Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-060

Prepared by: New York City Regional Office

Issue Date: Nov 19, 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: 10 month(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 05/29/2021
Initial Date OCFS Notified: 05/29/2021

Presenting Information

An SCR report received on 5/29/21 alleged the 10-month-old infant passed away on that date while he was in the care and custody of the father. A duplicate report received on the same date alleged the infant woke up early and the father changed his diaper. At an unknown time later, the father placed the infant down for a nap on a queen sized bed. The father placed a crib up against the side of the bed to prevent the infant from rolling off the bed. Shortly before 12:48 PM, the father went to check on the infant and he found the infant between the bed and the crib railing. The infant was unconscious, not breathing, and blue in the face. The father immediately notified the paternal grandmother, who notified authorities. The paternal uncles drove the infant to the hospital and they arrived at 12:55 PM. At that time, hospital staff performed CPR on the infant, but were unsuccessful. As a result, the infant died at 2:42 PM due to unsafe sleep.

Executive Summary

This fatality report concerns the death of the 10-month-old male infant that occurred on 5/29/21. Two reports were made to the SCR on that same date, with allegations of DOA/Fatality and Inadequate Guardianship against the infant's father. The Administration for Children's Services (ACS) received the reports and investigated the infant's death. At the time of the infant's death, he resided with his parents and 4-year-old sibling. The family resided in a multi-family home with the paternal grandparents, 18-year-old paternal uncle, a paternal aunt and uncle and their 8-month-old and 2-year-old children (cousins).

The investigation revealed that on 5/29/21, the mother fed the infant a bottle then placed him on the parents' queen-sized bed to sleep. She placed pillows around the infant, and made sure the crib was pushed up against the bed to prevent him from rolling off the bed. She told the father, who was sleeping on the couch with the sibling, that she was leaving and she went to work around 7:00 AM. When the father got up around 8:00 AM, he went upstairs to check on the infant. The infant was sleeping on the bed and he appeared to be fine at that time. The father went back downstairs and made breakfast for the sibling. When the father checked on the infant a second time, he found the infant to be wedged between the bed and the crib and he was unresponsive. The father ran downstairs with the infant and alerted the grandparents, aunt and uncles, and 911 was called at 12:48 PM. The family believed first responders were taking too long so the two uncles drove the infant to the nearby hospital. Attempts to resuscitate the infant were unsuccessful and he was pronounced deceased at 2:42 PM.

The family objected to a complete/internal autopsy, therefore only an external examination was conducted and there were no injuries observed. The manner of death was ruled to be accidental, and the cause of death was positional asphyxia. Law enforcement found no criminality or foul play and they closed their investigation with no charges filed.

The home was assessed to be safe, and the cousins and sibling were assessed to be safe in their parents' care. Safe sleep education was provided to the aunt and uncle for the 8-month-old cousin and a safe sleep environment was observed.

ACS unsubstantiated the allegation of DOA/Fatality against the father due to the medical examiner stating he was unable to determine if the parents' actions contributed to or caused the infant's death. ACS unsubstantiated the allegation of Inadequate Guardianship against the father since the father was present in the home when the incident occurred, he had previously checked on the infant and found him to be asleep and breathing and the father immediately sought medical attention for the infant upon discovering he was unresponsive. Based on the evidence gathered, the allegation of

Inadequate Guardianship should have been added against the mother and substantiated against both parents. ACS' investigation found credible evidence that the parents placed the infant at risk of harm, and they failed to meet a minimum degree of care by leaving the 10-month-old infant unattended for several hours in an unsafe sleep environment on an adult bed with pillows. The parents had knowledge of the infants' age and stage of development and based on the likelihood that the infant could fall off the bed if left unattended, they pushed a crib up against the side of the bed to prevent him from rolling off. While unattended the infant rolled off the bed and became wedged between the bed and the crib.

ACS conducted a child safety conference and family court intervention was not sought. The family was referred for bereavement services and the parents engaged in a grief support group. The parents planned to enroll the sibling in counseling services in the future if necessary and they declined burial assistance and preventive services.

PIP Requirement
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, 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.

