Child Fatality Report

Report Identification Number: NY-20-010

Prepared by: New York City Regional Office

Issue Date: Mar 21, 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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 11/27/2019
Initial Date OCFS Notified: 01/22/2020

Presenting Information

According to the information received, on 11-23-2019 the parents and the infant went to a family gathering. While at the gathering the infant was laid down in a crib about 4:30PM. The father checked on the baby at approximately 6:15PM, and the crib's mattress was over the infant's head. The father noticed the infant was not breathing and called the mother. The mother performed cardiopulmonary resuscitation, and a relative called 911. When EMS arrived they continued cardiopulmonary resuscitation, and were able to retrieve the infant's heartbeat. The infant was transported to the hospital and was admitted in the neonatal intensive care unit (NICU). She remained in the intensive care unit until 11/27/19 at 5:05PM when she was disconnected from life support .

Executive Summary

This seven-month-old female child died on 11/27/19, after being hospitalized since 11/23/19. The ME listed the cause death as positional asphyxia and the manner of death as accident.

ACS's investigation revealed the family, including the SC and the two surviving siblings, were visiting paternal relatives from11/23/19 and were expected to return to their home state of California on 11/26/19. On 11/23/19 the mother placed the child in the 'Pack and Play' where an extra mattress was added for support/comfort. At about 4:30 PM, the mother then took a bath and went into the dining room where the adults were having an early dinner. About an hour later, the father checked the child and found her lodged between the mattress and the side (mesh area/wall) of the 'Pack and Play'. He brought the child to BM who then performed CPR while the paternal aunt called for Emergency Medical Services. The NYPD and EMS noted the call came in at about 6:25 PM. The family met with EMS in the lobby of the building. The child was transported to the hospital and admitted to the Neonatal Intensive Care Unit (NICU). The child remained in the hospital until her death on 11/27/19 at 5:05AM.

Between 11/26/19 and 11/27/19, the CPS conducted a home assessment and found no physical conditions that would adversely affect the children. ACS documented the sleeping arrangements were appropriate for the surviving siblings but noted that a family member had placed two additional mattresses on the original 'Pack and Play' mattress "to provide support and comfort" for the infant. The CPS staff noted the mattresses did not fit snugly into the 'Pack and Play' and easily shifted when pushed.

The CPS observed the surviving siblings and documented the children appeared neat, clean and appropriately dressed. They had the appropriate weight and height for their ages. There were no visible marks or bruises observed.

The CPS also made relevant and appropriate collateral contacts with law enforcement in New York and California, medical providers, Almeda County DSS, and with members of the extended family. Nothing in the information obtained pointed to any abuse or maltreatment of the children.

The child was buried based on the family's religious customs and the family then left for California on 11/28/19.

ACS unsubstantiated the allegations of the report on the basis of lack of credible evidence. To support this decision ACS documented the police and medical personnel at the hospital deemed the child's death a tragic accident and there were no suspicions of abuse or neglect regarding the incident.

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:
The casework activities were commensurate with case circumstances as were the safety decisions.

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:
The decision to close the case was appropriate. All surviving children were assessed as safe. The risk of future abuse or maltreatment was sufficiently assessed, and the family refused services in NY.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS unsubstantiated the allegation of IG of the SC by the parents although there was credible evidence that the parents did not provide a safe sleeping surface for the child. The parents added two ill-fitting mattresses to the child's crib and these shifted while the child moved around and subsequently covered the child's face, preventing the child from breathing. ACS did not factor this into the determination narrative.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.
Issue:	Case record contains information that relevant, useful, factual and objective
Summary:	During the course of the investigation of the fatality report, ACS learned there were two surviving sibling in the home; however, these children were not added to the household composition in CONNECTIONS.

Child Fatality Report

Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/27/2019 **Time of Death:** 05:05 AM

Date of fatal incident, if different than date of death: 11/23/2019
Time of fatal incident, if different than time of death: 06:15 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 06:25 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? Yes
How long before incident was the child last seen by caretaker? 2 Hours
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 01
Adults: 00

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	6 Month(s)
Deceased Child's Household	Father	No Role	Male	38 Year(s)
Deceased Child's Household	Mother	No Role	Female	41 Year(s)
Deceased Child's Household	Sibling	No Role	Female	07 Year(s)
Deceased Child's Household	Sibling	No Role	Female	05 Year(s)

LDSS Response

The death of this child occurred four days after she was hospitalized on 11/23/19. A report was registered by the SCR with allegations of Inadequate Guardianship of the child by the parents at the time the child was found unresponsive. During that time, ACS initiated the investigation of the report and made relevant collateral contacts.

ACS interviewed medical personnel, EMS technicians, law enforcement both in New York and California, and family members. None of those interviewed had any concerns regarding the level of care provided by the family who was visiting the paternal relatives in New York.

