Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-060

Prepared by: New York City Regional Office

Issue Date: Nov 25, 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		

Case Information

Report Type: Child Deceased
Age: 11 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 05/28/2019
Initial Date OCFS Notified: 05/28/2019

Presenting Information

On 5/28/19, the SCR registered initial and duplicate reports that alleged DOA/Fatality, and IG of the eleven-month-old female subject child (SC). The SC's BM and BF were listed as the subjects of the report.

The initial and duplicate reports alleged at 8:00 PM on 5/27/19, the parents fed the 11-month-old SC. The SC immediately went to sleep after receiving her formula. The parents placed the SC next to the 2-year-old SS on the bed every night. At 1:00AM on 5/28/19, the parents checked the SC and found the SC lying face up in bed with the 2-year-old SS lying on top of her. The SC was unresponsive. The parents called EMS. EMS responded to the home and attempted to revive the SC. EMS then transported the SC to the hospital where further attempts to revive her were unsuccessful. The hospital staff pronounced the SC deceased at 1:46AM.

Executive Summary

On 5/28/19, the eleven-month-old female SC died while in the care of her biological parents (BPs). The ME determined the SC's cause of death was positional asphyxia with overlay. The manner of death was accident (bed sharing with another child). ACS' investigation revealed at about 9:30PM on 5/27/19, the BM was bedsharing with both the SC and the SS. At about 12:00AM on 5/28/19, the BM left the home to visit a family friend who also resided in the same building with the family. The BF and the maternal grandparents (MGPs) were in the home at the time. The case records did not reflect the BF and the MGPs checked the children while the BM was out of the home. About twenty minutes later, the BM returned to the home, checked the SC and found her laying face up in bed sandwiched between pillows, and the SS asleep laying his head on the SC's head. The BM moved the SS from the SC and observed the SC to be blue and was unresponsive. The BPs immediately called 911. The MGF gave the SC CPR as instructed over the phone by the 911 operator prior to EMS' arrival. EMS responded to the home, took over CPR on the SC and then transported her to the hospital where further attempts to revive her were unsuccessful. At 1:46AM, the hospital staff pronounced the SC deceased.

At the time of the fatality, the family resided with the MGPs. The MGM had two other minor children, ages eleven and eight respectively. The eleven-year-old female child was visiting with the MGGM out of state when the incident occurred.

On 5/28/19, ACS received the report and initiated the CPS fatality investigation within the required timeframe. During the investigation, ACS obtained information from collaterals such as the pediatrician, the ER Dr., LE, the DC and service providers. They did not report any concerns of abuse or neglect for the children. They all confirmed the parents were compliant with services for the children. Also, LE did not identify any criminality regarding the SC's death, and no arrest was made. Additionally, ACS assessed the SS and the eight-year-old MU and deemed them safe. LE from the county where the MGGM resided reported the minor MA was assessed and deemed safe in the MGGM's home.

ACS completed PPRS referral for the family. The family declined services; however, they agreed to obtain services on their own. They reported the SS was attending DC and already in receipt of EI services. The SS would be enrolled in play therapy through the DC. The BPs purchased a toddler bed and it was being utilized for the SS.

On 8/14/19, ACS substantiated the allegation IG of the SC against the parents. The parents reported their children sleep in the bed with them. The eight-year-old MU also reported he was also in the bed with the children

ACS unsubstantiated the allegation DOA/FATL of the SC against the parents. The medical personnel reported there were no signs of abuse to the SC. LE reported there was no criminality suspected regarding the SC's death. Additionally, the ME determined the SC's cause of death was positional asphyxia with overlay. The manner of death was accident (bed sharing with another child).

