



Report Identification Number: NY-17-128

Prepared by: New York City Regional Office

Issue Date: Apr 25, 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
Age: 2 month(s)

Jurisdiction: Kings
Gender: Female

Date of Death: 11/20/2017
Initial Date OCFS Notified: 11/20/2017

Presenting Information

On 11/20/17 at 12:00 AM, the BM placed the SC to sleep in an unknown location in the home. The SC seemed fine at that time. At approximately 2:00 AM, the BM found the SC unresponsive; it appeared the SC vomited as she slept. The MA performed CPR while someone summoned 911. EMS transported the SC to the hospital where she was pronounced dead at 2:42 AM. The SC had no known pre-existing medical condition as she was an otherwise healthy child. The BM was responsible for the SC.

On the same day the SCR registered two subsequent reports regarding the death of the SC adding the MA and the maternal grandparents as subjects.

Executive Summary

On 11/20/17, this two-month-old SC, who had no preexisting medical condition, died while sharing an adult bed with her one-year-old sibling. The SCR registered a report of the death on 11/20/17 with allegations DOA/Fatality and IG of the SC by the BM. There were no allegations pertaining to the SS.

ACS initiated the investigation in a timely manner and made contact with the appropriate collaterals which included the Dr, LE, and the ME. The attending Dr who conducted an external examination of the SC's body in the emergency room reported no signs of maltreatment or abuse. LE found no foul play and is awaiting the final report from the ME.

ACS learned from the BM at approximately 12:00 AM she fed the SC four ounces of formula and at 12:45 AM she put the SC to sleep on the MGM's queen size bed face down. At 2:20 AM, the SC was found unresponsive and 911 was summoned for emergency medical attention. EMS responded to the home and transported the SC to Kings County Hospital where she was pronounced dead at 3:04 AM, on 11/20/17.

The BM reported that the SC usually slept with adults on the bed and the SS on the twin mattress. In spite of the safe sleep training she received at the hospital, the BM opted to place the SC face down, in the center of the adult bed, with the SS who was asleep at the foot of the bed. She explained that the SC cried and was uncomfortable when placed supine. The BM also stated the SC had been fussy due to congestion from a cold and she was constipated.

ACS interviewed the MGM, MGF, and the MA, all of whom were in the home at the time of the incident. ACS used a language interpreter in the interviews with the MGPs; their accounts were the same. ACS learned it was the MGM who checked the children and discovered the SC unresponsive. She yelled for someone to call 911. She added that she observed vomit on the bed and the SC's clothing. The MA responded by initiating CPR (for which she is certified). ACS also interviewed neighbors; no one expressed any concerns regarding the care the children received.

ACS learned that the BM was no longer taking medication for her clinical condition and that she had recently moved in with her parents where the sleeping accommodations were inappropriate. A child safety conference was held on 11/20/17 and concerns regarding mental health, ACS history, inappropriate sleep accommodations and co-sleeping were discussed by all participants. As a result of the conference, on 11/21/17 ACS removed the SS and placed her with the MA. ACS filed an Article Ten Petition of Neglect and Abuse on behalf to the SS seeking a remand on the basis that the BM had an untreated clinical condition and temporary, inappropriate living condition; however, the petition was withdrawn with the stipulation the BM would cooperate with preventive services. The SS returned to the care of the BM.



ACS assisted with the process of reinstating medical insurance for the SS which led to updating her immunizations and assisted the BM with obtaining public assistance. ACS also ordered a bed for the SS which the BM accepted. The BM and SS are currently receiving services to address all concerns.

To date, ACS has not yet made a determination on the allegations.

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?** N/A

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:

ACS has not yet made a determination on the investigation.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS did not explore the delay in seeking medical attention.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
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: 11/20/2017

Time of Death: 02:42 AM

Time of fatal incident, if different than time of death:

02:22 AM

County where fatality incident occurred:

Kings

Was 911 or local emergency number called?

