Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-024

Prepared by: New York City Regional Office

Issue Date: Aug 29, 2019

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: 2 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 02/28/2019
Initial Date OCFS Notified: 02/28/2019

Presenting Information

On 2/27/19, the SM and the two-month-old male infant (SC) were at a friend's residence. The SF reported they put the SC to sleep at 4:00 AM, on 2/28/19 and when they checked on him at 10 AM, he was unresponsive. The parents called for emergency medical assistance and the SC was transported to the Lincoln Hospital (LH) where he was pronounced dead. The SC appeared to be dead longer than the parents reported and there was no explanation for the SC's death. The SC had no known preexisting medical conditions.

Executive Summary

The SCR registered a report regarding the death of this two-month-old male that occurred on 2/28/19. The allegations of the report were DOA/Fatality and IG of the SC by the parents. The report alleged the SC had no known preexisting medical conditions and the parents had no plausible explanation for the SC's death. The reported allegations are DOA/Fatality and IG of the SC by the parents. There are no surviving siblings or other children in the household.

Following the receipt of the report, the Bronx Field Office Specialist contacted LE, LH staff and parents and obtained information regarding the incident. ACS learned the parents reported they arrived at the relative's home at 2:00 AM on 2/28/19. The parents stated they placed the SC in the car seat next to the air mattress where they slept, in the living room. The SC was placed in his car seat at 3:00 AM and last checked on at 4:00 AM. This was an isolated incident. The SM stated she awoke at 10:00 AM and found the SC foaming from the mouth and unresponsive. The SF summoned 911 for emergency medical assistance and was instructed to administer CPR. EMS responded and transported the SC to LH where he was pronounced dead at 10:40 AM.

LE reported upon their arrival to the relative's home where the incident occurred, the SC was found unresponsive. The attending Dr. reported the SC was found with no signs of maltreatment or abuse on his body and that his weight and height were normal for his age. LE reported they found no criminality and no arrest was made. There were no other children in the home. The adult relative in the home declined to be interviewed and refused to provide identification.

On 2/28/19, ACS obtained information from Woodhull Hospital where the SC had received previously medical care. The SC was last examined on 2/8/19 and was doing well; there were no medical concerns. The Dr. had no concerns regarding the care the SM provided.

The SM and SC were involved in an open investigation dated 1/20/19, that alleged the SM was disabled and provided inadequate care to the SC. The report alleged the SM dressed the SC inappropriately for the weather despite having provisions. The allegations of that report were IG and IF/C/S of the SC by the SM and during the investigation, the SF was added. ACS visited the SM's unit at the shelter on 2/8/19 and it was assessed to be safe with appropriate provisions including a crib. The SC was assessed to be well. ACS provided literature and discussed safe sleep with the parents. The SM's family shelter staff reported no concerns.

The SM reported she had an untreated mental health condition, she alleged she was able to function without medication or therapy. The SM disclosed she smoked marijuana once since she gave birth; however, declined to be tested. The SM was referred to the NY Psychotherapy but she declined. The SM and SC had visited the male shelter where the SF resided; there were no reported concerns. The parents declined PPRS services but accepted information for bereavement counseling. It is unknown if either parent engaged the service.

The ME reported preliminary findings or the SC's autopsy showed no signs of trauma, abuse or injuries consistent with roll over. The ME final cause and manner of death for the SC is pending to date.

On 4/29/19, ACS substantiated the DOA/Fatality allegation of the SC by the parents citing credible evidence was found. ACS determination narrative stated the parents left the SC in a car seat throughout the night because there was no crib or play pen in the home where they spent the night.

On 4/29/19, ACS indicated the IG allegation of the SC by the parents and wrote that the parents took the SC to a home that had no crib or playpen; they failed to consider the SC's safety. The parents reported they left the SC in a car seat throughout the night and he was found unresponsive the following morning.

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:
There were no surviving siblings or other children that required CPS services.

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:
There were no surviving siblings and the parents were resistant to services.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Supervisor Review
Summary:	The same determination narrative used for the IG allegation substantiated on the 1/20/19 report was used for the DOA/Fatality allegation from the 2/28/19 report. The narrative only stated the SC slept in a car seat and not what caused the death.

Legal Reference:	18 NYCRR 432.2(b)(3)(v)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/28/2019 **Time of Death:** 10:40 AM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: Bronx
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? 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? 6 Hours
At time of incident supervisor was: Unknown if they were 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	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	21 Year(s)

LDSS Response

On 2/28/19, ACS responded to the report registered by the SCR regarding the death of the SC by contacting LH and confirming the report narrative. The parents did not have an explanation for the SC's death. The parents were named

subjects of the report.

