Child Fatality Report

Report Identification Number: NY-18-117

Prepared by: New York City Regional Office

Issue Date: May 14, 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: 8 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 11/12/2018
Initial Date OCFS Notified: 11/12/2018

Presenting Information

The initial and subsequent reports alleged at about 6:30PM on 11/12/18, the BF was sleeping in the same bed with the SC. At approximately 8:00PM, the BF awoke and found the SC unresponsive with blue lips. The BM was also present in the home and the appropriate emergency services were notified at 7:58PM. The BF began CPR until EMS arrived. The SC was transported to a hospital where she was pronounced deceased at 9:02PM.

Executive Summary

On 11/12/18, the SC passed away while bed sharing with her BF in a twin-size bed. The case records revealed at about 8:00PM, the BF awoke and found the SC unresponsive with blue lips. The BM called 911 and the BF began CPR on the SC until EMS arrived. The SC was transported to a hospital where she was pronounced deceased at 9:02PM. At the time of writing this report, the final autopsy report was pending.

At the time of the fatality, the SC resided with her bio-parents (BPs) and 4 SS in a family shelter. The BPs had the SC and the 4 SS in common; however, the BF had three other boys ages 10, 12 and 13 from a previous relationship. The 3 children resided out of New York City with their mother. The case notes reflected there was an active OOP against the BF on behalf of the children and their mother.

On 11/12/18, ACS received the report and visited the hospital to interview LE and ER staff. They did not report any suspicion of child abuse to the SC. LE did not seek criminal action against the BPs. Also, the family's service and medical providers did not report any concerns for the family.

The family reported the SC had a medical condition and 3 prior hospitalizations. She was prescribed medication which the BPs administered as prescribed. She was scheduled to receive a higher level of medical care and monitoring at a specialized hospital a few days prior to her death. On the day of her death, the SC's medical condition worsened despite being given her medication. At about 6:30PM, the BM changed the SC and laid her on her back in bed next to the BF. Due to the SC's medical condition, it was the BPs normal practice to co-sleep with the SC as a safety measure; to ensure she received immediate attention. The family stated this was why the BF was bed sharing with the SC at the time of her death.

Following the fatality, the family left the shelter and moved in with the paternal grandparents (PGPs) for support. ACS completed clearances on the PGPs. They did not have any criminal or CPS history. ACS also deemed the PGPs' home appropriate for the family. ACS assessed the 4 SS and deemed them safe under the care and supervision of their BPs and the PGPs.

During the investigation, ACS collaborated with the LDSS and LE where the BF's 3 oldest children resided for an assessment. The LDSS and LE did not report any concerns for the family.

ACS attempted to file an Article 10 Neglect Petition against the BPs in Family Court; however, the case was not accepted due to lack of evidence. ACS offered the family PPRS services. The family initially agreed to engage in services but declined once services were initiated.

On 2/26/19, ACS substantiated the allegation IG against the BPs. The BPs reported they co-slept with the SC as a safety

measure despite being educated and aware of the risk of co-sleeping with children.

ACS unsubstantiated the allegation DOA/Fatality against the BPs due to lack of any credible evidence. The ME stated the SC's cause of death was upper and lower respiratory tract infection. The manner of death was natural.

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:
ACS failed to complete the 24Hour Safety Assessment in a timely manner.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS failed to complete the 24 Hour Safety Assessment within the required timeframe.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(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 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: 11/12/2018 **Time of Death:** 09:02 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 07:52 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
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	Female	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)

LDSS Response

On 11/12/18, ACS interviewed EMS, LE, ER staff, and the family. EMS, LE, and ER staff did not report any suspicion of abuse to the SC. The ER staff confirmed the SC was diagnosed with a medical condition. LE stated based on the preliminary findings, there was no criminality found and no arrests made. The family provided an account of the incident which was consistent with the information that was already known.

On 11/13/18, the shelter and the SS' school staff did not report any concerns for the family. The shelter stated the family received safe sleep instructions. The school staff did not report any behavioral concerns for the SS.

On 11/13/18, ACS contacted the LDSS and local LE where the BF's other children resided and requested a courtesy visit to the family.

