Child Fatality Report

Report Identification Number: SV-19-040

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

Issue Date: Dec 09, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Rockland
Gender: Female
Date of Death: 07/26/2019
Initial Date OCFS Notified: 07/29/2019

Presenting Information

On 7/26/19, Rockland County Department of Social Services (RCDSS) received a report from the SCR regarding the deaths of one-year-old twins that occurred on the same date. The report alleged the father was driving when he pulled over abruptly. He got out of the vehicle and began pacing up and down, screaming on the phone that his children were dead. The two children were strapped in their car seats, in the back of the vehicle. Both children were deceased after sustaining first degree burns from exposure to heat. Their skin was molting and peeling off, and the children had been foaming from their noses. The interior of the car was very hot, and the windows were closed. Rigor mortis had set in on the children approximately 3 to 5 hours earlier.

Executive Summary

On 7/26/19, the Rockland County Department of Social Services received a report regarding the death of the 1-year-old twins who were exposed to extreme heat after being left in their father's car when he went to work. At the time of the death, the twins resided with their mother, father, and 3 siblings, ages 4, 12, and 17.

Through a joint investigation with law enforcement, it was learned on 7/26/19 at 4:00 PM, the father was driving home from work when he stopped abruptly upon noticing his 1-year-old twins strapped in their car seats in the backseat, where they had been placed prior to the father going to work. The temperature in the car was measured by the medical examiner to be 117 degrees Fahrenheit. Rigor Mortis had set in on the children approximately 3 to 5 hours earlier. The autopsy report was completed on 11/25/19, however because this was a homicide investigation, the DA's office needed to approve and release the report. The DA's office had not approved or released the autopsy report at the time of this writing.

The home was assessed to contain no safety hazards. A safety plan was put in place for the father to be supervised around the siblings. The 12 and 17-year-old siblings returned to their mother's home in Albany County. The 4-year-old sibling remained in the care of the mother and father, with supervised contact with the father. The siblings were assessed to be safe throughout the investigation.

The father was arrested by NYPD and charged with two counts of involuntary manslaughter and criminally negligent homicide; he entered a plea of not guilty. The father was bailed out of jail and the criminal case was ongoing.

RCDSS substantiated the allegations of inadequate guardianship, lack of supervision, and DOA/fatality against the father regarding the twins. The father drove to work and failed to drop the twins off at daycare, which he was regularly responsible for doing. The father worked from 8AM until 4PM while the twins were left in the vehicle, unattended for the entire day and died from exposure to the heat. RCDSS offered bereavement and trauma services to the family and closed the case when the family declined Preventive Services.

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

Explain:
RCDSS appropriately indicated and closed the case.

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:
Casework activity was commensurate with best casework practice.

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: 07/26/2019 **Time of Death:** 04:10 PM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 04:10 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 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: 2

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Deceased Child on Report	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Mother	No Role	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)

LDSS Response

On 7/26/19, RCDSS received an SCR report alleging DOA/Fatality, inadequate guardianship, lack of supervision, and burns/scalding against the father for his 1-year-old twins. RCDSS coordinated with LE and notified the DA's office about the death. Throughout the investigation, collateral contacts were made with the source of the report, personal collaterals for the family, medical personnel, and various service providers. There was a 4-year-old surviving sibling as well as a 12-year-old and 17-year-old half-sibling. All three siblings were assessed on an ongoing basis throughout the investigation. The 12 and 17-year-old siblings returned to their mother's home in Albany County and were assessed and interviewed by Albany County Department for Children, Youth and Families (ACDCYF). Neither they nor their mother had any concerns for the father's care of the children. The mother of the half-sibling reported the father was a very good father and had always acted appropriately in his care of all the children.

Through interviews with law enforcement, first responders, and the medical examiner, it was learned the father left for work on the morning of 7/26/19 with the twins and their 4-year-old sibling. The father dropped the 4-year-old off at his daycare in Nyack and then proceeded to work, forgetting to bring the twins to their daycare in Yonkers. The father worked his regular 8AM to 4PM shift. At no point during the day did the father go out to his car. His car was parked in the parking lot attached to the hospital where he worked. Upon leaving work at 4PM the father found the twins deceased in the car. Through interviews with the ME and first responders, it was learned Rigor Mortis had set in 3-5 hours earlier.

