Child Fatality Report

Report Identification Number: NY-20-111

Prepared by: New York City Regional Office

Issue Date: Jun 08, 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: 2 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/09/2020
Initial Date OCFS Notified: 12/09/2020

Presenting Information

On 12/9/20, the SCR registered a report alleging on 12/4/20, at 10:00PM, the thirteen-year-old maternal uncle fed the subject child a bottle of formula and laid him down to sleep. At 11:30PM, the mother picked up the subject child by his arms and placed him down to sleep on his side, facing a pillow, and with his pacifier. At 11:45PM, the maternal grandmother observed the subject child lying face down and unresponsive. The report alleged the subject child was not in a safe sleep arrangement. Someone in the home contacted 911 for emergency medical assistance; however, the mother and maternal grandmother opted to take the subject child to the emergency room which was in close proximity to their home. Upon arrival at the hospital's emergency room, the subject child presented as unresponsive. On 12/7/20, at 12:45AM, the doctor performed vitals on the subject child and found he had no heart or respiratory rate. The subject child was then placed on a ventilator. He was pronounced dead at 8:55 PM on 12/9/20. The two-month-old subject child was known as an otherwise healthy child and the caretakers provided no explanation for his death.

Executive Summary

This fatality report concerns the death of a two-month-old male subject child that occurred on 12/9/20. A report was made to the SCR on 12/9/20 with allegations of DOA/Fatality and Inadequate Guardianship against the subject child's mother and maternal grandmother. The Administration for Children's Services (ACS) received the report and investigated the subject child's death. An autopsy was completed; however, the cause and manner of death remained pending at the time of this writing.The Medical Examiner had indicated that the preliminary findings of manner of death was accidental, caused by unsafe sleep. The final autopsy was pending tests results.

The investigation revealed on 12/5/20, the subject child was fed and then placed in his crib to sleep. The subject child was placed on his stomach with his body off the pillow, his face was turned to the side on the pillow. At approximately 10:45PM he cried, and the mother placed a pacifier in his mouth and soothed him back to sleep. Although the mother received Safe Sleep information, she opted for the prone position and the use of a pillow, as advised by the maternal grandmother, to help the subject child to "sleep better." At approximately 11:45PM, the maternal grandmother checked and found the subject child with his face in the pillow. There was blood coming from his nose. The mother called 911 for emergency medical assistance, but chose not to wait for the ambulance because the operator was asking too many questions. The family ran towards the hospital which was close by and as they reached the corner of their street, they observed an ambulance leaving the hospital and sought help from the technicians in the ambulance. EMS reported they received the call at 11:57PM and confirmed they met the parents on the street; they initiated CPR as they transported the subject child to the emergency room.

On 12/7/20, at 12:45AM, the subject child was placed on a ventilator due to no brain activity. He was found with no visible signs of maltreatment or abuse. On 12/9/20, medical staff reported the subject child died at 8:55PM due to multiple organ failure.

From the time the investigation began to the time of its closure, ACS interviewed and engaged with the family on numerous occasions. The family was cooperative. ACS spoke with collateral sources to gather information surrounding the fatality, which included law enforcement, emergency medical technicians, the district attorney, and the Medical Examiner. There was no criminality found regarding the death of the child. Law enforcement made no arrests and the Assistant District Attorney reported no criminal charges would be filed pending the final result of the autopsy. The pediatrician reported the subject child had been growing age appropriately and gaining adequate weight.

The record reflected the mother had been educated around safe sleep practices. ACS documented there were no aggravating factors which contributed to the child's death, such as multiple people on the same sleeping surface and loose bedding surrounding the child. Therefore, on 2/5/21, ACS unsubstantiated the allegations in the report, and closed the investigation after a referral was made for community based services.

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

Explain:
Sufficient information was gathered to make determination for all allegations.

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 level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion, was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Although ACS obtained information to reflect the mother placed the child in an unsafe sleep situation when she placed the infant face down on a pillow, and with a pacifier in his mouth, ACS unsubstantiated the allegation of Inadequate Guardianship of the child by the mother.

Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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: 12/09/2020 **Time of Death:** 08:55 PM

Date of fatal incident, if different than date of death: 12/04/2020
Time of fatal incident, if different than time of death: 11:45 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 11:57 PM
Did EMS respond to the scene? No
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? 30 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **In another room**

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	40 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Other Child - MA	No Role	Female	8 Year(s)

Deceased Child's Household	Other Child - MU	No Role	Male	13 Year(s)

LDSS Response

This fatality concerns the death of a two-month-old male who was rushed to the emergency room on 12/5/20. The subject child later died on 12/9/20 at 8:55PM. The medical staff reported that at the time of his death, the subject child was in a state of "metabolic acidosis." The medical tests performed prior to the subject child's death were unremarkable and there was no indication of trauma. The medical staff did not suspect child abuse. The subject child was found free of visible injuries.

The mother disclosed that the subject child was born full term, but with a medical condition. He spent four days in the Neonatal Intensive Care Unit and was discharged in good health. The SC was fed three to four ounces of formula every two hours. The Specialist documented that the mother's practice of placing the child in the unsafe sleep position at the time of the incident, was not an isolated incident, and although she was aware of the dangers of unsafe sleep position for infants, she did not understand the seriousness and consequences of the unsafe safe sleep practice. The mother declined to disclose information regarding the father of the subject child.

