Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-111

Prepared by: New York City Regional Office

Issue Date: Apr 13, 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: 3 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 10/14/2017
Initial Date OCFS Notified: 10/14/2017

Presenting Information

On 10/14/17, the SCR registered a report alleging DOA/FATL and IG of the three-month-old female subject child (SC). The SC's biological parents and the PGA were the subjects of the report.

The report alleged the SC had been ill the week of the report and at approximately 5:30 P.M. on 10/14/17, the BF placed the SC in her crib for a nap. At 7:45 P.M., the BF checked the SC and found her not breathing and non-responsive. The report, alleged there was no reasonable explanation for the SC's cause of death. The SC was in the care of her parents and the PGA at the time of the incident.

Executive Summary

The 3-month-old SC died on 10/14/17 while in the care of her BF. ACS documentation revealed the BF was visiting the PGA's home with his three children while the BM was at work. At approximately 7:45 P.M., the BF found the SC in her crib, on her back, face up and unresponsive. The BF performed CPR on the SC while the PGA called 911 and noticed a police car stationed near the home. She told the police officers about the SC and they went to her home and immediately performed CPR on the SC until EMS arrived. EMS arrived at the home and continued CPR while they transported the SC to the hospital. ACS documented the SC was unresponsive when the ambulance arrived at the hospital. The medical staff attempted, unsuccessfully, to revive the SC who was pronounced dead at 8:20 P.M. The final autopsy report stated the SC's cause of death was undetermined (infant in bassinette with excessive soft bedding). The manner of death was undetermined.

The SC did not have any pre-existing medical condition; however, she was seen by her primary Dr. for a minor illness two weeks prior to her death. The Dr. did not prescribe any medication for the SC.

Following the fatality, the BM moved the two SSs to the MGA's home in Suffolk County. The Suffolk County LDSS (SCLDSS) CPS Specialist visited the family once and assessed the SSs to be safe. The BM refused all further attempts to contact her, and any involvement with CPS. She also declined ACS' offer to receive bereavement counseling and stated she was getting assistance from her church. In January 2018, the BM reunited with the BF and returned to New York City. Since the death of the SC, the BF has not agreed to be interviewed by ACS and was also opposed to the SSs interviewed by ACS or LE.

During the investigation, ACS explored possible Family Court intervention for the family on two separate occasions but no action was taken because of insufficient evidence. The two SSs remained in the care of their parents and there was no evidence the children were maltreated or neglected.

ACS has not yet determined this CPS investigation.

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?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS assessed the PGA's home and observed the basement where the BF and children were sleeping while visiting was cold, damp, and had water stains on part of the ceiling. This was a health hazard for an infant who was seen by her Dr. two weeks prior for medical issues. ACS did not address this with the PGA.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS assessed the PGA's home and observed that the basement was damp and had signs of mold. This was a health hazard for an infant who was seen by her Dr. two weeks prior for respiratory issues. ACS did not address this health hazard with the PGA.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation identified in the fatality report. ACS must meet with staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The BF last saw the SC alive at 5:00 P.M. and then went to get a haircut. He did not state for how long he was away. It was unclear if the SS were supervised at the time. ACS should have added and investigated the allegation LS of the 3 children.
Legal Reference:	18 NYCRR 428.1 (b)(1)

Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation identified in the fatality report. ACS must meet with staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	ACS did not complete a 30-Day Safety Assessment.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation identified in the fatality report. ACS must meet with staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/14/2017 **Time of Death:** 08:20 PM

Time of fatal incident, if different than time of death: 07:45 PM

County where fatality incident occurred: Queens
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 2
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	3 Month(s)

Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

On 10/15/17, ACS contacted the LE staff who stated that per the ER Dr., the SC arrived to the hospital stiff and not breathing, but did not have any indications of physical trauma. LE told ACS there was no criminality pending the autopsy. The ME reported the SC had "some sort of breathing issues."

Later that same date, ACS visited the homes of the PGM and the PGA. ACS accessed the PGA's home and observed appropriate sleeping arrangement in the home but the basement where the incident occurred was cold, damp, and had water stains on part of the ceiling. The case records did not reflect ACS addressed this health hazard with the PGA. According to ACS documentation, the PGA was a foster parent with the Jewish Child Care Association. ACS observed the PGA's two foster children (FC) and deemed them safe at the time of the visit.

The PGM confirmed her home was the family's legal address. She did not report any concerns regarding the parents' ability to provide adequate care for the SC.

ACS attempted to interview the BF on numerous occasions, 10/16/17, 10/17/17, 10/18/17, and 10/19/17 but he consistently refused to speak with ACS regarding the SC's death. The BF did say the ME did not find any criminality with the SC's death and he "was not ready to continue to speak with many more people" about the incident.

On 10/16/17, the ME reported that based on preliminary findings, there was nothing suspicious about the SC's death. The cause of death was pending the results of further tests.

