Child Fatality Report

Report Identification Number: NY-20-059

Prepared by: New York City Regional Office

Issue Date: Dec 01, 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: 1 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/28/2020
Initial Date OCFS Notified: 06/28/2020

Presenting Information

The report alleged on 6/28/20, the SM and SF were riding in their car with the SC. The SM and SF overheard the SC gurgling in her car seat and observed formula and blood coming out of the SC's mouth. The SM began CPR until emergency services arrived. The SC's heart rate; however, continued to slow down. Efforts were made to revive the SC; however, the SC succumbed to a heart attack and was pronounced dead. The SC was an otherwise healthy child and the SM and SF had no explanation for the cause of the SC's death.

Executive Summary

The 1-month-old female child (SC) died on 6/28/20. As of 12/1/20, NYCRO had not yet received the ME's report.

According to the SM, the SC had no pre-existing health condition. On 6/28/20, the SM and SF dropped off the two SSs to their father home to visit. Afterwards, the SM and SF took the SC to the home of the paternal grand parents (PGPs). At about 3:00 PM, the SM fed the SC. The SM burped her and then held her until 4:30 PM when she put the SC in her car seat in preparation to leave the PGP's home. The infant's car seat was reportedly located behind the passenger seat, and faced towards the rear. The SM and SF said they properly strapped the SC's car seat, and there were no other items in the car seat. They traveled from the PGP's home and visited the cousin. They exited the vehicle and spoke with the cousin, who came to the car and the SM opened the car door for her cousin to see the SC. The SC opened her eyes. The SM closed the car door and when the SC fussed, the SF exited the car, went to the SC's side and told the SM there was formula coming out of the SC's nose. The SM went to the vehicle and saw the SC seemed to be choking as there was formula coming out of her nose and bright red blood coming from her mouth. The SM wiped the blood and then performed CPR; the SF called 911. EMS and LE responded and the SC was transported to the hospital.

The SF reported a similar account. According to the SF's account, they arrived at the cousin's home and the SM exited the vehicle to speak with her cousin. He stayed in the car with the SC who was in her car seat. He was outside the driver's door while the SM spoke to her cousin. The cousin came to the car to observe the SC. The SM continued to speak with her cousin, and he returned to the driver's side of the vehicle. The SF heard the SC fuss and make a gasping sound. He went to the other side of the car and saw milk in the SC's nose; the SM came to the car. The SM entered the car and looked at the SC who seemed to be choking. He told the SM to take the SC out of her car seat. When she took her out, he saw the SC had blood in her mouth. The SM told him the SC was choking as her lips were blue. The SM turned the SC over and performed CPR. During that time, he called 911.

On 6/29/20, LE said the preliminary results of the autopsy showed there were no initial signs of foul play or trauma. LE said the ME stated preliminary findings showed there were no signs of fractures or healing from past trauma, no hematoma or damage to the optic nerve. Further studies needed to be conducted.

The SC had 4-year-old and 6-year-old female siblings who resided in the SM and SF's home, and two female SS (ages 17 and 14) who resided with their mother.

On 7/1/20, ACS opened a preventive services case for the family. On 7/6/20, a conference occurred, and the outcome was PPRS, and individual and family counseling for the family. ACS provided the SF with a list of substance abuse treatment resources. Later, ACS obtained a legal consultation and determined there was no basis to file an Article Ten Neglect petition. On 7/10/20, a referral for PPRS was submitted.

On 10/19/20, the ME's office said the ME's report was pending. The exam was unremarkable which meant there was no evidence of trauma or abuse.

On 10/26/20, ACS Unsub the allegations of DOA/Fatality and IG of the SC by the SM and SF. The preliminary medical reports noted the SC died due to cardiac arrest. Preliminary reports received from the autopsy reflected there were no signs of foul play or trauma. The SM acted appropriately when the SC was in distress by performing CPR and having the SF call EMS. There was no indication the SC died due to neglect by the SM and SF. The SM and SF seemed to have provided the SC with adequate care. The home conditions were appropriate. ACS saw infant clothes, formula and a crib free of clutter for the SC. The two SSs reported the parents took great care of the SC and reported no concerns.

