons	052870 - Father, Male, 26 Year(s)	Inadequate Guardianship	Pending
052869 - Deceased Child, Female, 4 Mons	052870 - Father, Male, 26 Year(s)	Lack of Supervision	Pending
052869 - Deceased Child, Female, 4 Mons	052872 - Grandparent, Male, 64 Year(s)	DOA / Fatality	Pending
052869 - Deceased Child, Female, 4 Mons	052872 - Grandparent, Male, 64 Year(s)	Inadequate Guardianship	Pending

052869 - Deceased Child, Female, 4 Mons	052872 - Grandparent, Male, 64 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐
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 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	☒	☐	☐	☐
Explain: The parents engaged in PPRS that included Bereavement counseling.				

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	☐	☐	☐	☐	☐	☒	☐

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? Yes
Explain:
The SS received Day Care Services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents engaged in PPRS under the auspices of Sheltering Arms.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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 is no CPS history more than three years prior to the fatality.

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