On 12/6/20, law enforcement completed a re-enactment of the incident and reported no criminality was found. The Assistant District Attorney reported no criminal charges were filed. The subject child's pediatrician reported the subject child was healthy and that the mother was caring and appeared very happy with the subject child.

On 12/9/20, ACS made face-to-face contact with the family at the case address and interviewed them. There were no major discrepancies in their accounts of the incident. The maternal uncle stated he felt bad about the subject child’s hospitalization and death. The maternal aunt stated that no one knew what happened to the subject child. They described how they provided care to the subject child and how fond they had grown of him.

According to case notes entered on 12/28/20, the maternal grand mother reported the maternal aunt did not seem to be affected by the loss of the subject child; however, the maternal uncle was found pensive at times and when asked he said he missed the subject child.

The Specialist assessed the maternal aunt and uncle and they were observed free of marks and bruises. They were progressing academically in remote school, and were up to date in immunizations. The home was found clean and safe, and it had appropriate accommodations for everyone. The family declined bereavement services; however, they accepted referral information. The family denied domestic violence and drug or alcohol use by the adults in the home. The family declined assistance with the burial costs and accepted assistance for rent arrears.

ACS gathered relevant information and completed safety assessments on 12/10/20, 12/11/20, 1/6/21, 2/1/21, and 2/3/21. The assessments reflected there were no safety factors identified.

On 2/5/21, ACS unsubstantiated the allegation of DOA/Fatality and Inadequate Guardianship of the subject child by the mother and maternal grandmother. ACS documented the Medical Examiner's preliminary finding included the manner of death as accident caused by unsafe sleep. However, ACS further documented the receipt or failure to receive safe sleep counseling did not impact the determination whether the parent or other person legally responsible exercised a minimum degree of care in regard to the fatality. ACS documented the mother had followed the advice of her own mother to place the subject child on his side or on his belly to help him sleep better.

ACS unsubstantiated the allegation of Inadequate Guardianship of the subject child by the mother and maternal grandmother due to a lack of credible evidence. ACS documented the family's home was appropriate; there were adequate

provisions for the children and the subject child had been developing appropriately before his death.

The family was referred to community-based services.

Official Manner and Cause of Death

Official Manner: Accident
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
057127 - Deceased Child, Male, 2 Mons	057128 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
057127 - Deceased Child, Male, 2 Mons	057129 - Grandparent, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
057127 - Deceased Child, Male, 2 Mons	057128 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
057127 - Deceased Child, Male, 2 Mons	057129 - Grandparent, Female, 40 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?	☒	☐	☐	☐
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	☒	☐	☐	☐

Explain:
During the course of the investigation sufficient information was gathered to assess risk to all surviving children in the household.

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: There was an adequate assessment of impending or immediate danger to the surviving children in the home.				

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	☐	☐	☐	☐	☐	☒	☐

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? No

Explain:
The family declined bereavement counseling 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?	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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/05/2020	Deceased Child, Male, 2 Months	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 2 Months	Grandparent, Female, 40 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
At approximately 10:00PM, on 12/4/20, the mother placed the two-month-old subject child on his side in his crib to sleep. At 11:00PM, the maternal grandmother checked the subject child and observed him on his stomach. There was blood oozing from his nostrils. He was taken to the emergency room by EMS. He had no brain activity and was placed on a ventilator. The mother signed a Do Not Resuscitate order for the subject child.

Report Determination: Unfounded | **Date of Determination:** 02/03/2021

Basis for Determination:
ACS unsubstantiated the allegations of the report based on no credible evidence. ACS based their decision on the Medical Examiner's preliminary finding of an accidental death. ACS documented the home was safe with appropriate accommodations for the subject child and noted that the mother followed the maternal grandmother's advice to place the subject child on his side or tummy to help him sleep better.

OCFS Review Results:
ACS initiated the investigation in a timely manner and made contact with medical personnel, the Medical Examiner, the family, the Assistant District Attorney, and detectives assigned to investigate possible criminal elements surrounding the injury and subsequent death of the child. ACS obtained relevant information and followed up when necessary. The report met the criteria for the ACS Heightened Oversight Protocol (HOP) and the record reflected the HOP response. There was evidence of supervisory involvement during the investigation. During the investigation of this report, the subject child died and a new report was registered with the allegations of DOA/Fatality and Inadequate Guardianship of the subject child by the mother.

ACS continued the investigation of both reports and made a determination on 2/3/21.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

The mother had no CPS history as an adult. However, the maternal grandmother had four indicated reports prior to the fatality in which the mother was the maltreated child.

Three reports dated from 5/25/07 to 4/15/10 had the concern of Educational Neglect of the mother by the maternal grandmother, and were all indicated.

The allegations of the 7/31/16 report were Lacerations, Bruises, Welts and Inadequate Guardianship of the mother by the maternal grandmother. ACS substantiated the allegation of Inadequate Guardianship on the basis of some credible evidence. ACS documented the maternal grandmother admitted to an altercation between her and the mother which caused her to put the mother out of the home without making plans for the mother's care. ACS unsubstantiated the allegation of Lacerations, Bruises, Welts, as the mother was not observed with any marks or bruises. The family received PPRS.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

The family engaged in PPRS that began on 8/18/16. The mother and her siblings engaged in casework counseling and general preventive services; the maternal grandmother received casework counseling and parenting classes. At the close of the service case on 4/21/17, there were no unmet needs.

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