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? 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 opened a preventive services case for the family.

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 24-hour Child Fatality Summary Report was not completed in a timely manner as it was not completed until 6/30/20.

Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The Investigation Progress Notes were not entered contemporaneously. An event occurred on 7/6/20 but was not entered until 10/16/20.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/28/2020 **Time of Death:** 07:22 PM

Time of fatal incident, if different than time of death: 05:15 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: The SC was alert.

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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Other Household 1	Other Adult - Father to 4-yo and 6-yo SS's	No Role	Male	30 Year(s)
Other Household 2	Other Adult - Mother of SF's 17-yo and 14-yo daughters	No Role	Female	35 Year(s)
Other Household 2	Sibling	No Role	Female	17 Year(s)
Other Household 2	Sibling	No Role	Female	14 Year(s)

LDSS Response

On 6/28/20, the ME reported the parents were interviewed and there were no suspicions..

On 6/29/20, the SM reported she brought the SC to a health facility for a well-child follow up examination, and the SC was healthy. The SM denied past and present substance abuse. The SF said he saw the 17-yo and 14-yo SS on a bi-weekly basis. The SF said he used marijuana but not to the point where he was intoxicated. The last time he used was on 6/27/20 and he used marijuana outside of the home.

The SM said the day of the incident, the family dropped off the two SSs at their father's home. They took the SC to the PGP's home and then visited her cousin's home. The SM left the car to speak with the cousin. The SM saw the SC was sleeping in the car seat, but briefly opened her eyes. While speaking to her cousin, the SF exited the car and said the SC was fussing. The SM saw the SF pick up the SC, and saw what she believed was formula coming from her nose and blood coming from her mouth. The SM told the SF to call 911. The SC seemed to be choking, so she turned her over and patted her back. The SM said although the SC was born premature, she was a healthy child. The SM was interested in bereavement counseling and burial assistance.

On 6/29/20, the PGM said the SM and SF took good care of the SC. On the same date, the SM's cousin stated when she saw the SC on 6/28/20, the SC seemed healthy.

On 6/29/20, ACS visited the home of the father of the 6-yo and 4-yo SSs. During the visit, ACS was unable to interview the two SSs as they were asleep. The SSs were not aware of the SC's passing. There were no suspicious marks or bruises observed. The father had no concerns about the care the SM and SF provided the SSs. Later, the 4-yo SS said the SM and SF took good care of the SC. The 6-yo SS initially said she received beatings. The 4-yo, who was listening, said they did not get beatings; they were placed on timeout. The 6-yo recanted her statement and said she sat in the timeout chair in the corner. When asked why she said she received beatings, the 6-yo said it was a mistake. The father said the SM did not use corporal punishment to discipline the SS. He denied using physical discipline. No marks or bruises were observed on the SS.

On 6/29/20, ACS visited the home of the mother of the SS ages 17 and 14 years. The mother said she last spoke with the SF on 6/28/20. She denied having any issues or concerns with the SS being in his care. The SS appeared to have received a

minimum degree of care.

On 6/29/20, the PGF said he had no concerns prior to the SC's death. The same day, the PA said she saw the SC the day of the incident and she seemed healthy.

On 6/29/20, the attending physician said the SC had no physical injuries. The physician was unable to provide additional explanation. Later, the physician said there was a correlation between the SC being premature and the death. The physician stated the SC was very small and premature babies had higher risk of complications such as asphyxiation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The case documentation did not reflect there was a MDT response.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055405 - Deceased Child, Female, 1 Mons	055407 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
055405 - Deceased Child, Female, 1 Mons	055406 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
055405 - Deceased Child, Female, 1 Mons	055406 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
055405 - Deceased Child, Female, 1 Mons	055407 - Father, Male, 37 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?	☐	☒	☐	☐

Other	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
ACS attempted to contact the neighbors.

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?	☐	☐	☒	☐

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:
The documentation reflected that a legal consultation occurred and the results were that there was no basis to file an Article Ten petition at this time.

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: PPRS							

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:
ACS provided a referral for PPRS and bereavement services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
A PPRS referral was made for bereavement and counseling for the family.

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? No
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

There was no CPS investigative 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