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?** No

Explain:
There was credible evidence gathered that the parents failed to meet a minimum degree of care by leaving the infant unattended on an adult bed with pillows and a crib pushed against the side of the bed. Given the infants' stage of development, the unsafe sleep environment combined with the parents' failure to properly supervise the infant, placed him at risk of harm.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The case determination was not consistent with regulatory requirements.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	There was credible evidence gathered to substantiate the allegation of Inadequate Guardianship against the mother and father.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/29/2021 **Time of Death:** 02:42 PM

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

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: 12:48 PM
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? N/A
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 was supervisor impaired? Not impaired.
At time of incident supervisor was:

☒ Distracted ☐ Absent
☐ 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	Aunt/Uncle	No Role	Male	28 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	27 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	63 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	54 Year(s)
Deceased Child's Household	Mother	No Role	Female	29 Year(s)
Deceased Child's Household	Other Child - 2-year-old Cousin	No Role	Female	2 Year(s)
Deceased Child's Household	Other Child - 8-month-old Cousin	No Role	Female	8 Month(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

ACS began their investigation upon receipt of the SCR reports on 5/29/21. They adhered to approved protocols for a joint investigation with law enforcement and they interviewed the mother, father, grandparents, aunt, and uncles. Attempts to interview the sibling were unsuccessful. ACS spoke to the sources of the reports, family members, law enforcement, the medical examiner's office, hospital staff, and the pediatrician.

ACS conducted a home visit on 5/29/21 following receipt of the SCR report. The paternal uncles were interviewed, and they denied entry to the home or access to the parents or children since the family was grieving. The uncles stated that they were on the first floor of the home when the father found the infant unresponsive and he carried the infant downstairs to them. The father did CPR and 911 was contacted. When first responders did not arrive as quickly as expected, the uncles drove the infant to the hospital, which was only a few minutes away. Neither uncle had concerns for the parents' care of the children.

Hospital staff stated that the two uncles arrived at the hospital with the infant around 1:00 PM. Upon arrival, the infant was not breathing, was bluish in color and his body temperature was 87.5 degrees. Rigor mortis had begun and the infant's jaw was frozen in place. The infant was found to have no nerve activity. Efforts to resuscitate the infant lasted one and a half hours without success and the infant was pronounced deceased at 2:42 PM. The infant's body was observed to have no marks or bruises and the infant had no known illness or medical condition prior to the incident. The parents arrived at the hospital after the infant was pronounced deceased.

Law enforcement reported that the mother fed the infant then placed him on a bed to sleep in the upstairs bedroom before she left for work around 7:00 AM. The father was downstairs with the sibling, and he made breakfast and bathed the sibling prior to checking on the infant. When the father checked on the infant around noon, he found the infant lying between the bed and the crib unresponsive. The father alerted family members and 911 was called at 12:48 PM. The uncles decided to drive the infant to the hospital. No criminality was suspected, and the incident appeared to be an accident. Pediatrician records showed the infant was not meeting some of his milestones, but he was healthy and had no diagnosis or medical condition.

The parents, paternal grandparents, paternal uncles, and paternal aunt were interviewed on 5/31/21 and the home was assessed to be safe. The mother reported that the infant was rolling over and pulling himself up, but she had never seen him try to walk or get off the bed. She said the infant slept in his crib at times and in bed with her at times. The infant's

crib was always pushed up against one side of the bed to prevent the infant from falling off the bed. On 5/29/21, she laid the infant in the middle of the bed, she placed pillows on one side of the bed, and she made sure the crib was pushed up against the bed on the other side. She told the father she was leaving, and she left for work. She later received a phone call from the father telling her to come home. The father reported that he and the sibling were sleeping on the couch downstairs when the mother left for work around 7:00 AM. He woke up around 8:00 AM and he checked on the infant. He observed the infant on the queen-sized bed surrounded by pillows and one side of the bed was secured by the crib. He went back downstairs to feed the sibling. He denied hearing the infant crying and just prior to 1:00 he found the infant wedged feet first between the crib and the bed.

The grandparents and aunt reported that they were on the main floor of the home when they heard the father yelling and he was holding the infant in his arms. They called 911 and the uncles did not want to wait for the ambulance to arrive. They had no concerns for the care of the children.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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
058623 - Deceased Child, Male, 10 Month(s)	058672 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
058623 - Deceased Child, Male, 10 Month(s)	058672 - Father, Male, 30 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:
ACS assessed the safety of the children within 24 hours by speaking to the uncles and collateral resources. The family would not allow ACS to have access to the children until 5/31/21, therefore the 24-hour Safety Assessment was

completed and approved in Connections one day late on 5/31/21. Risk was adequately assessed and services related to the fatality were offered.

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?	☐	☒	☐	☐

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 sibling was referred for grief counseling and the parents declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents enrolled in a grief support group. The family declined funeral assistance and Preventive 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

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 investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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