



Report Identification Number: NY-18-038

Prepared by: New York City Regional Office

Issue Date: Oct 05, 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: 3 month(s)

Jurisdiction: Queens
Gender: Female

Date of Death: 04/16/2018
Initial Date OCFS Notified: 04/16/2018

Presenting Information

The 4/16/18 SCR report alleged that on 4/16/18, the SC was in the care of the SF while the BM was at work. The SF woke the SC who was in the crib at 10:30 AM and observed the SC in distress and having trouble breathing. The SF attempted CPR and contacted authorities at approximately 10:45 AM. The authorities arrived at approximately 11:04 AM and the SC was transported to the hospital where she was pronounced dead at 11:22 AM. There was no cause of death at the time and there was no explanation from the SF. The SC was otherwise a healthy child with no known medical issues. The SF was the alleged subject as he was responsible for the SC during the incident. There were no known injuries to the child. The role of the BM was unknown as she was not present for the incident.

Executive Summary

The 3-month-old female SC died on 4/16/18. Due to religious observance, the BM and SF declined an autopsy of the SC. According to the ACS case record, the ME found there were no signs of trauma, marks or bruises upon the external physical examination of the SC. NYCRO had not yet received the ME's physical examination report as of date of issuance of this fatality report.

The allegations of the 4/16/18 SCR report were DOA/Fatality and IG of the SC by the SF.

ACS interviewed the SF regarding the circumstances surrounding the death of the SC. ACS findings showed the SC was breast fed by the BM at 7:00 AM. The BM left for work at approximately 8:10 AM. The BM left the home and the SF was at home with the SC. Then the SF slept on the sofa while the SC slept in her crib in the bedroom. The SF woke up at approximately 9:30 AM. Around 10:30 AM, he noticed the SC had not awoken at 9:00 AM as usual. The SF went into the bedroom and observed saliva outside of the SC's mouth. He observed the SC's breaths appeared labored. The SF took the SC to the bathroom, where he washed her face, turned her over and tapped her back approximately five times. The SC's labored breathing continued. The SF placed the SC on the floor and performed CPR on her. The SF dialed 911 at approximately 10:45 and received CPR instruction from the operator. Shortly thereafter, EMS arrived and escorted the SC and SF to Elmhurst Hospital. EMS continued CPR while transporting the SC to the hospital. The ER staff exhausted resuscitative efforts and the SC was pronounced dead at the hospital.

The BM, SF and SC shared a one-bedroom apartment. ACS observed the home and found it was clean and fully furnished. There was an adequate supply of formula and clothing for the SC in the home. The SC's crib was observed next to the BM and SF's queen-sized bed. The crib was free of items and adhered to safe sleep recommendations. The family had working and in-place smoke/carbon monoxide detectors in the home. There were no hazardous conditions in the home. There were no safety concerns as there were no surviving siblings or other children in the household.

During the investigation, ACS gathered pertinent information about the SC's death by observing the family's apartment, and obtaining accounts from the BM, SF, LE, medical and ER staff. ACS was conscientious and sensitive of the first-time parents' grief. ACS did not observe behaviors by the BM and SF to suggest there was DV, SA or MH issues in the home.

On 6/15/18, ACS unsubstantiated the allegations of DOA/Fatality and IG of SC by the BF on the basis the SF observed the SC was in distress, attempted CPR and called 911. The SF took appropriate steps to help and sought emergency medical assistance.



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 safety assessment documents were not required as there were no surviving siblings and no other children in the household and therefore, no children likely to be abused/maltreated.

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:

ACS' decision to unsubstantiate the allegations of the report was appropriate.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The SCR report was dated 4/16/18 and the 24-hour Fatality Report was approved on 4/19/18; not within the specified timeframe.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
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.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The SCR report was dated 4/16/18 and the 30-Day Fatality Report was approved on 5/21/18; not within the specified timeframe.



Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/16/2018

Time of Death: 11:22 AM

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

Unknown

County where fatality incident occurred:

Queens

Was 911 or local emergency number called?

Yes

Time of Call:

10:54 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

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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	42 Year(s)
Deceased Child's Household	Mother	No Role	Female	41 Year(s)

LDSS Response

According to LE, at 10:54 AM the call regarding the unconscious SC was received. LE and EMS arrived at the case address simultaneously. Upon their entry to the apartment, LE observed the SF on the floor administering CPR to the SC. LE observed the SC's eyes were closed and the SC was not breathing. EMS arrived at the hospital at 11:22 AM. LE found



no criminality and no arrest was made.

On 4/16/18, ACS interviewed the BM and SF. The BM said on 4/13/18, at approximately 6:30 AM, she had the SC in her arms when she spilled the water she was drinking. With the SC in her arms, she lost her balance, tripped forward, hit the right side of her own face on the archway of the bedroom door as she fell to the floor. The BM knocked on the wall to alert the SF of her need for his assistance. The BM was adamant that the SC never left her arms and when she got up from the floor, the SC remained in her grasp. The SF said he heard the bang when the BM fell. The SF said he responded and helped the BM up from the floor. The SF's statement was consistent with the BM's account as he stated he observed the BM on the floor and the SC was in her arms when he helped the BM. As a precaution, the BM researched symptoms to observe if the SC displayed any symptoms after the fall. The BM said she monitored the SC and noted there was no change in the SC's daily activities. The BM did not sense any concerns with the SC and did not seek medical attention for the SC.

On 4/16/18, the attending physician said there was no obstruction of the SC's airway nor were marks or bruises observed on the body.

On 4/16/18, a neighbor had no concerns regarding care the BM and SF provided the SC. The neighbor stated the SC appeared well cared for and the BM and SF often showed the SC affection.

On 4/17/18, pediatric staff said the SC was seen for routine care. The SC was last seen on 02/22/18 and was healthy. The Dr. noted there were no medical concerns or abnormal findings regarding the SC. The BM and SF were provided a four-month-old follow-up appointment for the SC. The BM and SF appeared to be appropriate and concerned with the growth and development of the SC.

On 5/14/18, ACS offered bereavement services. The BM and SF accepted community based referrals for additional support.

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 investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045705 - Deceased Child, Female, 3 Mons	045707 - Father, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
045705 - Deceased Child, Female, 3 Mons	045707 - Father, Male, 42 Year(s)	DOA / Fatality	Unsubstantiated



CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>

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? 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



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 no 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.

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