Child Fatality Report

Report Identification Number: NY-20-075

Prepared by: New York City Regional Office

Issue Date: Feb 07, 2021

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: Male
Date of Death: 08/09/2020
Initial Date OCFS Notified: 08/09/2020

Presenting Information

On 8/9/20, at 7:00 AM, the SM placed the one-month-old female child on a U-shape pillow in bed along with her four-year-old nephew; they slept in the same bed. The SM awoke at approximately 12:50 PM and found the SC face down on the bed, unresponsive. The SM contacted 911. LE and FDNY responded and initiated CPR. EMS transported the SC to the hospital where she was pronounced dead. The SC was an otherwise healthy child and the SM had no explanation.

Executive Summary

ACS initiated an investigation into the death of the one-month-old male child that occurred on 8/9/20, within the required timeframe. ACS contacted LE, ME and the hospital. ACS interviewed the SM who stated she had no other children. At the time of the incident, there was a two-year-old male cousin in the home. ACS assessed and deemed the two-year-old child safe in the care of his mother the (MA).

According to the information ACS received, the SM arrived at the MA's home between 5:30 AM and 6:00 AM on 8/9/20. The MA had been babysitting the SC the previous night. The MA left the SM in the home with the SC asleep in his Pack-n-Play and the two-year-old asleep in his bed. The SM reported the SC cried and she took him from the Pack-n-Play, placed him on a "Boppy Pillow" on the adult bed next to her. She placed him face down with his arms over his head and a pacifier in his mouth, this occurred at approximately 7:00 AM. The SM fell asleep and later, while asleep, the two-year-old cousin got into the bed behind the SM, the SC was in front of the SM. The SM awoke at 12:45 PM and found the SC face down on the bed, unresponsive, he slid from the pillow.

EMS transported the SC to the hospital where he was pronounced dead. The medical personnel found no visual signs of maltreatment or abuse on the SC. LE found no evidence of criminality. The ME reported the incident appeared accidental; the final report was pending additional tests results.

ACS learned from the MA that the SC was well the night before the incident. After the ACS initial home visit, the MA did not allow ACS to re-enter the home; she discontinued communication. The SM reiterated she could no longer repeat the details of the event and she discontinued communication. The SM and MA declined services.

On 10/14/20, ACS unsubstantiated the allegation of DOA/fatality, substantiated the allegation of IG and closed the case. ACS found credible evidence that the SM opted to co-sleep with the SC despite her awareness of the dangers of co-sleeping with an infant. ACS cited that the ME reported the manner of death was an accident; however, the cause was pending. ACS also cited that LE made no arrest and closed their case.

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

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:
The ME reported the SC's death was an accident based on the SM's account and re-enactment of the incident.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/09/2020 **Time of Death:** 01:50 PM

Time of fatal incident, if different than time of death: 12:50 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 12:55 PM
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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 5 Hours
At time of incident supervisor was:

☐ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☒ Asleep

☐ Distracted
☐ Impaired by disability
☐ Impaired by illness
☐ Other:

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	Mother	Alleged Perpetrator	Female	19 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	26 Year(s)
Other Household 1	Other Child - Cousin	No Role	Male	2 Year(s)

LDSS Response

ACS interviewed hospital personnel on 8/9/20 and learned that the SC arrived at the ER, via EMS, at approximately 1:00 PM. The SC was pronounced dead at 1:50 PM. The physician reported there were no signs of neglect or abuse found on the SC and based on the SM's explanation, asphyxia was likely the cause.

According to the ME, the death of the SC was accidental based on the circumstances surrounding the incident. The final report was pending.

LE reported they arrived at the home at 12:58 PM and observed the FDNY (EMS) exiting with the SC. ACS learned from LE that the SM placed the SC face down on the "Boppy pillow" with a pacifier, on the adult bed where she slept. The SM awoke at 12:45 PM when the two-year-old climbed into the bed; she found the SC faced down on the bed, unresponsive. It was approximately five hours when the SM last saw the SC alive. LE reported the SM did not appear to be under the influence of drug or alcohol. LE found no evidence of criminality; they closed their case.

On 8/9/20, ACS visited the home where the SM resided and the MGF allowed the ACS to view the SM's room where she and the SC occupied. The MGF reported that he, the MGM, SM, SC and the maternal-grandaunt resided in the home. ACS documented the sleep conditions were appropriate.

On 8/9/20, ACS visited the MA's home where the incident occurred and documented that the home had appropriate sleep accommodations and supplies for the SC. The SM was distraught and reported she repeated the details of the incident for the past four hours and she refused to answer additional questions. The SM called the BF, who told the Specialist he did not reside with the SC; he declined the interview.

According to the MA, she had two children, the two-year-old who was in the home at the time of the incident and a ten-year-old male child who was at his grandmother's home when the incident occurred; however, ACS did not add him to the household composition. The MA refused to allow the ACS to assess the two-year-old; however, the ACS observed his arms and legs and found he did not have bruises or marks, as he walked around. The MA told the ACS she taught the SM how to appropriately care for the SC. She stated she allowed the SM to stay at her home for a few days to stay away from the BF with whom she was involved in DV incidents. The SM and MA declined to be re-interviewed. The MGM declined an interview. ACS attempted to interview multiple collateral contacts to no avail.

On 10/14/20, ACS unsubstantiated the allegation of DOA/fatality of the SC by the SM citing the ME reported the manner of death was accidental and the criminal investigation was closed. ACS explained that, prior to the fatality, the SC was considered a well child.

ACS substantiated the allegation of IG of the SC by the SM. ACS found credible evidence that the SM co-slept with the SC despite receiving Safe Sleep training. The SM moved the SC from his Pack-n-Play to a shared space in the adult bed where they fell asleep and she later found him unresponsive.

Official Manner and Cause of Death

Official Manner: Accident
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 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 NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056227 - Deceased Child, Female, 1 Mons	056228 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
056227 - Deceased Child, Female, 1 Mons	056228 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated

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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The SM declined to give information regarding the SC's physician.

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 SM requested housing assistance; however, it is unknown whether she followed through with an application.

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:
The SM had no other children; however, the other child in the home at the time of the incident was two years old and the ACS noted he was not aware of the circumstances. Both parents declined services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SM declined services.

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

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