# Child Fatality Report

## Report Identification Number: NY-20-118

**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:** 2 month(s)
**Jurisdiction:** Kings
**Gender:** Female
**Date of Death:** 12/22/2020
**Initial Date OCFS Notified:** 12/22/2020

### Presenting Information

The SCR report alleged the two-month-old female SC died on 12/22/20 while in the care of her parents. At approximately 6:00AM, when the SC awoke, the SM fed, then placed the SC on the bed between her and the father. On the bed were fitted and flat sheets, a comforter, and a throw blanket. The SM went back to sleep, awoke approximately four hours later, and observed the SC face down in the sheets and the blanket. She turned the SC over and observed the SC was blue and unresponsive. The SM called 911. EMS responded to the home and transported the SC to the hospital where she was pronounced dead. The parents had no explanation for the cause of the SC's death.

### Executive Summary

The two-month-old female SC died on 12/22/20. The SCR report of the SC's death had allegations of DOA/Fatality and Inadequate Guardianship of the SC by the parents. As of the writing of this report, NYCRO had not received the final autopsy report from the ME. However, the ME's preliminary finding was asphyxiation because of co-sleeping.

At the time of the fatality the SC resided with her parents and an eight-year-old surviving half sibling. The surviving half sibling remained in the home with the SM and the SF.

According to ACS's documentation, the SM placed the SC to sleep on a blanket, between her and the SF on their full-size bed. The SM folded the blanket and propped the SC on an angle on the blanket to prevent the SC from choking should the SC vomit during the night. The SC was found tangled in the sheets and blanket that were on the bed. The SC was bluish in color and unresponsive. The SF called 911. EMS responded to the case address and transported the SC to the hospital where she was pronounced dead on 12/22/20 at 10:21 AM. The SC had no marks or bruises indicative of maltreatment or abuse.

ACS contacted the appropriate collaterals including the hospital, LE and the ME to gather information regarding the report. ACS also interviewed the SM, SF, SS, MGM, and MA. The accounts provided by the family members were consistent with information obtained from law enforcement who were involved to investigate possible criminal elements of the child's death. LE found no criminality. The family denied DV, MH concerns or any substance abuse. The parents were referred to PPRS, but they declined. The parents also stated they sometimes co-slept with the SC. They reported the SC had received two vaccines, had a fever, and was cranky. The SM showed the Specialist that she had been in communication with the pediatrician who advised her to take the SC to the ER if the SC's condition did not improve.

The SS was interviewed but her responses were limited due to her cognitive delay. The MGM and MA supported the parents and had no concerns regarding the care provided to both children.

On 2/9/21, ACS unsubstantiated allegations of DOA/Fatality and Inadequate Guardianship of the SC by the parents citing no credible evidence was found to support the allegations. ACS noted that the SS was free of marks and bruises, and the basic needs of both children were met prior to the fatality. However, ACS did not take into account the fact that the SM placed the SC in the bed she was sharing with the SF at the time and added a blanket, which she used to prop the SC up. The co-sleeping conditions created an unsafe sleep situation for the two-month-old SC.

## 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:**
Sufficient information was gathered to make the determination for the allegations of the report.

**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:**
The level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion was commensurate with the case circumstances.

**Required Actions Related to the Fatality**

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

| | |
|---|---|
| **Issue:** | Appropriateness of allegation determination |
| **Summary:** | ACS did not take into account the SM placed the SC in the bed she was sharing with the SF at the time and added a blanket which she used to prop the SC up. The co-sleeping conditions created an unsafe sleep situation for the two-month-old SC. |
| **Legal Reference:** | FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv) |
| **Action:** | ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed. |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 12/22/2020 **Time of Death:** 10:21 AM

**Time of fatal incident, if different than time of death:** 09:54 AM

**County where fatality incident occurred:** Kings
**Was 911 or local emergency number called?** Yes
**Time of Call:** 09:54 AM
**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?** Yes
**How long before incident was the child last seen by caretaker?** 4 Hours
**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 | Female | 2 Month(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 26 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 30 Year(s) |
| Deceased Child's Household | Sibling | No Role | Female | 8 Year(s) |

### LDSS Response

ACS initiated the investigation within the required timeframe. The ACS Specialist interviewed the hospital staff, LE, and the ME. The Specialist learned from the hospital staff the SC remained unresponsive despite resuscitation efforts and that EMS arrived at the ER with the SC at 10:19AM. The SC was pronounced dead at 10:21 AM. The SC presented with no marks or bruises indicative of maltreatment or abuse. The staff reported the parents were distraught.

ACS contacted the ME and was informed the preliminary cause of death was physical asphyxiation, since the SC was co-sleeping and she was found face down in a pillow. LE found no criminality.

