Child Fatality Report

Report Identification Number: NY-21-014

Prepared by: New York City Regional Office

Issue Date: Aug 06, 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 | **Jurisdiction:** Bronx | **Date of Death:** 02/09/2021
Age: 2 month(s) | **Gender:** Male | **Initial Date OCFS Notified:** 02/09/2021

Presenting Information

According to the narrative of the SCR report , the father fed the two-month-old male and placed him to sleep on the sofa, face down. The SM and PGM were in their respective bedrooms. At approximately 7:00AM, the mother awoke and found the child unresponsive. She called 911. EMS responded to the case address and transported the child to the hospital where he was pronounced dead at 8:10AM, on 2/9/21.

Executive Summary

This fatality report concerns the death of a two-month-old male that occurred on 2/9/21. A report was registered by the SCR on the same date. The allegations of the report were DOA/Fatality, and Inadequate Guardianship of the two-month-old male subject child by his parents and paternal grandmother. The ME reported the preliminary cause of the SC's death "positional asphyxia;" however, the final report was pending.

At the time of the fatality the subject child resided with his parents; his grandmother was visiting the home. The SF had a five-year-old son who resided with his mother at a separate location. There were no other siblings.

According to ACS's investigation, on 2/9/21 at approximately 4:00 AM the SC awoke for feeding. The SM handed him to the SF as it was his turn to provide care for the SC. The SF fed the SC and placed him to sleep on the sofa, wrapped in an infant's blanket, positioned face down which was soothing. The SF also fell asleep on the sofa with the child. At approximately 7:00AM, the SM awoke and found the SC unresponsive. She alerted the SF to the SC's condition and he initiated CPR while the SM contacted 911. EMS responded to the case address and transported the SC to the hospital where he was pronounced dead at 8:10AM, on 2/9/21.

Medical staff reported the SC was dead upon arrival. The SC's body had no visible sign of injury. The ME reported there was no evidence of trauma to the SC; the toxicology and microbiology tests results were negative. LE found no evidence of criminality.

ACS referred the parents to bereavement counseling. The parents declined to submit to drug tests.

On 6/4/2021, ACS unfounded the report citing a lack of credible evidence to support the substantiation of the allegations.

OCFS does not agree with the determination regarding Inadequate Guardianship. ACS's investigation revealed the child was wrapped in a baby blanket and placed face down to sleep on a sofa that was already being occupied by her father. The parents actions and inactions created an unsafe sleep situation.

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?**	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?**	No

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 ACS investigation met regulatory requirements. 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:	Referring to the allegation of IG, the parents wrapped the two-month-old male child in an infant blanket and placed the child face down on a sofa that was being used by the father. The parents actions and inactions created an unsafe sleep situation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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 attended and what was discussed

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/09/2021 **Time of Death:** 08:10 AM

Time of fatal incident, if different than time of death: 07:11 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 07:11 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:

- [x] 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? 3 Hours
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- [ ] Distracted
- [ ] Absent
- [x] Asleep
- [ ] 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	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	57 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

ACS initiated an investigation into the death of the two-month-old SC by interviewing the hospital staff and the parents. The physician reported the SC arrived at the hospital at 7:51AM on 2/9/21, via EMS. All efforts to resuscitate the SC failed and he was pronounced dead at 8:10AM on the same day. The SC was free of marks and bruises and there were no concerns of foul play.

The SM explained to the Specialist that approximately 4:00AM, when the SC began to cry, she got up and carried the SC to the BF who was on the sofa. The SM explained she and the SF took turns feeding and caring for the SC and that time was the SF’s turn. The SM stated she gave the SC to the SF who laid the SC face down on the couch. BM stated that she went back to the bedroom to sleep. She awoke at 7:11 AM, went into the living room to check the SC, and found him unresponsive. She shook the SF, woke him up and told him the child was not moving. She stated she immediately called 911 while the SF took the SC to the bedroom, placed him on the changing bed, and initiated CPR, for which he was trained. The parents reported EMS responded quickly and continued resuscitation efforts. EMS transported the SC and the SM, while the SF stayed behind to pack a bag for the SC because the SC had been taken from the home without clothes. The BF’s account was similar to that of the SM. The SM explained that the BF must have been very tired because he would have placed the SC in the crib as usual and go to bed. The BF added that when he went downstairs, the ambulance

had left, he took an Uber to the hospital, where he was met by two officers who questioned him about the incident. There was no arrest made. The parents denied alcohol or drug use, mental health, or DV in the home.

The PGM stated she arrived at the home at approximately 8:00AM on the day before the incident to visit the grandchildren; however, the SS was not there and was expected later in the afternoon. She routinely visited on weekends. She explained everything was normal, they fed, played with, and attended to the SC. She reported the SC had no marks or bruises and did not appear to have had any difficulty breathing. The PGM said the following morning she learned that the parents had woken up and found the SC not breathing. The PGM reported she did not observe any signs of drug or alcohol use. Both parents denied they received Safe Sleep training and ACS verified the statement made by the parents that they did not receive safe sleep information.

The SC's pediatrician reported the last well-baby visit occurred on 12/2/20 and the SC was deemed well; there were no concerns. He did not receive immunizations at that time. The ACS Specialist received the SS's medical information that reflected immunizations were current. The SS's mother declined an interview and reluctantly allowed the Specialist access to the SS who was deemed safe.

As of 5/11/21, ACS received information from the ME that the SC's tests results were negative. The ME noted there were no additional findings to date; the death was consistent with Sudden Unexpected Infant Death related to unsafe sleep conditions. However, the final report was pending.

On 6/7/21, ACS unsubstantiated the allegations of DOA/ fatality and IG of the SC by the parents and PGM. The Specialist cited the results of their investigation that reflected the parents acted appropriately in calling EMS when they found the SC responsive. ACS supported their determination by summarizing the results of their investigation.

NYCRO does not agree with the determination as it pertains to Inadequate Guardianship. The parents placed the child face down on a sofa that was being used by the SF. This created an unsafe sleep location and position (condition) for the child.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057912 - Deceased Child, Male, 2 Mons	057913 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
057912 - Deceased Child, Male, 2 Mons	057913 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
057912 - Deceased Child, Male, 2 Mons	057914 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated

057912 - Deceased Child, Male, 2 Mons	057914 - Father, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
057912 - Deceased Child, Male, 2 Mons	057915 - Grandparent, Female, 57 Year(s)	DOA / Fatality	Unsubstantiated
057912 - Deceased Child, Male, 2 Mons	057915 - Grandparent, Female, 57 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?	☐	☒	☐	☐

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:
Sufficient information gathered to assess risk to all surviving children. The parents accepted information regarding bereavement counseling; however, it was unknown whether they enrolled. The parents received burial funds.

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 SS resided with his mother and visited the SF on weekends. The mother declined any involvement with the ACS; however, allowed the SS to be assessed and interviewed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were referred for bereavement counseling.

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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:
- ☐ Drug exposed
- ☐ With fetal alcohol effects or syndrome
- ☒ With neither of the issues listed noted in case record

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

The SF was known to ACS as a confirmed subject in two reports. On 4/14/16, the SCR reported an allegation of IG of the SS by the SF. The allegation of IG by the SF was substantiated based on the results of the ACS investigation.

On 5/5/17, the SCR registered another report that alleged LS and PD/AM of the SS by the BF. The allegation of PD/AM was substantiated and LS was unsubstantiated.

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