Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-115

Prepared by: New York City Regional Office

Issue Date: Mar 28, 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 **Jurisdiction:** Queens **Date of Death:** 10/25/2017
Age: 4 month(s) **Gender:** Female **Initial Date OCFS Notified:** 10/25/2017

Presenting Information

On 10/25/17, the SM, 4-month-old SC, and SS were staying with the parent substitute. At 4:00 A.M., the SM laid both children on a bed in a separate room from where she and her partner were sleeping. The SM checked the SC and SS and found the SC had rolled from the bed. The SC was found faced down in a car seat that was on the floor. EMS responded and the SC was not able to be revived. The SC was pronounced dead on arrival at the hospital. The roles of the grandmother and the SS were unknown.

Executive Summary

This 4-month-old female SC died on 10/25/17. NYCRO had not yet received an autopsy report; however, ACS received a call from the ME; the SC died of positional asphyxia due to obstruction of the nose and mouth. The manner of death was accident.

The allegations of the 10/25/17 SCR report were DOA/Fatality and IG of the SC by the SM, MGM and her partner.

The Specialist interviewed the SM regarding the circumstances leading to the SC death on 10/25/17. Per the SM's account, at about 4:00 A.M. the SM checked on the SC and observed the SC wiggling. The SM stated that she fed the SC and placed her to sleep vertically on the full-size bed. The SM reported that the SC was placed vertically on the bed with a pillow diagonally to prevent the SC from falling. The SM stated that she woke up at 10:00 A.M. and found the SC face down, unconscious in a car seat (Graco Snug Ride Click Connect 35 Infant Car Seat), on the floor near the bed. The SM stated she called 911, and was advised to perform CPR until EMS arrived. The SM reported that resuscitation was unsuccessful and the SC was transferred to the local hospital by EMS. The SM and SS were escorted to the hospital in the second ambulance. Upon arrival at the hospital, the SC was considered dead upon arrival.

The attending physician reported that EMS arrived at the home and observed the SC was not breathing. EMS reported that the SC's body appeared cold and rigor mortis had set in the SC's arms and legs. The attending physician reported that the SC died at 10:25 A.M. The physician stated that there were no marks or bruises observed on the SC's body and no record of the SC being seen in the ER. The SC was reported to have no pre-existing medical conditions. The physician stated that the SM appeared distraught.

The ME stated that the SC had an abrasion on her scalp; however, there was no skull fracture. The ME observed small scars on the SC's upper back and an abrasion on the right side of the SC's buttocks. The ME also observed Mongolian spots on the SC's buttocks with benign discoloration.

The family resided in a three-bedroom apartment with the MGM. The SM shared a bedroom with the SC and SS. The room included a twin-size bed that the SM shared with the SS and a bassinet for the SC. ACS observed the sleeping arrangements were appropriate. The home was observed to have in place a working smoke alarm and carbon monoxide detector. The home appeared safe. ACS contacted the SS's Dr. and learned that the SS had no medical conditions and was a well child.

During the investigation, the Specialist made relevant contacts and sufficient face-to-face contact with the SM, SS and MGM in the home. The Specialist obtained relevant information from significant collateral contacts. Attempts were made to visit the SM's partners home; however, all attempts were unsuccessful. The family was cooperative and receptive of

offered services. On 11/8/17, ACS opened a Family Services Stage, offered the SM and BF parenting services and made a referral for bereavement counseling. ACS also referred the SS to play therapy. ACS did not document attempts to offer the family burial assistance or discuss safe sleep with the SM.

On 3/27/18, ACS substantiated the allegation of IG of the SC by the SM. The allegation of DOA Fatality of the SC by the SM, MU, MGM and SM's partner was unsubstantiated. The allegation of IG of the SC by the MGM, MU and SM's partner was unsubstantiated.

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:
The allegation of DOA/Fatality of the SC by the SM, MGM, MU and SM's partner was unsubstantiated. The allegation of IG of the SC by the MGM, MU and SM's partner was unsubstantiated. The allegation of IG of the SC by the SM was substantiated.

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:
The 10/25/17 fatality report was indicated on 3/27/18.

