Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-002

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

Issue Date: Jul 12, 2021

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: 2 year(s)
Jurisdiction: Nassau
Gender: Female
Date of Death: 01/12/2021
Initial Date OCFS Notified: 01/12/2021

Presenting Information

An SCR report was received which alleged that on 1/12/21, the mother, father and two-year-old subject child were outside the home, when at an unknown time, the mother brought the child into the home to use a child's toilet. The mother then joined the father back outside leaving the child unsupervised in the home between five and twenty minutes. While unsupervised, a box with a crib packaged inside and leaned up against a wall fell onto the child. When the mother entered the home again, she found the child unresponsive. The mother brought the child outside and emergency services were contacted. While in the ambulance, the child was in full cardiopulmonary arrest. The child was unable to be resuscitated, and was pronounced deceased.

Executive Summary

This fatality report concerns the death of a two-year-old female subject child that occurred on 1/12/21. A report was made to the SCR on that same date with allegations of Lack of Supervision and DOA/Fatality against the child's mother and father. Nassau County Department of Social Services (NCDSS) received the report and investigated the child's death. An autopsy was completed; however, the final report had not yet been released at the time of this writing.

At the time of the child's death, she resided with her mother and father. There were no surviving siblings or other children in the household. The investigation revealed that at approximately 4:00PM on 1/12/21, the family returned home from visiting a relative and were outside while the father placed stickers he had purchased inside the car. The child was potty training and informed the parents she had to use the bathroom, so the mother brought her inside the home. The child used her potty, and the mother then gave the child a piece of fruit and brought her into the family room in front of a large bay window. The mother then went back outside to where the father was and could see the child through the window. The mother was outside for approximately nine minutes before noticing the child was no longer in sight, so she went inside to check on her. The mother found the child pinned up against the wall in the hallway by a box that contained a 112lb unassembled crib. The mother was pregnant, and the parents were setting up a nursery. The crib had just been delivered that day and was stored leaning up against the wall in the hallway. The box had fallen onto the child's chest, and the child was unresponsive. The mother removed the box and carried the child outside to the father, yelling for help. Neighbors called emergency services and an ambulance transported the child to the local hospital. The child could not be revived and was pronounced dead at 5:19PM.

From the time the investigation began to the time of its closure, NCDSS interviewed family members and collateral sources, which included hospital staff, the medical examiner and law enforcement. Law enforcement found no criminality regarding the death of the child and referred to it as "oversight" and accidental. Due to the child's age and developmental stage, the parents placed the child at imminent risk of harm by leaving her unattended and free to roam inside the home for nine minutes. Further, the record did not reflect the amount of time that passed before the mother noticed the child was no longer visible in the window. For these reasons, there was some credible evidence gathered to substantiate the allegation of Lack of Supervision; however, NCDSS unfounded and closed the case.

PIP Requirement

This review resulted in citations related to casework practice. In response, NCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the NCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, NCDSS will review the plan(s) and revise as needed.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
There was some evidence gathered to support substantiating the allegation of Lack of Supervision; however, NCDSS unfounded the report. There were no surviving siblings or other children in the household, therefore, a final safety assessment was not required.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	SC was left unattended for approximately 9 minutes, and it was unclear how much time had passed before the parents last saw her. Due to SC's age, she required a high level of supervision. NCDSS had evidence to indicate for LS but did not.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	NCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/12/2021 **Time of Death:** 05:19 PM

Time of fatal incident, if different than time of death: 04:40 PM

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? Yes
Time of Call: 04:43 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? No - but needed
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☒ Distracted
- ☒ Absent
- ☐ Asleep
- ☐ 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 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)

LDSS Response

On 1/12/21, NCDSS received the SCR report regarding the death of SC, which occurred on that same date. NCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. NCDSS learned there were no surviving siblings or other children in the household.

On 1/12/21, NCDSS met with SM and SF at the hospital where SC had been transported and pronounced deceased. NCDSS was informed SM did not speak much English; however, SF was fluent. NCDSS spoke with SF regarding the report allegations. SF explained he, SM and SC had just returned home from a relative's house and were all outside while SF put some items in his car. SF stated SC expressed she had to go to the bathroom, so SM brought SC inside to use the child-sized "potty." SF stated there was a box in the hallway that contained a crib, as SM was pregnant and they were preparing the nursery; the crib had not yet been assembled and remained in the box, leaned up against a wall. SF reported SM left SC on the "potty" and went back outside. SF said SM was outside for about 3 minutes before returning inside to

check on SC. SF said SM found SC in the hallway with the crib box laying on her chest. SF said SM ran outside carrying SC, and the neighbors called 911. NCDSS noted both parents as being distraught so the interviews were concluded.

