Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-118

Prepared by: New York City Regional Office

Issue Date: Mar 23, 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: Queens
Gender: Female
Date of Death: 11/05/2019
Initial Date OCFS Notified: 11/05/2019

Presenting Information

On 11/5/19 the mother fell asleep with the 1-month-old in her arms for an unknown period of time. When the mother awoke, the child was found facing upward towards the ceiling, not breathing, and unresponsive. The child was taken to the hospital and was pronounced dead. The report alleged the lack of supervision and the unsafe sleeping arrangement contributed to the child's death. The report stated the father's role was unknown.

Executive Summary

This 1-month-old male child died on 11/5/19 and on the same date the SCR registered a report of the child's death with allegations of DOA/Fatality, Lack of Supervision, and Inadquate Guardianship of the child by the mother. There were no surviving children in the home.

Initially it was believed the mother's action of falling asleep with the child in her arms contributed to the death of the child; however, the Medical Examiner (ME) listed the cause of death as interstitial pneumonia complicated by human rhinovirus/enterovirus infection, with a contributory congenital heart disease including patent foramen ovale and patent ductus arteriosus. The manner of death was listed as natural.

ACS initiated the investigation in a timely manner and made contact with law enforcement, medical personnel at the hospital where the child had been taken before his death, the child's pediatrician, parents, and neighbors. The information provided by collaterals did not reveal any suspicions of abuse or neglect. The parents' statements remained consistent throughout the investigation and the statements were corroborated by medical records.

Based on the information obtained, the child had been ill since birth; he would "spit a lot" despite the changes the doctors made to his formula. The child often coughed and was taken to the hospital on 11/4/19 at about 7:00 PM when the mother noticed there was blood in his sputum. The mother said the physician attributed the blood to her overfeeding the child and recommended that she burped the child more often. The family returned home from the hospital at about 10:00PM on 11/4/19; the child slept until about 11:00 PM. When the child awoke the mother fed and burped him and he went back to sleep. The child awoke again at 3:00 AM on 11/5/19 and at that time he was coughing and throwing up. The child then went back to sleep and awoke at 6:00 AM at which time the mother again fed and burped him. She kept the child in bed with her; at the time the child was in bed with her, there was a blanket, pillows, and a baby blanket under the child. At 10:00 AM she noticed the child was "yellow and not responsive;" the child was in her left arm and was facing upwards. The mother initiated CPR and observed a white mucus like substance seep out from the child's mouth and nose. The mother called 911 at 10:05 AM. This information was verified by the NYPD. EMS continued CPR but the child did not respond. EMS transported the child to the hospital and the police took items of clothing and the baby's blanket as evidence. The child was pronounced dead at 10:38 AM. The father said he was not at home when the incident unfolded. This was confirmed by law enforcement.

ACS utilized various resources such as the IC who accompanied the Specialist to the hospital and to the parents address. The case documentation reflected consultation with the supervisor during the investigation. The parents were notified of the investigation as required by law.

On 3/16/20, ACS unsubstantiated the allegations of the report. To support the determination ACS used the information from the final autopsy report which listed the manner of death as natural.

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 children in the household; therefore no safety assessments were required. 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.

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 case documentation reflected the case was initiated timely, there was supervisory involvement with the ICs and Specialist. 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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/05/2019 **Time of Death:** 10:05 AM

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

County where fatality incident occurred: Queens

Was 911 or local emergency number called? Yes
Time of Call: 10:05 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:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ 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	Father	No Role	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

On 11/5/19, ACS initiated the investigation of the report by contacting law enforcement. ACS learned according to the mother when she realized the child was unresponsive, she began CPR then called 911 at 10:05 AM. EMS, FDNY, and NYPD personnel responded to the home and continued CPR. Resuscitative efforts were futile. The child was transported to the hospital and was pronounced dead at 10:38 AM. The ME's investigator along with NYPD conducted a death scene investigation and informed ACS there were no safety concerns or suspicions of abuse. NYPD further reported there were no other children in the home.

Also, on 11/5/19, the IC, Specialist, and supervisory staff conducted an initial Heightened Oversight Process (HOP) meeting as the case met the criteria for such a meeting. Following the meeting the IC accompanied the Specialist to the case address to interview the parents. The Specialist interviewed neighbors who did not report any concerns regarding the family. The neighbors expressed sympathy on the loss of the family's only child.