Required Actions Related to the Fatality

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

Issue:	Failure to offer services

Summary:	ACS did not document offering the SM burial assistance.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Failure to provide safe sleep education/information
Summary:	ACS did not discuss safe sleep with the SM.
Legal Reference:	13-OCFS-ADM-02
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS did not contact the SC's medical doctor, or document the interview assessment of the SC. ACS interviewed the MGM on two occasions.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	ACS did not complete the 30 day fatality report in a timely manner. The report was completed on 1/12/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/25/2017 **Time of Death:** 10:25 AM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: Queens

Was 911 or local emergency number called? Yes

Time of Call: 10:00 AM
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:

- [x] 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:

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	Aunt/Uncle	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	004 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Other Household 1	Mother's Partner	Alleged Perpetrator	Male	19 Year(s)

LDSS Response

Throughout the 10/25/17 investigation, the Specialist made diligent efforts to interview the SM’s partner; however, the Specialist was unsuccessful. ACS made collateral contact with the SC’s PA. The PA had concerns regarding the SM’s care of the subject children. The PA reported that the SM left the SC in a car seat to sleep during a previous visit to the BF’s home.

On 10/25/17, the ACS Instant Response Team Coordinator, (IRTC) spoke to the attending physician and learned, that the SC arrived at the local hospital at 10:15 A.M. by EMS. The attending physician reported that there were no attempts to resuscitate the SC because she was dead upon arrival. LE assessed the home in which the SC died and observed garbage on the floor, insects on the dresser, and marijuana on the T.V. stand. however, according to LE, the SM and her partner denied drug or alcohol use.

ACS convened the Heightened Oversight Process (HOP) conference, with the Investigative Consultant (IC) to discuss the allegations of the case on 10/26/17. The IC recommended that the Specialist conduct a follow-up visit to the address where the incident occurred and photograph the bedroom, height of bed, car seat, interview the SM’s partner and follow-up with the ME. ACS also convened an Initial Child Safety Conference (ICSC) with the subject family. During the conference, ACS learned that the BF of the SC, last saw the SC on 10/21/17. The SM stated that she woke up at approximately 10:00 A.M. and found the SC face down in her car seat. The SM reported she last saw the SC at 4:00 A.M. during feeding. The SM reported she was sleep in an adjacent room at the time of the SC's death. The SM immediately contacted 911 after discovering the SC unresponsive. ACS determined that an Article Ten Neglect petition would be filed in Queens County

Family Court as a result of this fatality report.

ACS attempted to file the case in court on 10/26/17 and 11/2/17; however, the Specialist had difficulty in assessing the home where the SC died. The ACS Supervisor had a telephone conference with the CAC and it was determined "there was not enough information to decide on the case." ACS spoke to LE and learned that there were no arrests related to the fatality of the SC. ACS referred the SM to bereavement counseling and random drug testing. The SM tested negative for both drugs and alcohol.

On 10/27/17, ACS interviewed the MGM and obtained her account of the SC's death. The MGM stated that the SM did not have a clinical illness. Subsequently, ACS spoke to the ME and obtained the preliminary findings of the SC's death. The preliminary results indicated anterior lividity on the nose and mouth of the SC. ACS learned that the SC was cremated.

Official Manner and Cause of Death

Official Manner: Accident
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)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no 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
044906 - Deceased Child, Female, 004 Month(s)	044743 - Grandparent, Female, 44 Year(s)	Inadequate Guardianship	Unsubstantiated
044906 - Deceased Child, Female, 004 Month(s)	044742 - Aunt/Uncle, Male, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
044906 - Deceased Child, Female, 004 Month(s)	044742 - Aunt/Uncle, Male, 39 Year(s)	DOA / Fatality	Unsubstantiated
044906 - Deceased Child, Female, 004 Month(s)	044732 - Mother's Partner, Male, 19 Year(s)	Inadequate Guardianship	Unsubstantiated
044906 - Deceased Child, Female, 004 Month(s)	044743 - Grandparent, Female, 44 Year(s)	DOA / Fatality	Unsubstantiated
044906 - Deceased Child, Female, 004 Month(s)	044731 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Substantiated
044906 - Deceased Child, Female, 004 Month(s)	044732 - Mother's Partner, Male, 19 Year(s)	DOA / Fatality	Unsubstantiated
044906 - Deceased Child, Female, 004 Month(s)	044731 - Mother, Female, 18 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

ACS entered timely progress notes. ACS attempted to interview the SM's partner; however, despite multiple visits to his home, contact with the SM's partner probation officer and father, and repeated telephone calls he remained unavailable.

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?				

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: There was no removal of the SS.				

Legal Activity Related to the Fatality

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

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: 01/18/2018	**To:** Unknown
Explain: The SM reported obtained an Order of Protection against her partner after the death of the SC.	

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 SM received bereavement counseling, parenting, and a referral for mental health services as a result of the Fatality investigation.

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:
ACS provided the SS with a referral for play therapy.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided the SM with a referral for parenting, bereavement and mental health counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ Drug exposed
- ☐ With fetal alcohol effects or syndrome
- ☒ With neither of the issues listed noted in case record

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 of 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

Additional Local District Comments

There are no additional Local district comments.

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