Child Fatality Report

Report Identification Number: NY-20-117

Prepared by: New York City Regional Office

Issue Date: Jun 22, 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: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/20/2020
Initial Date OCFS Notified: 12/21/2020

Presenting Information

The SCR report alleged on 12/19/20, the subject child (SC) was asleep in a bassinet. At about 5:15PM, the SC was observed to be sleeping soundly. At about 5:45PM, a cousin found the SC's bassinet tipped over and he was unresponsive. There was blood found in the SC's bassinet. The cousin performed CPR on the SC and blood came out of the SC's nose. EMS was called and the SC was transported to the hospital. The SC was immediately put on life-support. At 1:06PM on 12/20/20, the SC was pronounced deceased. The SC had a runny nose but was otherwise healthy. When at the hospital, a scan was performed, and it was found that he had a brain bleed. The parents did not have any explanation as to what happened to the SC.

Executive Summary

The six-week-old SC died on 12/20/20 while in the care of his parents. According to the ME, the cause and manner of death were undetermined.

ACS' case documentation reflected on 12/19/20, the SC was placed to sleep face down on his stomach in a portable, foldable, baby-bed travel bassinet that was placed on top of a bed, with one of the bassinet's sides leaning on and being supported by a wall. The lights in the room were turned off due to the family's religious observance, and there was no adult with the SC in the room. At 5:45PM, an adult cousin checked the SC and found the SC's bassinet tipped over to the side and the SC was unresponsive. The cousin brought the SC downstairs to the rest of the family and 911 was called. The MA performed CPR on the SC until EMS' arrival on the scene.

EMS arrived and found the SC pulseless with blood in his mouth and nostrils. EMS continued CPR and then transported the SC to the hospital where he was placed on a life-support equipment. A CAT-scan, skeletal survey, and ophthalmological examinations were performed; no abnormalities were noted. The SC was stabilized and admitted to the pediatric intensive care unit (PICU) for further care. The SC again became pulseless while in the PICU and required another round of resuscitation; however, his condition was unresponsive. At 1:06PM on 12/20/20, the medical team pronounced the SC deceased.

The family objected to an autopsy due to their religious beliefs; however, the ME stated based on the external examination only, there were no suspicious marks or bruises on the SC. At the time of the fatality, the family was visiting extended family members for a religious holiday.

ACS initiated the CPS investigation within the mandated timeframe and obtained information from the family and relevant collaterals such as the ME, the pediatrician, the school staff, the service provider, and the hospital staff. ACS also visited the address where the incident took place and interviewed the assigned LE. The information obtained did not reveal the SC's death was indicative of abuse. LE did not suspect any criminality, and no arrest was made. The parents and the pediatrician did not report any preexisting medical condition for the SC and there were no immediate concerns reported for the care of the two SSs. Throughout the investigation, ACS assessed both SSs and deemed them safe through home and virtual visits, interviews with the family, and medical providers.

ACS held a child safety conference and the participants at the conference recommended PPRS for the family. The family accepted the services and the service provider reported the family was cooperating with the service plan. Additionally, the family attended a forensic interview at the Child Advocacy Center, but the two SSs refused to be interviewed.

On 2/11/2021, ACS substantiated the allegation of IG of the SC by the parents based on the evidence obtained from the ME, the medical staff as well the family. The parents left the SC unattended upstairs while the family remained on the first floor eating dinner. The family did not properly check the SC. The SC was also placed in an unsafe sleep position in an unsafe sleeping apparatus. Based on tests conducted, the hospital's Child Abuse Specialist reported that the SC suffered a pulmonary hemorrhage from suffocating.

ACS unsubstantiated the allegations DOA/FATL and II of the SC by the parents due to lack of credible evidence. The ME deemed the SC's death accidental and reported the cause and manner of death were undetermined. The family was not aware that the bassinet was not a safe sleeping apparatus for the SC. Additionally, the ME and the medical staff stated there were no marks or bruises suspicious of abuse to the SC.

The SSs remained in the care of their parents.

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?** Yes

Explain:
Casework activity was commensurate with case circumstances and sufficient information was gathered to make a determination for all the allegations.

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

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 surviving siblings remained in the care and custody of their parents. The parents were engaged in services, and the service provider reported the family was functioning well. The BM stated that she was happy for the opportunity to

obtain parenting classes. The family did not need additional support or services as they had the family support and the services they needed to cope with their loss.

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: 12/20/2020 **Time of Death:** 01:06 PM

Date of fatal incident, if different than date of death: 12/19/2020
Time of fatal incident, if different than time of death: 05:42 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 05:42 PM
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? No - but needed
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	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

On 12/21/2020, LE reported the SC's cousin who found him unresponsive was not a person legally responsible for the SC. Based on initial medical findings, LE was not making any arrests.

On 12/21/2020, the ME stated an external examination of the SC was conducted due to the family's objection to an autopsy. As a result, the cause and manner of death were undetermined, but cited poor supervision as the SC was placed in an unsafe sleep situation and not properly supervised. The ME deemed the SC's death accidental.