The Specialist contacted the parents via phone. The parents indicated they had temporarily relocated to a maternal uncle's home as they could not bear the thought that the child had died in the apartment. The parents agreed to meet with the Specialist to provide more in-depth information regarding the incident.

ACS staff conducted a number of clearances and learned the adults had no criminal history.

On 11/6/19, ACS visited the family's home and documented the one-bedroom apartment was clean. There was a crib and baby formula for the child and the home was equipped with fully functioning smoke alarm and carbon monoxide detectors.

When interviewed, the mother explained that the child had been ill since birth; he would "spit a lot" despite the changes the doctors made to his formula. The mother said the child often coughed. The mother said she took the child to the hospital on 11/4/19 at about 7:00 PM when she noticed there was blood in his sputum. The mother said the physician attributed the blood to her overfeeding the child and recommended that she burped the child more often. The mother said once she left the hospital the child began stretching and appeared to be in pain. The mother said she fed the child and he eventually fell asleep.

According to the mother the family returned home from the hospital at about 10:00PM; the child slept until about 11:00 PM. When the child awoke the mother fed and burped him and he went back to sleep. The mother stated the child awoke again at 3:00 AM on 11/5/19 and at that time he was coughing and throwing up. The mother said the child went back to sleep and awoke at 6:00 AM at which time she again fed and burped him. The mother said she kept the child in bed with her. She said at the time the child was in bed with her, there was a blanket, pillows, and a baby blanket under the child. The mother said at 10:00 AM she noticed the child was "yellow and not responsive;" the child was in her left arm and was facing upwards. The mom said she initiated CPR and observed as a white mucus like substance seeped out from the child's mouth and nose. The mother said she called 911 at 10:05 AM. This information was verified by the NYPD. EMS continued CPR but the child did not respond. EMS transported the child to the hospital and the police took items of clothing and the baby's blanket as evidence. The child was pronounced dead at 10:38 AM. The father said he was not at home when the incident unfolded.

On 11/7/19, ACS contacted the mother who reported the autopsy revealed the child had two holes in his heart, which had gone undetected at birth. Additionally, the child had pneumonia.

On 11/8/19, the Specialist obtained the child's medical records and confirmed the child had been taken to the hospital on 11/4/19. The information also confirmed the mother had reported the symptoms the child was experiencing prior to his death.

On 11/13/19, the Specialist contacted the child’s pediatrician and was told the child was seen in the office on 9/17/19, and 9/24/19 for newborn and weight checks; 10/4/19 when the mother reported the excessive spitting by the child; 10/17/19 for a well-baby visit. The doctor confirmed the mother reported the child’s apparent discomfort and spitting but stated the physical examination of the child did not reflect any issues. The pediatrician indicated the child had gained weight and had met the developmental milestone for a 1-month-old child. The doctor said the mother had prenatal care and the father was supportive.

Between 11/14/19 and 12/8/19, there were no case activities documented, and from 12/9/19 to 3/8/20 case activities involved a second HOP conference, making referrals for the parents for counseling, attempting visits to the parents’ new apartment, and contacting the ME for updates on the autopsy.

On 3/9/20, the Specialist made a visit to the family’s new apartment. The parents reported they had received the autopsy report and refused the Specialist’s referral for therapy.

Two days later, on 3/11/20, the Specialist obtained a copy of the autopsy report which listed the cause of death as interstitial pneumonia complicated by human rhinovirus/enterovirus infection, with a contributory congenital heart disease including patent foramen ovale and patent ductus arteriosus. The manner of death was listed as natural.

On 3/16/20, ACS unsubstantiated the allegations of the report on the basis that there was no credible evidence to support

the allegations of the report. ACS used the cause and manner of death provided by the ME to support the determination. The ME did not attribute the child's death to unsafe sleep.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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
053585 - Deceased Child, Female, 1 Mons	053586 - Mother, Female, 22 Year(s)	Lack of Supervision	Unsubstantiated
053585 - Deceased Child, Female, 1 Mons	053586 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
053585 - Deceased Child, Female, 1 Mons	053586 - Mother, Female, 22 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?	☒	☐	☐	☐

Additional information:

Not applicable.

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:
ACS referred the family to bereavement counseling.

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 in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services - community-based

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?	Yes

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 were no CPS investigations that occurred more than three years before the fatality that involved the deceased child and there were no other children residing in the deceased child's household at the time of 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