Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-115

Prepared by: New York City Regional Office

Issue Date: Jan 27, 2020

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: 2 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 10/23/2019
Initial Date OCFS Notified: 10/23/2019

Presenting Information

The 10/23/19 report alleged on 10/22/19 at approximately 11:30 PM, the SM and SF put the SC to bed. At 6:30 AM on 10/23/19, the SM and SF checked the SC and found him face down in the bed unresponsive. It was unclear if there were objects in the bed. The SM and SF contacted the authorities. The SC was pronounced dead on 10/23/19. The SC was an otherwise healthy CH and the SM and SF had no explanation for the death.

Executive Summary

The 2-year-old male child (SC) died on 10/23/19. OCFS had not yet received a copy of the autopsy report at the time of issuance of this fatality report.

The allegations of the 10/23/19 report were DOA/Fatality and IG of the SC by the SM and SF.

ACS investigated the report and found on 10/22/19, the SC fell asleep at 8:50 PM. At approximately 11:15 PM, the SM observed the SC's eyes were open. At approximately 11:30 PM, the SM returned the SC to sleep in his bed, and there appeared to be no concerns. On 10/23/19, at approximately 7:45 AM, the SF checked the SC and found him unresponsive. The SF alerted the SM who advised him to contact an ambulance. The SM then clutched the SC and went to a neighbor (friend) for assistance. The friend performed CPR, the ambulance arrived and transported the SC to the hospital. There were no surviving children in the SM and SF's household.

According to the SF, the SC was unresponsive and found face down, purple and cold. He contacted the PA for assistance and she advised him to call 911. The SF called 911. The SM brought the SC downstairs to the friend. The SM and friend performed CPR on the SC until the ambulance arrived.

On 10/22/19, LE reported the ME stated there was nothing suspicious observed pending autopsy results. LE interviewed the SC's medical provider who said the SC did not suffer from any pre-existing conditions. His daycare was also contacted, and they reported his behavior was normal and they had no concerns.

On 10/24/19, ACS interviewed the SM's friend who said on the morning of 10/23/19, the SM rang her buzzer. She heard the SM and saw her holding the SC. The SM told her the SF called 911. The friend said EMS told her to help. The friend began CPR on the floor. EMS provided the SM with instructions on the phone.

On 10/28/19, the ME stated that the autopsy report was pending results of additional tests. The ME said there were several small bruises observed on the SC's lower leg and one on the left side of his forehead, but the SC was 2 years old and the bruises were not concerning. The ME was aware of the SC's medical history.

The SM said she planned to obtain bereavement counseling. The SM disclosed details of her pregnancy and the expected date of her unborn child with ACS. The SM and SF asked ACS to discontinue visiting the home. The SM and SF stated they would seek an attorney for legal assistance.

On 1/14/20, the ME confirmed the SC's toxicology reports were negative. However, other reports were pending, and those reports related to the SC's brain as it related to any diseases and trauma.

On 1/16/20, ACS Unsub the allegations of DOA/Fatality and IG of the SC by the SM and SF. ACS based the decision on preliminary ME findings that showed there were no abnormal findings for the SC and the toxicology results were negative. The SM and SF provided the SC's basic needs. During the time the SC was found unresponsive in his bed, the SM and SF responded appropriately by seeking assistance from a neighbor and calling emergency services.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
NA

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:
There were no other children in the BM and BF's care.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The ACS documentation did not reflect that EMS/EMS Liaison was contacted and interviewed.
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 has taken or will take 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: 10/23/2019 **Time of Death:** 08:20 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 07:45 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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
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	Male	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)

LDSS Response

On 10/23/19, the medical personnel said the SM and SF reported the SC went to sleep in his own bed at 8:30 PM but the SC awoke between 11:00 PM and 11:30 PM. The SC was returned to sleep in his own bed and there were no concerns. The SM and SF said they checked the SC on 10/23/19 at approximately 7:45 AM, and found him face down in his bed. According to the parents' account, there were no signs of trauma, but rigor mortis had set in. The SC was healthy with no pre-existing medical conditions. Later, the medical personnel said there was no suspicion regarding the SC's body. The SC was found on the floor in the living room when EMS arrived, and the SM performed CPR.

On 10/23/19, ACS interviewed the SM and SF. ACS permitted the SM's friend to observe the interview. Per the SM's account, on 10/22/19, she took the SC to school at 8:45 AM. She visited the SC's classroom between 10:40 AM and 11:00 AM. The SC was alert and playful. The friend picked up the SC from school at 4:00 PM and walked to her home; the SF picked the SC up at 5:00 PM. The SM arrived home at 7:05 PM. The SC fell asleep at 8:50 PM. The SF's alarm went off at 11:15 PM and the SM saw the SC's eyes were open. The SC returned to sleep at approximately 11:20 PM. On 10/23/19,

the SM went to the basement at 7:15 AM, and remained there until approximately 7:45 AM. The SM said at approximately 7:45 AM, the SF checked the SC and found the SC unresponsive. The SM stated the SF called her. She told the SF to call the ambulance. The SM clutched the SC and went to her friend, who performed CPR. The SM said she planned to seek bereavement counseling.

The SM and SF denied substance abuse. The SF said in 2018, the SC was ill and was transported by an ambulance to the hospital where he received medical care. ACS offered the SF assistance with burial arrangements.

On 10/24/19, ACS interviewed the SC's physician about the SC's medical history. The physician said the parents must have taken the SC to the hospital in 2018 as the illness, referenced by the parents, was not documented in the physician's charts. The last well-child visit occurred on 10/30/18, and there were no concerns.

ACS visited the SC's school and interviewed school staff. The staff had no concerns regarding the care the SM and SF provided the SC.

On 11/19/19, ACS visited the friend's home. The friend said she babysat the SC. ACS did not observe any hazardous conditions in the friend's home.

On 11/15/19, ACS visited the SM and SF's home, and the SM completed documentation for the SC's medical records to be released from the medical facility. The SM discussed her current pregnancy and expected date of delivery. The SM and SF said they would not agree to ACS visits pending discussion with their attorney.

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)?No
Comments: The case documentation did not reflect there was a MDT response.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052272 - Deceased Child, Male, 2 Year(s)	052274 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
052272 - Deceased Child, Male, 2 Year(s)	052274 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
052272 - Deceased Child, Male, 2 Year(s)	052273 - Mother, Female, 37 Year(s)	DOA / Fatality	Unsubstantiated
052272 - Deceased Child, Male, 2 Year(s)	052273 - Mother, Female, 37 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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 ACS documentation did not reflect EMS/EMS Liaison was contacted and interviewed.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☐	☐	☐	☒	☐

Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: The SM said she would obtain bereavement counseling.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving CHN in the home at the time of the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SM said she would seek bereavement counseling.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

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

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

The SM and SF were not known to the SCR or ACS more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

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