Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-129

Prepared by: New York City Regional Office

Issue Date: Mar 25, 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: 2 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/20/2019
Initial Date OCFS Notified: 12/20/2019

Presenting Information

The initial 12/20/19 SCR report alleged on 12/19/19, the SM and SC went to sleep in the same bed. The report further alleged the SM customarily slept in the same bed as the SC and with her arm around him. The SM checked the SC at 2:00 AM on 12/20/19, and he appeared to be well. The SM woke up at a later unknown time and found the SC unresponsive in her bed. The SM called for EMS at 7:50 AM. EMS arrived at the home, found the SC cold to the touch and transported the SC to the hospital; they arrived at 8:20 AM. Hospital staff performed CPR on the SC for twenty-five minutes and pronounced him dead at 8:45 AM.

A subsequent report was registered the same day and alleged that on the morning of 12/20/19, the SM checked the SC and discovered he was not breathing. SM immediately alerted the grandparents. The grandfather performed CPR on the SC.

Executive Summary

This two-month-old male child died on 12/20/19. As of the writing of this report, the cause and manner of death have not yet been determined by the ME.

On the same date, the SCR registered two reports with allegations of DOA/Fatality and Inadequate Guardianship of the two-month-old child by the mother and the maternal grandparents who were named as the subjects of the report.

According to the information obtained, sometime after 3:00 AM on 12/20/19, the mother went to sleep with the child in the full-size bed, and with her left arm around the child, as she was accustomed to doing. At about 7:50 AM when she awoke, she found the child on his left side, facing her, unresponsive, and “blue”. After the mother screamed, the maternal grandparents went to help her and attempted to resuscitate the child; however, their efforts were futile. The mother called 911 for emergency medical assistance. EMS responded to the home and transported the child to the hospital where resuscitative efforts continued. The child did not respond and was pronounced dead at 8:45 AM on the same date.

Law enforcement and the ME conducted a death scene investigation and reported no criminality associated with the death of the child. ACS confirmed with EMS the emergency call was placed at 7:56 AM and the child was pronounced dead on arrival at 8:45 AM. There were no surviving siblings or children in the home; therefore, no safety or risk assessment forms were required. The mother denied drug and alcohol use.

The case documentation reflected supervisory involvement throughout the investigation. As per ACS’s protocol involving the death of a child under three, ACS held an initial Heightened Oversight Process (HOP) conference on 12/20/19 and a follow-up conference on 1/10/20. ACS completed mental health and domestic violence consults and as a result the family was referred for bereavement counseling. The case documentation also reflected contact with the mother, maternal grandmother, maternal grandfather, godmother, neighbors, law enforcement, and the pediatrician. These contacts were interviewed separately, and no concerns were noted.

On 2/18/20, ACS substantiated the allegation of Inadequate Guardianship of the child by the mother and indicated the report. The family was referred for community-based bereavement counseling.

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?** 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

Explain:
The casework activities were commensurate with case circumstances. The Specialist made the appropriate contacts and explored information obtained. There were no surviving siblings or other children in the home; therefore, the safety assessment form was not necessary.

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:
Case documentation reflected appropriate initiation and case progression. There are no surviving siblings in the home. There was evidence of the appropriate supervisory guidance and involvement.

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 timely as it was not completed until 1/10/20.
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.

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 12/20/2019 **Time of Death:** 08:45 AM

Time of fatal incident, if different than time of death: 07:40 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 07:50 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	Male	2 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	52 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	59 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

Upon receipt of the fatality report on 12/20/19, ACS staff initiated the investigation of the report by convening a Heightened Oversight Process (HOP) conference which involved the IC and investigative staff as the child who died was under the age of three years old. ACS also convened a Multidisciplinary Team (MDT) conference and contacted law enforcement. From law enforcement, ACS learned the mother stated she went to sleep with the child on the bed, placed him on his back, and with her left arm around the child, as was her routine. At about 3:00 AM she was on a call with the child's father and when she ended the call, the child was alive. The mother said at about 7:50 AM when she awoke, she found the child unresponsive; he was on his left side facing her. The mother screamed for assistance; the maternal grandparents responded and attempted CPR. The mother called for EMS at 7:56 AM. EMS responded to the home and continued resuscitative efforts. The child did not respond; EMS transported the child to the hospital where he was pronounced dead at 8:45 AM. Law enforcement further indicated there were no signs of trauma to the child's body, and no marks or bruises.

