Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-081

Prepared by: New York City Regional Office

Issue Date: Jan 20, 2022

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: 2 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 08/15/2021
Initial Date OCFS Notified: 08/15/2021

Presenting Information

An SCR report alleged on 8/15/21, the subject mothers were co-sleeping with the 2-month-old infant. The parents last observed the infant alive around 5:00 AM. At 7:00 AM, the infant was cold and stiff. The infant died while in the care of the parents and they had no explanation for his death. A subsequent SCR report alleged while in the care of subject mother 1, the infant became unresponsive and was later pronounced deceased. EMS arrived to the home and observed someone performing CPR on the infant. The infant presented with a swollen right eye and blood coming out of his nostril. At the time, the infant was stiff and cold to the touch. CPR continued as the infant was transported to receive further medical intervention. Emergency department staff continued CPR until the infant was pronounced deceased. Subject mother 1 was unable to provide an explanation for the otherwise healthy infant's death.

Executive Summary

On 8/15/21, two SCR reports were received regarding the death of the 2-month-old male infant that occurred on that date. The first SCR report had allegations of DOA/Fatality and Inadequate Guardianship against subject mothers 1 and 2 and the second SCR report contained additional allegations of Swelling/Dislocation/Sprains and Internal Injuries against subject mother 1. 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 subject mother 1 (biological mother), subject mother 2 (non-biological mother), and the biological maternal grandfather. The parents had no CPS history and no other children. The infant's father was unknown.

The investigation revealed that on 8/15/21, subject mother 2 took the infant out of the bassinet at 6:00 AM. She placed the infant in bed between herself and subject mother 1 and she fell asleep. Subject mother 2 woke up around 7:00 AM and the infant was cold and slightly blue in color. Subject mother 1 called 911 at 7:06 AM and subject mother 2 ran to the nearby fire station for help. No one was there so she returned home. Subject mother 1 called 911 a second time at 7:18 AM when EMS had not arrived. Subject mother 1 performed CPR per the dispatcher's instructions until EMS arrived. The infant was transported to the hospital via ambulance where lifesaving measures continued. The infant was pronounced deceased at 8:01 AM.

An autopsy was performed; and the final report had not yet been received at the time of this writing. The medical examiner reported that the infant appeared healthy and there were no injuries observed. There were no findings at the scene or concerns with the reenactment. The medical examiner further stated that the parents' account of the incident was consistent with the observed sleeping environment. The law enforcement investigation remained open pending the final autopsy report.

ACS unsubstantiated the allegations based on a lack of credible evidence that the parents caused any harm to the infant and the medical examiner indicating that there was no external trauma to the infant's body. ACS provided funeral assistance to the parents and they offered the family bereavement services but the parents declined. ACS unfounded and closed both investigations on 10/13/21.

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

Explain:
There were no surviving siblings or other children residing in the home therefore safety assessments were not required to be completed. The case was appropriately unfounded and closed.

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was commensurate with case circumstances.

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: 08/15/2021 **Time of Death:** 08:01 AM

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

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 07:06 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? Yes
How long before incident was the child last seen by caretaker? 1 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted
☒ Asleep
☐ Absent
☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Grandparent	No Role	Male	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Other Adult - Non-biological Mother	Alleged Perpetrator	Female	31 Year(s)

LDSS Response

ACS began their investigation upon receipt of the SCR reports on 8/15/21. They adhered to approved protocols for a joint investigation with law enforcement and they interviewed the parents and the grandfather. ACS spoke to the sources of the reports, family members, neighbors, the landlord, law enforcement, first responders from the fire department, staff from the medical examiner's office, hospital staff, the DA's office, and the pediatrician. Collateral contacts expressed no concerns for the parents' care of the infant. ACS completed 24-hour and 30-day fatality reports timely and accurately and they provided Notice of Existence letters to the parents and grandfather timely.

Through interviews with the parents, it was learned that the infant was healthy, and he had been eating and sleeping normally leading up to the incident on 8/15/21. The infant usually slept in his bassinet, but he occasionally napped in the adult bed. On 8/15/21, subject mother 2 took the infant out of his bassinet to feed him around 6:00 AM. Subject mother 2 first reported that she fed the infant and burped him then laid him down on his back on the bed between herself and subject mother 1 and she must have fallen asleep. She later reported that the infant did not eat so she played with him for about 5 minutes prior to placing him on the bed. Around 7:00 AM, subject mother 2 awoke and she saw that the infant's right arm was up, and his head was turned slightly inward into his arm. She noticed he was cold and slightly blue, so she woke up subject mother 1. Subject mother 1 called 911 at 7:06 AM and they said the dispatcher did not instruct them to perform CPR at that time. Subject mother 2 ran to the nearby fire station for assistance and there was no one there. She ran back home when she saw an ambulance drive by. Subject mother 1 called 911 a second time at 7:18 AM when EMS had not yet arrived, and at that time she performed CPR per the dispatcher's instructions. She observed blood coming from the infant's nose. The parents denied substance misuse and they denied rolling over on the infant, stating they were both light sleepers. They reported being aware of safe sleep guidelines.

The grandfather stated that he was away for the weekend at the time of the incident. Subject mother 1 called him around 7:00 AM and told him the infant was not breathing. He drove to the hospital and comforted the parents. He said both

mothers were good parents, and they took excellent care of the infant. ACS observed the apartment to be clean and the necessary infant supplies and a bassinet were observed in the parent's bedroom.

Law enforcement reported that the infant arrived at the hospital with a body temperature of 89 degrees and there was no trauma observed to his body. Hospital records showed the infant arrived with no pulse at 7:48 AM. CPR continued until 8:00 AM and the infant was pronounced deceased at 8:01 AM. The postmortem head CT showed no intercranial hemorrhages and there was no evidence of fractures. Pediatrician records showed the infant was up to date with well-child visits and immunizations. He was last seen on 8/6/21 and there were no concerns for the infant's health or development.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in New York City.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059321 - Deceased Child, Male, 2 Mons	059322 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
059321 - Deceased Child, Male, 2 Mons	059322 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
059321 - Deceased Child, Male, 2 Mons	059323 - Other Adult - Non-biological Mother , Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
059321 - Deceased Child, Male, 2 Mons	059323 - Other Adult - Non-biological Mother , Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
059321 - Deceased Child, Male, 2 Mons	059322 - Mother, Female, 25 Year(s)	Internal Injuries	Unsubstantiated
059321 - Deceased Child, Male, 2 Mons	059322 - Mother, Female, 25 Year(s)	Swelling / Dislocations / Sprains	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?	☐	☒	☐	☐

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were provided with funeral assistance and they were referred for bereavement 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? 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 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