The mother was interviewed and reported the father regularly dropped the children off at daycare and they alternated who

picked them up. On the day of the fatality, the father called the mother requesting she pick the children up from daycare as he had to run an errand after work. The mother called back, and the father hysterically screamed that he killed the children over and over into the phone. The mother reported she had no concerns for the father's care of the children and reported nothing being "off" on the day of the fatality.

The father corroborated the information received from LE and first responders. The father reported he left for work at 7AM to take the children to daycare. The father reported he routinely brought the children to daycare. He dropped the 4-year-old sibling off at daycare. He reported he got to work around 8:15AM and did not realize the twins were still in the car. He said he met the mother for their marriage counseling session at noon. He walked to the location and the mother drove him back to work following the session. He left work at 4PM and started driving when he observed the car seats and the deceased twins. He immediately called 911 and flagged down a passerby.

In speaking with the surviving sibling's daycare, RCDSS learned that on the date of the fatality, the father dropped the sibling off at daycare and it was assumed he left the twins in the car as they did not enter the daycare with him. The daycare reported never having concerns for the father's care of any of the children. In speaking with the twins' daycare provider, it was learned they had a long relationship with the father. They never had concerns for his care of the children and never observed erratic or strange behavior. The worker said it was not uncommon for the children not to be dropped off, as occurred on 7/26/19 because occasionally the parents would take a long weekend and the twins would not attend on either a Monday or a Friday.

In response to the fatality, RCDSS accurately determined the allegations after conducting a thorough investigation. The family declined Preventive Services and the case was indicated and closed once all case objectives were met.

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: There is no OCFS approved Child Fatality Review Team in Rockland County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052181 - Deceased Child, Female, 1 Year(s)	052182 - Father, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
052181 - Deceased Child, Female, 1 Year(s)	052182 - Father, Male, 39 Year(s)	Lack of Supervision	Substantiated
052181 - Deceased Child, Female, 1 Year(s)	052182 - Father, Male, 39 Year(s)	Burns / Scalding	Unsubstantiated
052181 - Deceased Child, Female, 1 Year(s)	052182 - Father, Male, 39 Year(s)	DOA / Fatality	Substantiated

052185 - Deceased Child on Report, Male, 1 Year(s)	052182 - Father, Male, 39 Year(s)	Lack of Supervision	Substantiated
052185 - Deceased Child on Report, Male, 1 Year(s)	052182 - Father, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
052185 - Deceased Child on Report, Male, 1 Year(s)	052182 - Father, Male, 39 Year(s)	DOA / Fatality	Substantiated
052185 - Deceased Child on Report, Male, 1 Year(s)	052182 - Father, Male, 39 Year(s)	Burns / Scalding	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?	☒	☐	☐	☐

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 family was offered a multitude of services as well as Preventive Services. The family engaged in counseling and bereavement services, but declined a need for PS at the time the investigation was closed.

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:
There was no removal necessary regarding the surviving siblings.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Manslaughter **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
07/27/2019	Father	Pending	Pending

Comments:	The father was arrested on 07/27/19 and charged with Manslaughter 2 and Criminal Negligent Homicide. The father entered a not guilty plea and is currently out on bail while awaiting trial.

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 family was provided with a multitude of service referrals as well as a Preventive Services referral. The parents engaged in bereavement counseling, individual mental health counseling, and marriage counseling following the death. The family declined a need for Preventive 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? Yes
Explain:
A multitude of referrals were provided to the family. In October 2019, the parents reached out to RCDSS requesting a referral for counseling for the 4-year-old sibling. RCDSS provided the parents with a list of providers at that time.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

The parents were receiving bereavement services and mental health counseling, but declined a need for Preventive Services.

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

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 history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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