On 1/13/21, NCDSS spoke with the hospital physician who saw SC when she was brought to the emergency room. The doctor reported SC had no signs of trauma to her body and was informed by the parents that SM found SC wedged into the wall with a 112lb crib box on top of her. The doctor reported he believed SC could not move her airway due to the weight of the box and possibly suffocated because of this.

On this same date, NCDSS completed a visit to the family's residence and observed the home. NCDSS saw the bathroom was at the end of a "tight" hallway, and in that hallway, there was a crib box standing on the left side of the wall. NCDSS clarified events that occurred the previous day with SF. SF explained SC was potty training, and her potty was located just outside of the bathroom. SF said SC went potty and SM then gave SC a snack and brought SC into the living room by a large bay window where they could see her. SF said SC liked to sit by the window and look outside. SF reported SM went back outside to give him a pair of scissors he had asked for and was outside for no more than 3 to 4 minutes. SF said SM then went back inside and found SC. SF explained SC was a healthy child with no medical issues. NCDSS observed the rest of the home and no concerns were noted.

On 1/13/21, NCDSS met with SM; the CW was fluent in SM's language. SM's recollection of events corroborated that of SF's. SM explained she had left SC inside in front of the bay window for 4 to 5 minutes and could see her in the window when outside. SM said at one point, SC was no longer in the window, so SM went inside to check on her, and found her pinned against the wall by the box. SM said SC was still in a standing position with her hands up against the box as if she was trying to push it off. SM denied she nor SF ever left SC unsupervised in the past.

NCDSS spoke with LE who explained they felt SC must have pulled at the box, causing it to fall on her. On 2/5/21, NCDSS was informed by LE that video from the school across the street from the home showed SM was outside for 9 minutes, and then SM peeking into the front window. The video then showed SM running inside the house and then back outside with SC in her arms.

From the time the investigation began to the time of its closure, NCDSS spoke with family members and collateral sources. There were no criminal charges brought against the parents, and NCDSS provided the family with referrals for grief and bereavement services. NCDSS noted the parents did not act in an abusive or neglectful manner that would have caused SC's death, and therefore, unfounded and closed the case.

Official Manner and Cause of Death

Official Manner: Pending
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
Comments: This fatality investigation was conducted by the Nassau County multidisciplinary team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Nassau County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057458 - Deceased Child, Female, 2 Yrs	057459 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
057458 - Deceased Child, Female, 2 Yrs	057459 - Mother, Female, 25 Year(s)	Lack of Supervision	Unsubstantiated
057458 - Deceased Child, Female, 2 Yrs	057460 - Father, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
057458 - Deceased Child, Female, 2 Yrs	057460 - Father, Male, 28 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

Additional information:

NCDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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:
NCDSS provided the parents with bereavement counseling referrals and information on assistance with funeral costs.

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:
NCDSS provided the parents with referrals for grief and bereavement counseling.

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? N/A
Was the child acutely ill during the two weeks before death? No

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 investigative 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

Additional Local District Comments

NCDSS understands the circumstances that a fatality of this nature requires careful consideration and adherence to consultation of the CPS program manual for its definitions. We will always consult the manual when making decisions surrounding fatalities and any allegations attached to them. When questioning a possible determination, NCDSS will reach out to OCFS for clarification and/or further guidance. In this case, we did reach out to you to see if there were any further actions/steps/suggestions, however, there was nothing specific to questions about the determination. NCDSS recognizes we could have reached out for that specific input before making an incorrect determination. NCDSS agrees that the determination of unfounded for Lack of Supervision was not appropriate. The parents did place the child at imminent risk by leaving her unattended for an unspecified period of time. A portion of the time child was unattended was captured on video accounting for at least 9 minutes. Clearly, the two year old child required and should have had a higher level of supervision. Although NCDSS noted “parents did not act in an abusive or neglectful manner that would cause the child’s death,” in hindsight, they were neglectful and should have been indicated for Lack of Supervision.

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