Yes

Time of Call:

02:21 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? 2 Hours

Is the caretaker listed in the Household Composition? Yes - Caregiver 1

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	62 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	43 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	48 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	25 Year(s)

LDSS Response

According to ACS' case documentation, on 11/20/17, ACS responded to the report registered by the SCR within the required time frame. ACS obtained information from the first responders and interviewed the BM; all details were consistent. The emergency room Dr reported the SC had no external signs of neglect or abuse. LE reported they found no



criminality and there was no arrest. The preliminary findings from office of the ME stated the SC appeared to have died from natural causes; however, the final status is pending. The BF is not involved in the care of the SC.

The case documentation reflected that on 11/20/17 at midnight, the BM fed and burped the SC and placed her to sleep on the adult bed with the SS, who was already asleep. The BM chose to place the children on the MGM's queen size bed because the family had gathered in the living room where she occupied. The MGM was preparing to go to bed when she attempted to move the SC and found her face down in vomit; she appeared pale in color and was unresponsive. The MGM alerted the family to contact 911. The MA who was visiting and is CPR certified, initiated resuscitation efforts until EMS arrived. EMS transported the SC to Kings County Hospital Center where the SC was pronounced dead at 3:04 AM.

ACS learned that the BM, who had received safe sleep training, habitually placed the SC to sleep face down because the SC did not cry and appeared to be comfortable. ACS discovered the SC had been congested and constipated for three days; however, ACS did not address the reason the BM did not seek medical attention. Also in ACS' review of the BM's history, the BM had a mental health condition and was not currently receiving treatment, in addition to the unknown circumstances of the SC 's death. The BM had recently moved in with the MGP where the sleep accommodations were poor.

On 11/20/17, ACS staff held a child safety conference and discussed their concerns with the family. As a result, ACS removed the SS and placed her in the care of the MA. On 11/22/17, ACS' Family Court Legal Services file a neglect petition in the Kings County Family Court on behalf of the SS against the BM. However, on 11/28/17 the petition was withdrawn on the condition that the BM accept services, which she did.

The BM relocated with the SS to a secured home in the shelter system. According to the documentation, the BM continued to cooperate with ACS' court order to further ensure the safety and well being of the SS in her care.

At the time of this writing, ACS has not yet made a determination on the allegations in spite of NYCRO's query into the conclusion.

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

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.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
044492 - Deceased Child, Female, 2 Mons	044543 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Pending
044492 - Deceased Child, Female, 2 Mons	044543 - Mother, Female, 21 Year(s)	DOA / Fatality	Pending



CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Fatality Risk Assessment / Risk Assessment Profile



Child Fatality Report

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, court ordered?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explain as necessary: ACS physically removed the SS from the home and placed in the care of the MA; however, the court ordered the SS returned to the BM's care with ACS' supervision.				

Legal Activity Related to the Fatality

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

Family Court

Criminal Court

Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
11/22/2018	Not Adjudicated	Return to Parent
Respondent:	044543 Mother Female 21 Year(s)	
Comments:	FCLS filed a neglect petition and the SS was returned to the parent.	

Services Provided to the Family in Response to the Fatality



Child Fatality Report

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

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:

The SS was seen by a pediatrician and she received some immunizations; however, her status is not current. She was also enrolled in a daycare program.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

The BM enrolled in bereavement counseling, mental health evaluation and PPRS services.

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:**

- | | |
|---|--|
| <input type="checkbox"/> Had medical complications / infections
<input type="checkbox"/> Misused over-the-counter or prescription drugs
<input type="checkbox"/> Experienced domestic violence
<input checked="" type="checkbox"/> Was not noted in the case record to have any of the issues listed | <input type="checkbox"/> Had heavy alcohol use
<input type="checkbox"/> Smoked tobacco
<input type="checkbox"/> Used illicit drugs |
|---|--|

Infant was born:

- | | |
|---|---|
| <input type="checkbox"/> Drug exposed
<input checked="" type="checkbox"/> With neither of the issues listed noted in case record | <input type="checkbox"/> 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

There was no CPS history 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

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