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

Was the decision to close the case appropriate? Yes

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:
The SS was appropriately being cared for. ACS assessed the SS and the minor MU and deemed them safe in the home. Also, collaterals reported the family continued to be compliant. There were no further CPS concerns to be addressed with the family.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	ACS did not complete a 30-Day Safety Assessment
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: 05/28/2019 **Time of Death:** 01:46 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 12:45 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:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 20 Minutes
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	19 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	7 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	11 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	44 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	48 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

On 5/28/19, ACS initiated the CPS investigation and contacted the ER Dr., LE, the children's primary care provider (PCP), DC, and service providers. The PCP, DC and service providers did not report any concerns of abuse or neglect to the SC. LE did not identify any criminality regarding the SC's death, and no arrest was being made. LE reported there was

a play pen in the home; however, it was full of clothing at the time of the SC's death. LE deemed the family's home a crime scene and barred ACS from accessing the home. ACS met with the family and addressed the reported concern. The family was distraught and declined an interview by ACS; however, ACS assessed the SS and the MU and deemed them safe.

Following the contact with the family, ACS contacted LE at the county where the MGGM resided and requested a well check visit on the minor MA.

Also, on 5/28/19, LE forensically interviewed the minor MU at the Child Advocacy Center. He reported being in the bed with the SC and the SS prior to the incident. The BPs were in the living room at the time. He stated the SC suffocated due to the SS being on top of the SC.

Later that same day, LE from the MGGM's county reported the minor MA was assessed and deemed safe in the MGGMs home.

On 5/29/19, the family provided an account of events prior to the SC being found unresponsive. Their account was the same as the information that was already known regarding the incident. The BPs reported they co-slept with their children.

Also, on 5/29/19, ACS contacted collaterals such as the pediatrician, the ER Dr., the DC and service providers. They did not report any concerns of abuse or neglect for the children. They all confirmed the parents were compliant with services for the children. The children were current with their vaccines.

On 5/30/19, LE reported the SC's death was accidental and no crime was committed. According to LE, the BM's account of the incident was consistent with the preliminary findings pending further tests. The hospital staff reported the SC was seen at the ER in February 2019 due to rolling off the parent's bed. The SC did not have any other hospital visits.

Also, on 5/30/19, ACS requested the LDSS where the MGGM resided to conduct a home assessment and criminal background check on the MGGM.

On 5/31/19, ACS held a child safety conference (CSC). The CSC did not seek court intervention but recommended PPRS services for the family. ACS discussed safe sleep with the family. The family declined additional services from ACS but agreed to seek services on their own.

On 7/17/19, the LDSS of the MGGM's county of residence declined a home assessment and criminal background check on the MGGM due to no allegations reported against the family.

Between 6/7/19 and 8/12/19, ACS made several casework contacts with the family and pertinent collaterals. During the period, ACS provided the family with referrals for PPRS services, but they continued to decline. The family reported they were doing fine and would enroll in services on their own. ACS assessed the SS and the minor MU and deemed them safe in the home. The family had purchased a toddler bed for the SS and appeared to understand the dangers of co-sleeping. The BPs stated they would continue to provide adequate sleeping arrangements for the SS. ACS did not observe any unsafe conditions in the home during home visits. The service providers reported the family continued to be compliant.

NYCRO received a copy of the ME's final autopsy report which indicated the SC's cause of death was positional asphyxia with overlay. The manner of death was accident (bed sharing with another child).

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)? Yes
Comments: The investigation adhered to 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
050182 - Deceased Child, Female, 11 Mons	050184 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
050182 - Deceased Child, Female, 11 Mons	050184 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
050182 - Deceased Child, Female, 11 Mons	050183 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
050182 - Deceased Child, Female, 11 Mons	050183 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated

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?	☒	☐	☐	☐
Explain: ACS did not complete the required 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	☒	☐	☐	☐
Explain: The SS was in receipt of EI services at his day care center. The family declined additional services from ACS but agreed to seek services on their own.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐

Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☒	☐	☐	☐	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The family declined ACS' offer for services and stated they would seek counseling on their own. The SS received EI through the day care provider.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

The family was not known to the SCR or to ACS prior to the fatality report.

Known CPS History Outside of NYS

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

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