On 11/13/18, ACS visited the family at the PGM's home. The BPs provided ACS with copies of medical documentation showing multiple hospital visits made to have the SC medically assessed. The BF denied he rolled over on the SC. The BM also denied any concerns or suspicions of the BF rolling over on the SC or harming her. ACS discussed safe sleep practice with the BPs moving forward. The PGPs did not report any concerns of child abuse or neglect against the BPs. ACS assessed the SS to be safe at the time of the visit.

On 11/14/18, ACS contacted the mother of the BF's three oldest children. She reported past DV issues with the BF and confirmed she had an active OOP for her and her sons against the BF.

On 11/16/18, ACS received the SC's medical records from her primary Dr. The records reflected the SC's immunizations were current. There were no concerns about the care the SC received.

On 11/19/18, the LDSS and the local LE where the BF's oldest 3 sons resided documented the family did not have any LE, and CPS records. The children were assessed and deemed safe with their mother.

Later that same day, ACS held a child safety conference (CSC). The CSC recommended court ordered supervision and PPRS services for the family. The following day, ACS filed an Article 10 Neglect Petition against the BPs in Family Court. The petition was not accepted due to lack of evidence.

On 11/21/18, the SC's specialist Dr. stated the SC's prognosis was not good. The Dr. confirmed the SC's prior hospitalizations. The SC was scheduled for a genetic testing on 11/26/18. She was to commence special diet and be on a 2-week monitoring at a specialized hospital on that same day.

On 11/29/18, ACS visited the family and assessed all the SS to be safe. The family stated they were doing well. ACS discussed and provided the BPs with information about bereavement services. The family was receptive to services.

On 12/11/18, ME stated the final autopsy was pending. Also, LE reported they were closing the criminal investigation.

On 12/18/18, the BF stated the family was no longer interested in services and would not want the PPRS worker to visit his home.

Between 12/17/18 and 2/19/19, ACS made multiple casework visits to the family and contacts with collaterals. There was no new information regarding the fatality. ACS did not observe any concerns for the SS during home and school visits. ACS had ordered a toddler bed for the 2-year-old SS. The SS did not disclose any abuse or neglect by the BPs. The school aged SS continued to attend school and there were reported concerns. The family continued to decline services and reported they were doing fine and had support from the PGPs.

On 2/27/19, NYCRO received the SC's autopsy report which reflected the cause of death was upper and lower respiratory tract infection. The manner of death was natural.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical 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

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
048361 - Deceased Child, Female, 8 Mons	048363 - Father, Male, 31 Year(s)	Inadequate Guardianship	Substantiated
048361 - Deceased Child, Female, 8 Mons	048362 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
048361 - Deceased Child, Female, 8 Mons	048362 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
048361 - Deceased Child, Female, 8 Mons	048363 - Father, Male, 31 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?	☒	☐	☐	☐
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: Although ACS visited the family and assessed the 4 SS to be safe within 24 hours, ACS failed to complete the 24 Hour Safety Assessment within the required timeframe.				

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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	☐	☐	☐	☐	☐	☒	☐

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? Yes

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 had one prior indicated case dated 10/20/13. The BM of this fatality report disclosed ongoing DV incidents by the BF in the presence of the children. On 10/20/13, the BF choked the BM in the presence of the now 7, 6, and 5-year-old SS. The children were agitated and cried because of the BF's behavior. The police went to the home and observed the oldest child to be screaming and visibly upset. The BF was arrested.

On. 10/28/13, ACS filed an Article 10 petition in family court against the BF. The court released the children to the BM with court ordered supervision. The court also issued a full OOP against the BF and mandated batterer's accountability, anger management and parenting classes for the BF. The court ordered early intervention and committee of special education evaluations for the now 7 and 6-year-old SS. The BM was to engage in a parenting skills program. The family was referred to Puerto Rican Family Institute Inc.

On 12/17/13, ACS substantiated the allegation of IG against the BF.

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?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 12/05/2017	**To:** 12/04/2018

Explain:
On 12/5/17, Kings County Family Court granted a full stay away order of protection against the BF on behalf of his 3 older sons and their bio-logical mother due to DV.

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