On the same date, SCLDSS visited the MGA's home and documented there were no concerns for the two SS. The BM declined all referrals for bereavement counseling for the family and stated she was speaking with her church leadership about the SC's death, and "this helped." The BM refused to sign HIPPA forms to release medical information for the surviving siblings.

On 10/17/17, the PGA's CP reported being in the home at about 11:00 A.M. on the day of the incident but denied any contact with the SC or the BF. The CP briefly saw the two SS upstairs in the older FC's room and then left the home with the younger FC. The older FC remained home in her room alone at the time.

On 10/19/17, the responding PO stated that the SC was found lying face up in the crib. There was a blanket in the crib. The BF reportedly last saw the SC alive at 5:00 P.M. and then went to get a haircut afterwards. He did not state for how long he was away. At about 7:00 P.M., the BF called the BM and told her the SC was not breathing. It was unclear if the two SS were adequately supervised while the BF was away from the home.

On 11/2/17, SCDSS visited the MGA's home a second time and documented there were no safety concerns for the two SSs. The BM again declined offers for bereavement counseling services and stated she was getting help talking to her pastor. In addition, the BM again declined to sign HIPAA forms for the surviving siblings.

On 11/13/17, ACS visited the PGA's home. The PGA and her two FC denied having child care responsibilities of the family's children. They also denied having any contact with the SC on the day of her death as she remained in the basement with the BF. The PGA stated she was seeking counseling services for the FC and an intake appointment was

pending.

Between 11/29/17 and 3/6/18, ACS made several casework contacts with the family. The family continued to be uncooperative with ACS and reported that the SC died of natural causes. The two SSs remained in the care of their parents. The older SS was attending school and the school staff had not reported any concerns for her.

On 3/30/18, ACS received the final autopsy from the ME. The SC's cause of death was undetermined (infant in bassinette with excessive soft bedding). The manner of death was undetermined.

At the time of writing this report, ACS had not yet determined the CPS investigation.

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 investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
044824 - Deceased Child, Female, 3 Month(s)	044821 - Father, Male, 28 Year(s)	Inadequate Guardianship	Pending
044824 - Deceased Child, Female, 3 Month(s)	044821 - Father, Male, 28 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The BF refused to meet with, or even speak with ACS, to discuss the death of the SC. ACS interviewed the agency case planners for the foster children who reside with the PGA, who is a certified foster parent.

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?	☐	☐	☒	☐
Explain: ACS did not complete a 30-Day Safety Assessment				

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?	☐	☒	☐	☐
Explain as necessary: The surviving siblings were first seen and assessed on 10/16/17 at the home of the MGM.				

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:
The parents declined all of ACS' offers for services.

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? No
Explain:
The BM declined services for the children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Both parents declined services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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? 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)

09/28/2017	Sibling, Female, 3 Years	Father, Male, 28 Years	Lack of Supervision	Indicated	Yes

Report Summary:
On 9/28/17, the family had a FAR report with the concern of LS. Per the case records, on 9/27/17 and 9/28/17, the BF left the SC alone in a parked car and went inside to pick up the 6-year-old SS from her school. The FAR case was transferred to a CPS unit for a CPS investigation at the family's request. The CPS/FAR worker made reasonable efforts to educate the family about the benefits of FAR; however, the parents insisted on having a CPS investigation so the father would be cleared of the neglect allegation.

Determination: Indicated **Date of Determination:** 11/28/2017

Basis for Determination:
The school staff reported that on two occasions, the BF left the SC alone in the car in her car seat while he went across the street to pick up the six-year-old SS from her school. The approximate time the child was left alone on the two occasions was five minutes.

OCFS Review Results:
ACS did not conduct a thorough investigation of the report. ACS did not determine if the now deceased SC was left alone in the car by the BF or if it was the three-year-old child. Also, the investigation conclusion narrative discussed the newborn (deceased child), but the report was indicated for the three-year-old surviving sister. In addition, ACS failed to provide the "Notice of Indication" of the report to the subject father as required.

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

Issue:
Failure to Provide Notice of Indication
Summary:
ACS failed to provide "Notice of Indication" to the subject father.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation identified in the fatality report. ACS must meet with staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.

Issue:
Appropriateness of allegation determination
Summary:
ACS failed to determine if the now deceased child SC was left alone in the car by the BF or the three-year-old child. The investigation conclusion narrative discussed the SC but the report was indicated for the three-year-old sister.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation identified in the fatality report. ACS must meet with staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.

Issue:
Case record contains information that is relevant, useful, factual and objective
Summary:
The staff at the 6-year-old SS' school reported that the SS usually came to school tired. The SS disclosed that she would get up in middle of the night to feed the SC or assist BM care for the SC. Based on the information obtained, ACS failed to add or investigate the allegation of IG of the six-year-old SS by the parents.
Legal Reference:

18 NYCRR 428.1 (b)(1)

Action:

ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation identified in the fatality report. ACS must meet with staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.

[redacted]

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

The family did not have any CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family did not have any known CPS history outside of New York State.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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