Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-098

Prepared by: New York City Regional Office

Issue Date: Feb 20, 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: 6 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 08/21/2019
Initial Date OCFS Notified: 08/21/2019

Presenting Information

On 8/21/19, the SCR registered a report concerning the death of the SC. The report alleged that at approximately 1:30 A.M., the mother left the 6-month-old SC lying on a bed unattended. The mother fell asleep watching TV and awakened at 5:30 A.M. and when she returned to the room she found the SC face down and unresponsive. The mother called 911 and EMS responded to the call, administered CPR, then transported the SC to the hospital where he was pronounced dead at 6:30 A.M. The report alleged the SC had a bruise on his upper right forehead. The mother reported the SC hit the bed rail of the bed frame from either rolling off the bed or onto the frame on the bed. The mother's explanation was not plausible.

Executive Summary

The SC was 6 months old when he died on 8/21/19. The autopsy listed the cause of death as positional asphyxia and the manner of death as accidental (face down in adult bed).

On 8/21/19, the SCR registered a report regarding the death of the SC. The allegations of the report were DOA/FATL, L/B/W, LS, and IG of the SC by the mother.

The SC resided with his mother and the MA; the MA was on vacation at the time of the incident. The father resided separately with the PGM, and was co-parenting with the mother.

According to the mother, she placed the SC to sleep on her bed and then left him alone while she went to another room to talk to the maternal great cousin (MGC) who was visiting. The mother said she inadvertently fell asleep and when she awoke at 5:30 A.M., she went to check the SC who was found unresponsive. The mother called 911 and EMS transported the SC to the hospital where he was pronounced dead.

ACS initiated the investigation timely and assessed the home. ACS confirmed the mother had no other children and the SC was the only minor who resided in the home. ACS assessed the mother had adequate provisions in the home for the SC but failed to place him to sleep in his Pack-N-Play.

ACS contacted the NYPD who reported there was no criminality surrounding the death of the SC; therefore, their investigation was closed. The ME and the medical staff did not observe any suspicious marks or bruises on the SC's body.

The supervisory oversight/directives of this investigation were flawed as the CPS was allowed to complete safety assessments, RAP, and open a Family Services Stage (FSS) even though there were no surviving children in the home. In addition, ACS held Child Safety Conferences (CSCs) even though their protocol notes that these conferences should be held when there are safety concerns that might warrant court intervention. In this case, there was no surviving child in the home. ACS indicated the report but did not issue the required Notices of Indication (NOI).

ACS provided the mother with resources to seek bereavement counseling; however, it was unknown whether she followed up with this service.

On 12/30/19, ACS substantiated the allegations of LS and IG of the SC by the mother. ACS based their decision on the mother's poor judgment of laying the SC on the bed surrounded by pillows and blankets as opposed to placing him to

sleep in his Pack-N-Play, and then leaving him unattended. ACS also cited the ME's report that specified the SC had the ability to roll from a supine position to a prone position, but not from prone to supine, and this caused the SC to suffocate.

On 12/30/19, ACS unsubstantiated the allegation of DOA/FATL even though the information provided on the autopsy supported that the SC suffocated due to the mother's LS and IG which created a substantial risk of harm by which the SC died. ACS provided a narrative that was not relevant to the circumstances of this case. ACS unsubstantiated the allegation of L/B/W and based their decision on the ME's interview where it was noted that the L/B/W did not contribute to the SC's death.

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

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 casework activity reflected inadequate supervisory guidance related to the assessments and determination of this investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS did not apply the legal standard of maltreatment to properly substantiate the allegation of DOA/FATL allegation. ACS' narrative consisted of a definition of abuse which was not relevant to this report.
Legal Reference:	SSL 412(1) and 412(2)
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:	Pre-Determination/Supervisor Review
Summary:	The supervisory review was inadequate as actions taken were not relevant to the case circumstances. For instance, the CPS completed safety assessments, RAP, held CSCs and opened a Family Services Stage even though the mother had no other children.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
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:	Failure to Provide Notice of Indication
Summary:	The CONNECTIONS event list did not reflect that the relevant NOI were issued.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
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: 08/21/2019 **Time of Death:** 06:30 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 05:30 AM
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? No - but needed
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☒ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	Female	24 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	6 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)

LDSS Response

ACS initiated the investigation by interviewing the NYPD, the ME, medical staff and family members.