ACS obtained information from the first responders, LE and the ME investigator, who reported after a reenactment, they found no criminality and the incident appeared to have been accidental. EMS reported upon their arrival, they observed the SF administering CPR to the SC while he laid on the air mattress; the SM was hysterical. The SM told the DR. the SC had a respiratory condition. The Dr. reported the SC was found with no indication of abuse or neglect.

On 2/28/19, the ACS Specialist interviewed the parents and their accounts were similar. According to the parents, they attended a birthday party and since they had missed their curfew at the shelter, they went to a relative's home. They arrived at 2:00 AM and since they were aware of safe sleep; they opted for the SC to sleep in the car seat as opposed to sleeping with them on the air mattress. The SM last checked on the SC at 4:00 AM prior to sleeping, the SC was well. She awoke at approximately 10:00 AM, to find the SC foaming at the mouth and unresponsive. The SM reported the SC was bottle fed formula every three hours. The SM stated the SC was wheezing and had difficulty breathing so she took him to Woodhull Hospital (WH) on 2/26/19 for care as a walk-in patient and “nothing was done.” The SM declined to give details regarding this visit.

The SM reported she smoked marijuana since the SC was born; however, she refused to state whether she smoked on the night of the incident and she declined to submit to a drug test. The SM disclosed she had an untreated mental condition that she believed she manages well without medication or treatment. The SF was uncooperative and angry. The parents denied DV and reported they were each other’s only support. The Specialist noted that the SM and the SC attended a conference at the Bronx Field Office on 2/27/19 to discuss the allegations of the 1/20/19 report. The SC was assessed to be without signs of abuse or neglect and the SM was agitated.

ACS obtained information from the SC’s Dr. at WH and it was reported that the last visit was done on 1/25/19 and the SC was observed to be developing well, had good weight, no allergies, no respiratory condition, no medication, no hospitalizations, and was deemed a well child. The parents declined to address the inconsistent date of that Dr. visit. ACS made diligent efforts to interview the relative who resided at the home the incident occurred to no avail. However, in ACS' attempts, the Specialist observed the air mattress on the living room floor. the Specialist attempted to clarify the inconsistency regarding the SC's respiratory condition but the parents declined. The parents declined services.

On 4/29/19, ACS substantiated the DOA/fatality allegation of the SC by the parents citing they found credible evidence. ACS wrote that the parents left the SC in a car seat throughout the night because there was no crib or play pen in the home where they spent the night. ACS did not document the credible evidence that may have contributed to the SC’s death.

On 4/29/19, ACS indicated the IG allegation of the SC by the parents and wrote that the parents took the SC to a home that had no crib or playpen; they failed to consider the SC’s safety. The parents reported they left the SC in a car seat throughout the night and he was found unresponsive the following morning.

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved CFRT in the new York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051190 - Deceased Child, Male, 2 Mons	051192 - Father, Male, 21 Year(s)	DOA / Fatality	Substantiated
051190 - Deceased Child, Male, 2 Mons	051192 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
051190 - Deceased Child, Male, 2 Mons	051191 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
051190 - Deceased Child, Male, 2 Mons	051191 - Mother, Female, 23 Year(s)	DOA / Fatality	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 relative declined ACS' request for an interview.

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:
Both parents were resistant to ACS offers for any type of assistance.

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 were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents declined PPRS and were given a referral to community based services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)
01/20/2019	Deceased Child, Male, 2 Months	Father, Male, 21 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 2 Months	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 2 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The report alleged the SM was disabled and was inexperienced with parenting causing her to be an inadequate caregiver to the SC who was three weeks old at the time of the report. The report further alleged that the SM had provisions for the SC and did not dress him for the elements. During the investigation, ACS added the SF to the report.

The allegations were IG, IF/C/S of the SC by the SM and IG by the SF.

Report Determination: Indicated
Date of Determination: 03/20/2019

Basis for Determination:
ACS indicated IG of the SC by the parents citing they found credible evidence. ACS wrote that the parents took the SC to a friend's home where there was no crib or bed and the SC was left in a car seat throughout the night and the SC was found unresponsive the next morning. The SC was pronounced dead at the hospital on 2/28/19.

ACS unsubstantiated the IF/C/S of the SC by the SM due to lack of credible evidence. ACS wrote that they observed clothing and adequate food in the home for the SC.

OCFS Review Results:
ACS indicated the allegation of IG based on the inadequate sleep arrangements for the SC that may have lead to the SC's demise. However, the ME's final autopsy is pending.

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

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

There was no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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

Additional Local District Comments

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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