Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-091

Prepared by: New York City Regional Office

Issue Date: Jan 15, 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		

Case Information

Report Type: Child Deceased
Age: 25 day(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 07/28/2019
Initial Date OCFS Notified: 07/28/2019

Presenting Information

On 7/28/19, the SCR registered two reports regarding the SC's death.

According to the reports, at approximately 3:00 A.M., the mother was awake with the SC and fell asleep with him on her bed. The mother woke up at approximately 11:30 A.M. and found the SC unresponsive and bleeding from his mouth and nose. The family called 911 and administered CPR until EMS arrived and transported the SC to the hospital. The SC was pronounced dead at 12:27 P.M. The mother reported she might have rolled over on the SC. The report stated the SC had no pre-existing medical condition.

Executive Summary

The SC was 25 days old when he died on 7/28/19. The autopsy report listed the cause of death as undetermined (co-sleeping on adult bed) and the manner of death undetermined.

The SC resided with his mother, MGF and his paramour, and her 13-yo son who had special needs. The SC's father resided in a separate household; however, was co-parenting with the mother.

On 7/28/19, the SCR registered two reports with allegations of DOA/FATL, II and IG of the SC by the mother and the MGF.

According to the mother she fell asleep while breastfeeding the SC and when she woke up, he was unresponsive. EMS was called and transported the SC to the hospital where he was pronounced dead. This was the parents' only child.

ACS initiated the investigation timely and assessed the home to have adequate provisions for the SC prior to his death. ACS deemed the 13-yo to be safe in the care of his mother and the MGF. The 13-yo had no marks or bruises throughout the investigation, and all his needs were being met. ACS attempted to interview the 13-yo; however, due to his limited verbal skills, he was unable to articulate any details regarding the incident.

ACS made relevant collateral contact with the NYPD and was informed there were no signs of criminality surrounding the SC's death. Neither the medical staff nor the ME found any evidence of abuse or maltreatment.

ACS interviewed the children's pediatrician, neighbors, and family members; no one had concerns about the manner in which the mother cared for the SC.

The MGF had a 16-yo child, (MA) who was in the legal custody of the MGGM for the past three years. ACS requested a courtesy visit from Suffolk County and assessed the MA to be well cared for by the MGGM. The MGGM and the MA reported they had no concerns about the mother nor the MGF hurting the SC.

As per ACS' protocol, two Child Safety Conferences (CSC) were held with the mother even though she had no surviving children. During the last CSC, the mother reported that she was no longer staying with the MGF because he and the paramour blamed her for the SC's death. ACS offered the mother services; however, it was unknown whether she followed up with the referrals.

As of the writing of this report, ACS had not made a determination.

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?** N/A

Was the decision to close the case appropriate? N/A

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 determination is pending.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The CONNECTIONS event lists did not reflect that ACS issued a NOE to the father for each report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	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.,
Issue:	Overall Completeness and Adequacy of Investigations
Summary:	The case documentation did not reflect that the Specialist was provided with case specific supervisory directives; therefore, CSCs were held although the mother had no surviving children, and a FSS was opened.
Legal Reference:	SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:	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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/28/2019 **Time of Death:** 27:27 PM

Time of fatal incident, if different than time of death: 12:27 PM

County where fatality incident occurred: Kings
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? 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
How long before incident was the child last seen by caretaker? 5 Hours
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	Male	25 Day(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	50 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Other Adult - MGF's girlfriend	No Role	Female	47 Year(s)
Other Household 1	Father	No Role	Male	21 Year(s)

LDSS Response

Upon receipt of the reports, ACS interviewed first responders, providers, and family members.

According to the mother, on 7/27/19, she and the SC woke up at 7:00 A.M.; she fed him, changed him, and then laid with him on the bed. The mother said they usually played with the SC on the bed and she would put him on the right side of the bed as she felt it was the safer side because it was touching the wall. The mother used the wall to prevent him from falling off. The mother said the SC fell asleep and at about 4 P.M., her friend came over to visit her and the SC. At about at 6:51 P.M., she left the SC with the MGF and went out with her friend, and they returned to the home sometime between 8:00 P.M. and 8:30 P.M. The mother said once she arrived, she took the SC upstairs to their room and fed him. The mother said her friend left at 12:00 A.M. and she laid in bed with the SC. The mother said she fed the SC again and placed him to sleep in his crib. The mother reported that at 3:00 A.M. on 7/28/19, the SC woke up crying and she breastfed him and fell asleep while doing so. The mother said at approximately 11:30 A.M. she woke up and noticed there was blood all over. The mother said she picked up the SC and noticed the blood was from her cesarean section, but the SC was not responsive.

The mother said she placed the SC on the changing table and administered CPR, and then saw there was blood coming out of his nose. The mother said she noticed the SC was dead and ran over to the MGF who in turn called 911. The mother said she use to sit up to breastfeed the SC, but as a result of the epidural she received during the cesarean section she was experiencing back pain, so it was less painful when she laid down to feed him. The mother stated the SC's face was "smashed in and he had bruising on his rib wall;" however, none of the first responders nor the ME reported any marks or bruises on the SC. The mother reported she had received safe sleep education from the hospital prior to the SC's discharge and that the MGF constantly reminded her to place the SC to sleep in the crib.

The mother reported the SC had no medical complications at birth. Regarding the SC's father, the mother said they were not in a relationship, but were co-parenting. The mother reported she was not under the influence of drugs or alcohol. The mother and the MGF submitted to drug screenings and the results were negative.

The MGF reported he was in the bathroom at approximately 11:40 AM when he heard the mother frantically call him and when he saw her, she was covered with blood. The MGF said the mother was saying the "the baby's dead"; then she said, "what did I do?" The MGF said he checked the SC for a pulse and heartbeat, but there was neither, so he immediately called 911. The MGF reported the mother was thrilled when she gave birth to the SC even though she had a difficult pregnancy. The father said the mother was a very good parent and chose to breastfeed the SC. The MGF's paramour said she was in the lower level of the home when she heard the commotion coming from the mother's room. The paramour said she ran upstairs and observed the SC lying on the changing table with his arms extended out over the edge of the table. The paramour said the SC had blood coming from his nose down the right side of his face. The paramour said she was horrified and walked out of the room. The paramour said the mother was very loving and affectionate towards the SC and confirmed that she and the MGF had on several occasions reminded the mother to place the SC to sleep in the crib. The paramour said the mother's room had no window space, so they had two fans in the room and left the door open for the cool air from the air conditioner in the hallway to circulate into the room.

The pediatrician stated the SC was healthy and at the last well visit he weighed 7 pounds.

As of the writing of this report, the determination was pending.

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)?No

Comments: There was no documentation of an MDT response; however, the investigation adhered to previously approved protocols for joint investigations.

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
050941 - Deceased Child, Male, 25 Days	050942 - Mother, Female, 19 Year(s)	Internal Injuries	Pending
050941 - Deceased Child, Male, 25 Days	050942 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Pending
050941 - Deceased Child, Male, 25 Days	050942 - Mother, Female, 19 Year(s)	DOA / Fatality	Pending
050941 - Deceased Child, Male, 25 Days	052596 - Grandparent, Male, 50 Year(s)	DOA / Fatality	Pending
050941 - Deceased Child, Male, 25 Days	052596 - Grandparent, Male, 50 Year(s)	Inadequate Guardianship	Pending
050941 - Deceased Child, Male, 25 Days	052596 - Grandparent, Male, 50 Year(s)	Internal Injuries	Pending

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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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:
The parents had no surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There was no immediate needs in response to the fatality.

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 is no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family had no known CPS history outside 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