



Report Identification Number: NY-20-005

Prepared by: New York City Regional Office

Issue Date: Jun 21, 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: 18 day(s)

Jurisdiction: Kings
Gender: Female

Date of Death: 01/12/2020
Initial Date OCFS Notified: 01/12/2020

Presenting Information

The initial and duplicate SCR reports alleged on 1/10/2020, this 18-day-old child was discharged from the hospital to the mother, who was given discharge instructions to feed the child every three hours. On 1/11/20, at 9:00PM, the mother fed the SC and put her back to bed. On 1/12/20, at midnight, the mother attempted to feed the SC again; the SC would not take the formula and seemed somewhat lethargic. The mother was going to try again in 15 minutes; however, the mother fell asleep. The report alleged mother sleeps in the same bed with the SC. At 3:50 AM, the mother awoke to find the SC unresponsive and pale. The mother called an unknown friend and then called 911. FDNY paramedics responded and performed CPR enroute to the hospital. At 4:00AM EMS arrived at the hospital and CPR was continued by medical staff. At 4:47AM on 1/12/20 the SC was pronounced dead. SC had no preexisting conditions, thereby making her death suspicious. The report also alleged the father had an unknown role.

Executive Summary

This fatality report concerns the death of an 18-day-old female subject child (SC) that occurred on 1/10/20. A report was made to the SCR on 1/12/20 with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother (SM). The Administration for Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; the final report listed the cause and manner of death as Undetermined; however, there was reference to the child's prematurity at birth and the fact that the child had been swaddled and co-sleeping with an adult on an adult bed covered with soft bedding.

Two days prior to her death, the child was discharged from the hospital where she had been admitted since her birth in December 2019. The child's biological father resided elsewhere. He had not known about the mother's pregnancy until after the birth of the child. The investigation revealed since the child's discharge from the hospital, she had been sharing the mother's bed. The mother dog also slept on the same bed with the child. At discharge the mother was provided information regarding safe sleep and how to care for and feed the child.

On 1/11/20, at midnight, the mother attempted to feed the child; however, the child refused the bottle and appeared lethargic. The mother said she decided to wait for about fifteen minutes to attempt another feeding; however, she fell asleep. At about 3:50 AM when she awoke, she found the child pale and unresponsive. The mother called her friend and then 911 for emergency medical assistance.

Upon arrival, FDNY paramedics performed CPR and continued enroute to the hospital. The ambulance arrived at the hospital at 4:00AM and CPR was continued by the medical team. At 4:47AM on 1/12/20, the child was pronounced dead.

From the time the investigation began to the time of its closure, ACS met with parents and interviewed pertinent collateral sources. The mother relocated to a different state soon after the child's death. ACS determined the mother had been educated surrounding safe sleep practices and had placed the child at risk by choosing to co-sleep with the newborn.

However, ACS unsubstantiated the allegations of the report on the basis that before the child was discharged home the mother had asked the hospital for assistance, but no assistance was provided. The narrative did not appropriately address the determination of the allegations.

ACS closed the case as the mother had moved out of state and there were no other children in the home.



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:

The casework activity was commensurate with 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:

ACS gathered sufficient information to appropriately determine the allegations. There were no surviving siblings. Additionally, the case record reflected supervisory consultations throughout the investigation. The level of casework activity 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:	While ACS established the mother placed the newborn at risk when she co-slept with the child, ACS did not factor this into the allegation determination. Instead, ACS documented the hospital did not provide the appropriate assistance to the mother.
Legal Reference:	FCA 1012 (e) & (f); 18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities



Incident Information

Date of Death: 01/12/2020

Time of Death: 04:47 AM

Time of fatal incident, if different than time of death:

03:42 AM

County where fatality incident occurred:

Kings

Was 911 or local emergency number called?

Yes

Time of Call:

03:58 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

Absent

Alcohol Impaired

Asleep

Distracted

Impaired by illness

Impaired by disability

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	18 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Other Household 1	Father	No Role	Male	35 Year(s)

LDSS Response

On 1/12/20, ACS received the SCR report regarding the death of SC, which occurred on the same date. ACS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACS learned SC was an only child and promptly began gathering information surrounding her death.

On 1/13/20, the Specialist spoke with the mother. The mother reported that she became aware of her pregnancy on 12/22/19 after undergoing tests for what she thought was an unrelated issue. The mother said she had no symptoms of pregnancy. The mother said because she was not aware of the pregnancy she continued to drink alcohol and smoke cigarettes as usual. The child was born prematurely on Christmas Day and remained hospitalized for thirteen days. The child was transferred from Coney Island Hospital to Bellevue Hospital to undergo further treatment.



On 1/9/20, the child was discharged home. The mother said on 1/10/20, the child had difficulty drinking the formula and vomited. The mother said she called the father and indicated she wanted to take the child to the hospital; however, the father persuaded her to wait a while. On 1/11/20, the child appeared well and the father provided most of the care until he left for work at 8:30 PM. At about 9:00PM she fed the child and went to sleep on her bed. The mother said the child and her (the mother's) dog were also on the bed. At about 11:45PM she attempted to feed the child, but the child refused the bottle. The mother said she decided to wait for about 15 minutes before feeding the child, but fell asleep. The mother said when she awoke it was 3:45 AM the child was unresponsive and cold. The mother said she called a friend who then called 911. The mother said the ambulance arrived within 4minutes of the call and the child was taken to the hospital. The child was pronounced dead at 4:47 AM on 1/12/20.

ACS made contact with the father who's account was consistent with the mother's from the point at which she called him to alert him to the death of the child.

For the duration of the investigation, ACS contacted pertinent collateral sources such as the hospital, the friend whom the mother had called, neighbors, and some family members. Information obtained was explored.

On 5/22/20, ACS unsubstantiated the allegations of the report and closed their case.

Official Manner and Cause of Death

Official Manner: Undetermined

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
054269 - Deceased Child, Female, 18 Days	054270 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
054269 - Deceased Child, Female, 18 Days	054270 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

The CPS interviewed relevant collaterals and made follow-up visits as the circumstances necessitated.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Parenting Skills	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Domestic Violence Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Early Intervention	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Child Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Additional information, if necessary:
 Following the death of the child, the mother moved out of state.

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 other siblings and no other children in the household. The parents' only child had died.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No

Explain:

The parents refused all assistance from ACS.

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 investigation that occurred more than three years before the fatality that involved the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality. The parents only child died.

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

N/A

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