The Specialist visited the case address and documented the SS was safe; she remained in the care of the parents. The SM reported that the SC was fussy, feverish, and congested after she received two vaccines on 12/11/20. The SM said she administered Tylenol, gripe water, normal saline, and diluted prune juice, all in efforts to soothe the SC. The SC was fed every two to three hours and she drank four ounces of formula at each feeding. She received her last full feeding at 2:00AM, and between 5:00AM and 6:00AM, she drank about two ounces of formula. The SM reported although she received safe sleep training, and the SC had a crib, she often shared a bed with the SC. The SM explained since the SC was not feeling well, she opted to prop her on a blanket in case she regurgitated. They fell asleep and the SM awoke to feed the SC but found her face down, bluish in color and with a small amount of blood in her nose and mouth.

The SF corroborated the SM's account, and added that he was awakened by the SM's screams when she discovered the SC unresponsive. He also reported the SC had a fever three weeks prior; and three days ago, she relapsed.

ACS contacted the family's clinician who informed ACS of the SM's clinical health condition, which made it difficult for the SM to support the SS who had the same condition. According to the clinician, the family was given a referral for a specialized therapist. The clinician reported the MGM lent support by attending to the SS's personal needs and medical appointments. There were no reported concerns for the care the SS received. The SS's biological father had been supportive of the sibling.

Throughout the investigation, ACS held multiple conferences with the family around the SS's special medical needs. A medical consult was completed on 1/14/21. An early childhood consultation was also held at a later date. The SS had been receiving "virtual support services only." As a result, multiple services such as physical and occupational therapy were initiated. Counseling through the school was increased and individual services were added. The case documentation reflected that services to address the SS's mental and physical needs were initiated. The parents declined PPRS; however, they engaged in bereavement counseling through a private source.

The Specialist interviewed the SS several times and although there was limited engagement, the case documentation reflected the SS was aware that her sister would not be returning home. The SM noted the SS experienced mood swings which the therapist was addressing.

On 2/9/21, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the parents citing no credible evidence was found to support the claims. However, it was noted that the ME said the cause of death was due to asphyxiation as a result of co-sleeping. The Specialist documented that prior to the incident, the parents had been meeting the children's basic needs.

## Official Manner and Cause of Death

**Official Manner:** Pending
**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 |
|---|---|---|---|
| 057361 - Deceased Child, Female, 2 Mons | 057363 - Mother, Female, 30 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 057361 - Deceased Child, Female, 2 Mons | 057364 - Father, Male, 26 Year(s) | DOA / Fatality | Unsubstantiated |
| 057361 - Deceased Child, Female, 2 Mons | 057364 - Father, Male, 26 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 057361 - Deceased Child, Female, 2 Mons | 057363 - Mother, Female, 30 Year(s) | DOA / Fatality | 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:**
Sufficient information was gathered to assess risk to the SS. The SS received services through her school and community; however, the parents declined PPRS. The parents opted to engage in therapy through providers in the community.

## 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?** | ☐ | ☒ | ☐ | ☐ |

**Explain as necessary:**
The LDSS deemed the SS safe and she remained in the home under the care of the parents.

## 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 parents declined services.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
The parents declined 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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 06/01/2018 | Sibling, Female, 6 Years | Mother, Female, 26 Years | Educational Neglect | Unsubstantiated | No |

**Report Summary:**
On 6/1/18, the SCR registered a report alleging Educational Neglect of the SS by the SM. The SM admitted she did not send the SC to school due to the continued tension between her and the school. An incident occurred where the SS was received an injury to her forehead and the SS pointed to someone at the school who could not be identified. The incident caused additional tension.

**Report Determination:** Indicated **Date of Determination:** 07/28/2018

**Basis for Determination:**
ACS indicated the report on the basis of some credible evidence. ACS documented the SM deliberately kept the SS home from school due to the poor relationship with the school staff.

**OCFS Review Results:**
The determination was based on the SM's admission to keeping the SS from school; however, the SM requested an administrative review and the decision was overturned.

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 01/09/2018 | Sibling, Female, 6 Years | Mother, Female, 28 Years | Educational Neglect | Far-Closed | No |

**Report Summary:**
The SM became known to ACS on 1/9/18 when a FAR response was initiated due concerns of Educational Neglect of the SS. ACS assisted the SM and the SS received medical evaluations resulting in glasses and hearing aids. There was tension between the SM and the school, as the SM felt the school did not support her as needed or timely. The track ended on 2/27/18.

**OCFS Review Results:**
The LDSS intervention was helpful and due to the SM's cooperation, the SS received much needed support.

**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

There was no known CPS History outside of 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