Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-026

Prepared by: New York State Office of Children & Family Services

Issue Date: Aug 18, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 9 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 03/09/2020
Initial Date OCFS Notified: 03/09/2020

Presenting Information

An SCR report was received on 3/9/20 with concerns the nine-month-old subject child was found unresponsive by his mother. The report noted the mother contacted emergency medical services, and the child was declared deceased at the hospital due to respiratory arrest. It was not known when the child was last seen alive, and there was no reasonable explanation for his death. The role of the father was unknown.

Executive Summary

This fatality report concerns the death of a nine-month-old male subject child that occurred on 3/9/20. A report was made to the SCR on that same date, with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother. The Administration for Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; however, at the time of this writing, the results of such remained pending.

At the time of the child's death, he resided with his mother and father. There were no surviving siblings or other children in the household. The investigation revealed that in the afternoon of 3/9/20, the father was at work and the mother was home alone with the child. The mother laid the child down for a nap at approximately 2:30PM. The child was placed on a full-sized bed, surrounded by pillows. The mother began completing chores around the home. At approximately 4:35PM, the mother checked on the child and found he was wedged between the wall and the mattress, unresponsive. The mother attempted cardiopulmonary resuscitation and screamed for the maternal aunt who resided in an upstairs apartment in the same building. The maternal aunt and her husband responded to the mother's screams, and emergency services were called. The family decided they did not want to wait for an ambulance to arrive and were instead driven to the emergency room by the maternal aunt's husband. Hospital staff immediately began working on the child; however, efforts were unsuccessful, and he was pronounced deceased at 5:30PM.

From the time the investigation began to the time of its closure, ACS interviewed family members and collateral sources. ACS provided the family with appropriate service referrals in response to the death of the child. The 24-Hour Fatality Report was not completed timely, and the record did not reflect any attempts to interview the maternal aunt's husband, who was present on the date the events occurred. The Risk Assessment Profile correctly identified the elevated risk factor that the child's death was the result of abuse or maltreatment; however, ACS unsubstantiated all allegations and closed the case.

PIP Requirement
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.

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?** 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:
Despite evidence gathered showing the child was placed in an unsafe sleep environment, and the emergency room physician noting the child's death was due to positional asphyxiation, ACS unsubstantiated the allegations.

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 case record reflected supervisory consultations throughout the investigation. The level of casework activity 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:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24 Hour Fatality Report was not completed and approved until 3/11/20, one day past the due date.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
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:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect any attempts to interview the maternal aunt's husband or the child's pediatrician.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
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: 03/09/2020 **Time of Death:** 05:30 PM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Unknown
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? 1 Hours
At time of incident supervisor was: Not impaired.

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	9 Month(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)

LDSS Response

On 3/9/20, ACS received the SCR report regarding the death of SC, which occurred on that same date. ACS initiated their investigation within 24 hours and adhered to approved protocols for joint investigation. ACS learned there were no SS or other children in the household and promptly began gathering information surrounding SC's death.

On 3/9/20, ACS completed a visit to the family's home. SM and BF were unable to participate in an interview at that time due to their emotional state. ACS interviewed MA, who resided in the upstairs apartment in the same building. MA explained she heard SM screaming and went downstairs to find SM performing CPR on SC. MA stated she called 911, but they felt it would take too long for EMS. MA said her husband drove them all to the emergency room instead of waiting. MA reported she could not recall exact times of events. She denied any concerns surrounding SM or BF's care of SC, and

explained she last saw SC the previous day and he appeared well. ACS observed a crib pushed against a full-sized bed and the gate of the crib facing the bed was down. The rest of the home was observed, and no safety hazards were noted.

On 3/10/20, ACS interviewed SM at a relative's home. SM reported she was at home with SC on 3/9/20 while BF was at work. SM explained around 1:00PM, SC fell asleep while breastfeeding, so she placed him in her full-sized bed, on his back. SM said she put pillows around SC and then left the room to start cleaning the house. SM stated she checked on SC around 3:15PM and found him on his side with his arm over his head, still asleep. SM explained she then returned to cleaning the home and finished doing so around 4:35PM. SM stated she then checked on SC once again and found him wedged between the wall and the mattress. SM said she ran to SC and noticed he was not breathing so she began CPR. SM stated CPR did not seem to be working so she brought SC into the hall and started to scream for MA, who was upstairs in her apartment. SM stated MA called 911; however, MA's husband thought it would be faster to drive SC to the hospital rather than wait for an ambulance, so he transported them. SM explained when they arrived at the emergency room, SC was yellow in color and several doctors began working on him, but SC was already deceased. BF was also interviewed on this date and explained he was at work when he received a frantic call from SM saying SC was not breathing and to meet them at the hospital. BF stated he had no concerns surrounding SM's care of SC. Neither parent reported anything out of the ordinary in the hours leading up to SC's death. The record did not reflect if the parents were educated surrounding safe sleep practices.

Throughout the investigation, ACS spoke with family members and collateral sources, including hospital staff and the ME. Upon initial examination, the emergency room hospital physician noted SC's death was due to positional asphyxiation; however, at the close of the investigation, the final autopsy results remained pending. LE found no criminality on behalf of SM regarding SC's death. ACS noted no evidence SM's actions or inaction caused the death of SC, and therefore unfounded and closed the case.

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
Comments: This fatality investigation was conducted by the ACS MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054673 - Deceased Child, Male, 9 Mons	054674 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
054673 - Deceased Child, Male, 9 Mons	054674 - Mother, Female, 28 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 interviewed the mother, father, and maternal aunt; however, the record did not reflect any attempts to interview the maternal aunt's husband. Progress notes were completed and entered timely.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS provided the family with referrals for grief and bereavement counseling; however, they had not yet engaged at the close of the investigation.

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 siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS provided referrals for bereavement counseling to the family; however, they had not yet engaged at the close of the investigation.

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 ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ 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

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