On 12/21/2020, the physician reported the SC arrived at the hospital unresponsive, without a pulse, and in cardiac arrest. There were no marks or bruises on the SC.

On 12/21/2020, the pediatrician reported the SC was born full term and delivered by a midwife via a home birth. The SC's newborn screening tests were normal with no genetic concerns.

On 12/22/2020, ACS visited the family at the case address. ACS discussed safe sleep practices with the family. The BM stated she routinely placed the SC to sleep on his back and stomach. She stated she purchased the bassinet because it had great reviews. ACS observed that the bassinet was advertised as a travel bed, bassinet and changing table. The BM denied the SC was rolling or lifting himself. She also denied feeling overwhelmed. She stated to deal with their loss the family had self-engaged in services with a private service provider. ACS provided the family with referral information for services. ACS assessed the home and deemed it safe for the two SSs.

On 12/23/2020, ACS visited the MU's home where the incident occurred. The maternal family denied any concerns regarding the parents' ability to care for the children. They stated they were available to support the family.

On 12/28/2020, the school staff did not report any developmental delays or behavioral concerns for the 3-yo SS. There were no concerns regarding his care.

On 12/28/2020, medical staff reported that based on tests conducted, the SC had been unconscious for a long time. The SC suffered a pulmonary hemorrhage from suffocating.

On 12/28/2020, the service provider stated the family was in receipt of crisis and trauma intervention services.

On 12/28/2020, the pediatrician stated the children were immunized at a slower pace at the parents' request. The parents were involved with the children's care.

On 12/28/2020, the hospital Child Abuse Specialist (CAS) stated based on assessment and the information obtained from LE, the SC was likely a victim of accidental asphyxiation in an unsafe sleeping environment. The combination of the travel bassinet's non-reinforced, flexible bottom coupled with the soft surface of the bed allowed the SC to sink and become trapped between the wall and the bed. The CAS disagreed that the bassinet was a "safe" sleeper for infants. As a result, the CAS and the medical team decided to report the product to the Consumer Product Safety Commission to prevent similar situations from occurring in the future.

On 12/29/2020, ACS held a child safety conference (CSC). PPRS services were recommended for the family. The parents agreed to the service plan.

On 1/14/2021, the service provider reported the family had begun services and were functioning well.

Between 1/15/2021 and 2/9/2021, ACS made multiple home and virtual visits to the family and contacted collaterals. There was no new information regarding the fatality. ACS assessed the surviving siblings and deemed them safe. The parents reported the siblings were seen by the pediatrician on 1/13/2021 and were doing well. The family continued to engage in services. The BM stated she was happy for the opportunity to obtain parenting classes.

On 2/11/2021, ACS substantiated the allegation of IG of the SC by the parents. ACS unsubstantiated the allegations DOA/FATL and II of the SC by the parents.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055957 - Deceased Child, Male, 1 Mons	057411 - Father, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
055957 - Deceased Child, Male, 1 Mons	057411 - Father, Male, 40 Year(s)	Internal Injuries	Unsubstantiated
055957 - Deceased Child, Male, 1 Mons	057410 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
055957 - Deceased Child, Male, 1 Mons	057410 - Mother, Female, 38 Year(s)	Internal Injuries	Unsubstantiated
055957 - Deceased Child, Male, 1 Mons	057411 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
055957 - Deceased Child, Male, 1 Mons	057410 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated

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:

ACS attempted to interview the two SSs, but they were uncooperative despite their parents encouraging them to talk to ACS.

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: Sufficient information was gathered to assess risk to all surviving children in the household.				

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/19/2020	Deceased Child, Male, 2 Months	Father, Male, 40 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 2 Months	Aunt/Uncle, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Months	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	

Report Summary:
While visiting extended family members for a holiday, the parents placed the SC to sleep in his bassinet. When the BM's niece checked the SC, the niece found him unresponsive, on the floor. CPR was performed to revive the SC. The SC was in a coma.

Report Determination: Indicated **Date of Determination:** 02/11/2021

Basis for Determination:
ACS substantiated the allegation of IG of the SC by the parents due to the fact that the parents placed the SC in an unsafe

sleeping environment and did not provide an appropriate supervision plan for the SC. The family did not properly check the SC due to the holiday and were unable to turn on the light in the room where the SC was sleeping. The SC was later found wedged between the bed and the bassinet and was unresponsive. Based on the ME's assessment, the SC appeared to have been unconscious for a long period time.

ACS unsubstantiated the allegation of IG against the BM's niece. The niece was not the person legally responsible for the SC when the incident occurred.

OCFS Review Results:
ACS made the appropriate collateral contacts with the hospital staff, the ME, LE, the parents and relatives. There was evidence of supervisory involvement throughout the investigation. Based on the evidence gathered during the investigation, ACS' decision to substantiate the allegation of IG of the now deceased SC by the parents was appropriate.

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

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

The family had 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