The NYPD responded to the home due to the 911 call, examined the scene, and interviewed family members. The information provided by the mother was consistent with the information she provided to the medical staff and ACS. The NYPD determined there was no criminality suspected surrounding the death of the SC.

The social worker (SW) from the hospital stated that according to the mother she found the SC face down next to the metal bed frame. The SW stated the SC must have rolled over and hit his head on the frame. The SW stated the SC had no health problems, his immunizations were current, and his development was on target. This information was consistent with the information provided to the ME and the NYPD.

ACS contacted the ME who stated that based on the information gathered, the SC was placed on his back to sleep on the mother’s bed. The mother found the SC face down. The ME explained the SC was able to roll front to back but not from back to front. The ME stated it appeared the SC was unable to roll back to the supine position. The ME confirmed the SC had a contusion on the right side of his forehead; however, it did not contribute to the SC’s death.

ACS interviewed the mother and the MGC who were present at the time of the incident and their accounts were consistent. According to the mother, on 8/20/19 the MGM took the SC to the beach and later in the day she went to pick him up. The mother said she returned to her home with the SC at around 8:00 P.M. and placed him to sleep after she bathed and fed him. The mother said the SC woke up at around 11:30 P.M. and was fussing for another bottle. The mother said she fed him, and he fell asleep again. At around 1:30 A.M. the mother placed the SC on her bed with pillows and blankets surrounding him and went to talk to the MGC in another room. The mother said she left the SC on the bed because she intended to return to their room quickly. However, the mother fell asleep in the MGC’s room and woke up at approximately 5:30 A.M. The mother said she jumped up and then went to her room to check the SC who was unresponsive. The mother said when she picked the SC up from the bed, she saw a "gash/bruise" on the SC's right temple and it was "a little sunken in". The mother reported when she left the SC on the bed, he was lying on his back, close to the metal frame head board, surrounded by pillows and a bed blanket. However, when she returned, the SC was approximately 2 inches away from the foot rail of the bed, near an air conditioner, face down, with his “butt in the air”. The mother said she was scared and went to the MGC’s room, and called 911. The mother said she followed the operator’s instructions until EMS arrived. When asked, the mother said she had “sipped some Hennessey” at the beach earlier when she picked up the SC.

The MGC said the SC had a bump on his forehead that looked like “a dent.” The MGC stated the mother said she found the SC face down, on the edge of the bed, facing the wall. The MGC described the mother’s bed was against the wall and the SC was lying on the center of the bed surrounded with pillows and covers that served as a barrier to prevent him from falling. The MGC reported the SC appeared to have rolled over the pillows and his head was on the bar.

The father said that on 8/21/19 at about 6:00 A.M., the mother called him and said the SC had fallen off the bed and was being transported to the hospital by EMS. According to the father, the mother said she left the SC on the bed alone and when she returned, she found him on the floor. No one corroborated this account and it was unknown why the mother gave the father this information.

On 12/30/19, ACS indicated the report.

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)?No
Comments: There was no documentation of an MDT investigation; 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
051205 - Deceased Child, Male, 6 Mons	051206 - Mother, Female, 22 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
051205 - Deceased Child, Male, 6 Mons	051206 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
051205 - Deceased Child, Male, 6 Mons	051206 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
051205 - Deceased Child, Male, 6 Mons	051206 - Mother, Female, 22 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐
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:
There were no surviving children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The parents had 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

The parents were not listed in any SCR reports.

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