ACS staff conducted a home assessment and documented the home had adequate sleeping space and arrangements for the family. In their assessment ACS staff noted that while the sleeping arrangements were adequate, the sleeping space for the child was not appropriate as the parents had placed two additional mattresses on the original mattress in the 'Pack and Play'. The staff noted that the mattresses shifted with minimal application of force and concluded that the subject child's movements could had readily done the same. However, this was not factored into the determination to unsubstantiate the allegations of the report.

ACS contacted the Investigative Consultants who reported there were no domestic incidents involving the family. There was evidence of supervisory involvement and the safety assessments were appropriate.

On the same date, ACS staff confirmed the child died on 11/27/19 at 5:05 AM and the body was transported to the ME's office.

Following the death of the child on 11/27/19, ACS staff visited the home where the incident took place and was informed by the paternal grandparents that the family had returned to California. The paternal grandparents reported on the day of the incident, the infant was placed in the 'Pack and Play' while the adults had an early dinner. About an hour later, the father discovered the infant unresponsive. The mother, who is a medical doctor licensed in the state of California, initiated CPR while the paternal aunt called 911 for emergency medical services. The family met the ambulance downstairs in the lobby of the building and the child was transported to the hospital. The child remained on life support until the support was removed and she was declared dead. ACS interviewed the paternal aunt whose account was consistent with the other adults. The adults all denied substance/alcohol use.

Between 11/28/19 and 1/6/20, there was no casework activities except for supervisory reviews of the case.

On 1/7/20, 1/9/20 and again on 1/23/20, ACS contacted Almeda County DSS and the Oakland County Sheriff's Office and was informed the surviving children were doing well in the care of their parents and there were no safety concerns.

On 1/22/20, ACS contacted Family Court Legal Services (FCLS) for a consult. FCLS indicated there was no basis for legal intervention as it was determined by medical staff and law enforcement that the child's death was an accident.

On 1/23/20, ACS unsubstantiated the allegations of the report on the basis of no credible evidence. Additionally, ACS documented the family did not reside in this jurisdiction and had since returned to California.

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

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS showed diligence in contacting out of state collaterals and were able to obtain a wellness check of the children by the police in Almeda County, California.

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:
There was an adequate assessment of impending or immediate danger to the surviving children; however, the safety assessment form was not required.

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 regarding the surviving children. The surviving children were not in immediate or impending danger of serious harm.

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: Family returned to California following the fatality.							

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:
Child was buried one day after death and the family left New York state immediately after the child was buried. Family indicated they would receive counseling and other support services in California.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Child was buried one day after death and the family left New York state immediately after the child was buried. Family indicated they would receive counseling and other support services in California.

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

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)	Allegation Outcome	Compliance Issue(s)
11/24/2019	Deceased Child, Female, 7 Months	Mother, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 7 Months	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
According to the narrative of the report, on 11-23-2019 the parents, and the 7-month-old infant traveled to NYS from California to visit other relatives. The family went to a gathering and while there, the infant was laid down in a crib about 4:30PM. The father checked the infant at approximately 6:15PM, and the crib's mattress was over the infant's head. The father noticed the infant was not breathing, called the mother who performed CPR, and a relative called 911. When EMS arrived they continued CPR, retrieved the infant's heartbeat, and transported the infant to intensive care. The report alleged the mattress in the crib was not the proper mattress, thus the incident.

Report Determination: Unfounded | **Date of Determination:** 01/23/2020

Basis for Determination:
ACS unfounded the report against the parents based on no credible evidence to support the substantiation of the allegations of the report. ACS documented the child was found unresponsive in the 'Pack and Play' and the parents provided, and sought immediate medical attention for the child. ACS further documented the home was appropriate and had adequate sleeping arrangement for all the children. To further support the decision, ACS documented that law enforcement, and medical personnel deemed the child’s death and accident and not a result of child abuse or maltreatment.

OCFS Review Results:
ACS initiated the investigation and made the appropriate contacts with the ME, hospital, law enforcement, the Investigative Consultants and the out of state child protection agency. ACS also contacted parents and extended family to assess the family's functioning. The parents did not allow the CPS staff person to interview the surviving siblings.

The Safety and Risk Assessments were completed timely and accurately reflected the circumstances of the case. The CPS explored the information obtained and engaged the parents in the short time they remained in NYC.

There was evidence of supervisory involvement at the times specified by ACS and at other decision making points in the case.

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

Issue:
Required data and official documents

Summary:
ACS did not update the household information to reflect there were three children in the home.
Legal Reference:
428.3(b)(2)(i)
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 this 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.

[redacted]

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

Family had no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS. ACS contacted the state where the family permanently resided and there was no CPS history.

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