Further, it was noted the home was cluttered but there were supplies for the adults and the child, including a portable crib,

and a stationary crib, baby supplies, and food. The sheets that had been on the bed were taken by detectives as evidence. The mother said she did not allow the child to sleep in any of the cribs as the child would cry and not sleep when placed in them.

On the same date, the Specialist completed a visit at the hospital where the child had been taken. The attending physician reported when the child arrived at the hospital, he had a body temperature of 92 degrees which indicate the child may have been dead for hours before the mother realized. The physician corroborated the information regarding the absence of trauma, marks, and bruises. Hospital staff also provided background information regarding the child's birth and the fact that he was a well-child at birth.

On 12/20/19, the IC and Specialist visited the mother's home and conducted a home assessment prior to interviewing the mother. Staff documented there was a working smoke alarm and a carbon monoxide detector in the home; window guards were in place. ACS confirmed there was a full-size bed and two cribs. At the time of the visit, law enforcement had taken the sheets and blankets as evidence. When staff interviewed the mother, her account remained consistent with her previous statements. The mother denied drug and alcohol use and denied mental health conditions. The mother called 911 at 7:56 AM.

ACS learned on 12/16/19, the child was taken to the ER and was diagnosed with an upper respiratory infection. During the same home visit, the maternal grandparents were interviewed separately, and their statements were consistent with the mothers from the time she cried out for assistance until when the child was pronounced dead. The family was offered grief and bereavement counseling services. ACS staff spoke with neighbors who described the family as being very quiet and there were no concerns.

On 12/23/19, ACS completed requests for clinical consultation as the mother reported prior Domestic Incident Reports in which the father of the child had strangled her causing her to lose consciousness.

On 12/27/19, ACS contacted the father, but he was not interviewed at his request. Subsequent attempts to contact the father were made by phone on 12/30/19 and 1/10/20; however, they were unsuccessful and for the duration of the investigation the father did not make himself available for an interview. The Specialist went to the father's home on 1/14/20; again, he was not available.

On 12/30/19, the Specialist contacted the ME. No new information was obtained. The ME said the cause and manner of death were pending.

On 1/2/20, a home visit was conducted and during the visit the Specialist assessed family supports and offered services. The adults in the home agreed to participate in bereavement counseling.

On 1/7/20, ACS made contact with the babysitter(godmother) who recounted the birth mother's account to her. Again, the information was consistent with previous statements the mother made to law enforcement, medical personnel, and ACS.

On 1/16/20, ACS received a copy of the 911 transmittal and confirmed that the emergency call was placed at 7:56 AM on 12/20/19, and the ambulance left the home at 8:14 AM for the hospital. The ambulance arrived at 8:20 AM and the child was pronounced dead at 8:45 AM.

Between 1/17/20 and 2/18/20, the documentation reflected repeated contact with the ME for information on the autopsy, as well as contact with supervisory staff and the IC. The Specialist made home visits, but no new information was obtained except that the mother said the father had provided emotional and financial support for the child.

On 2/18/20, ACS substantiated the allegation of Inadequate Guardianship of the child by the mother on the basis of the

mother's statements that she had been co-sleeping with the child on the same bed, and when she awoke the child was unresponsive. The report was indicated.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or 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 NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052931 - Deceased Child, Male, 2 Mons	052932 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
052931 - Deceased Child, Male, 2 Mons	052932 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
052931 - Deceased Child, Male, 2 Mons	052933 - Grandparent, Female, 52 Year(s)	DOA / Fatality	Unsubstantiated
052931 - Deceased Child, Male, 2 Mons	052933 - Grandparent, Female, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
052931 - Deceased Child, Male, 2 Mons	052934 - Grandparent, Male, 59 Year(s)	DOA / Fatality	Unsubstantiated
052931 - Deceased Child, Male, 2 Mons	052934 - Grandparent, Male, 59 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐

Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The documentation reflected that ACS would refer the SM, MGM, and MGF to grief and bereavement counseling. ACS provided the family with referrals to Compassionate Friends, the Cope Line and the Crisis Text Line.

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? N/A
Explain:
There are no surviving siblings or children residing in the household.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:
☒ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☒ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

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 SM, MGM and MGF were not known to the SCR or ACS more than three years prior to the fatality.

Known CPS History Outside of NYS

The SM, MGM and MGF had 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