Child Fatality Report

Report Identification Number: NY-22-038

Prepared by: New York City Regional Office

Issue Date: Nov 07, 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 05/23/2022
Initial Date OCFS Notified: 05/24/2022

Presenting Information

On 5/24/2022, the Administration for Children's Services (ACS) received an SCR report that alleged the death of the 4-month-old subject child. Around 6:15 AM on 5/21/2022, the mother placed the child to sleep in bed with the father, surrounding the child with pillows so that he could not roll. The mother did not wake the father or tell the father the child was in the bed before leaving for work. The father awoke around 10:15 AM and found the child on the floor. The child was found to have blood on his face and the father contacted 911. EMS responded to the home and transported the child to the hospital. Life saving efforts continued at the hospital until the child was declared braindead. The child was removed from life support and pronounced deceased at 5:10 PM on 5/23/2022. The parents had no other children.

Executive Summary

This report concerns the death of the 4-month-old male child, which occurred on 5/23/2022. ACS received an SCR report on 5/22/2022 with allegations the child was hospitalized after being found unresponsive on 5/21/2022. ACS received a subsequent SCR report after the death of the child. At the time of the incident that led to the child's death, the child resided with his mother and father. There were no surviving siblings or other children residing in the home.

Through investigation, ACS learned the mother fed the child around 4:30 AM on 5/21/2022. The mother placed the child to sleep faceup on the adult bed where she also laid down until about 6:00 AM, when she got up to prepare for work. The mother surrounded the child with pillows on three sides and left the child on the bed when she departed for work. The father had been sleeping on the couch in the living room and the mother did not wake the father or tell him the child was sleeping on the adult bed before she left for work at 6:45 AM. The father woke around 10:15 AM and checked on the child around 10:19 AM. The father discovered the child was facedown on the mattress with his right arm and leg wedged between the mattress and the wall. The father called the child's name, and the child did not respond. The father rolled the baby over and noted the child had blood coming from his nose. The father contacted 911 around 10:21 AM, emergency services responded to the home and transported the child to the hospital.

The child was transferred to a pediatric intensive care unit. Multiple tests were administered, and it was determined the child had no brain activity. The decision was made by the parents and hospital staff to remove the child from life support systems, and the child was pronounced deceased on 5/23/2022 at 5:10 PM.

An autopsy was completed on 5/26/2022. The medical examiner reported to ACS that no signs of foul play or abuse were found regarding the child's death; however, the medical examiner had not yet determined the cause or manner of death at the time the CPS investigation was closed. ACS coordinated their investigation with law enforcement, completing home visits and interviews of the parents along with the police. The criminal investigation was closed with no charges or arrests on 6/19/2022, pending any new information from the medical examiner that would require further police intervention.

ACS closed the investigation on 7/21/2022, and the allegation of Inadequate Guardianship was substantiated against the mother. The investigation determination noted that despite her awareness of safe sleep practices, the mother placed the child to sleep on an adult bed and surrounded him with pillows, and that the unsafe sleep environment placed the child in immediate danger of harm. The allegation of DOA/Fatality was unsubstantiated against the mother as there was not a fair preponderance of evidence gathered to support that the child's death was definitively the result of the unsafe sleep environment. The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the father as it was determined he was unaware the child was placed in the unsafe sleep environment and took appropriate action when he

discovered the child unresponsive.

ACS referred the parents for bereavement counseling services which were declined by the family.

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?** Yes

Explain:
ACS conducted a thorough investigation.

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:
Although all other casework was completed timely and thoroughly, the 30-day fatality report was completed 26 days late.

Required Actions Related to the Fatality

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

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Fatality Report was completed 26 days late on 7/18/2022.
Legal Reference:	CPS Program Manual, Chapter 6, K-2

Child Fatality Report

Action:	ACS must document and approve a 30-Day Fatality Report within 30 days of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/23/2022 **Time of Death:** 05:10 PM

Date of fatal incident, if different than date of death: 05/21/2022
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 10:21 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

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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)

LDSS Response

ACS initiated their investigation immediately upon receipt of the 5/22/2022 SCR report. An appropriate search of history and check of law enforcement records was made within 24 hours, as were initial visits to the family's home and to the hospital, in cooperation with law enforcement, for the purposes of interviewing the mother and father.

The parents were interviewed separately and provided consistent information regarding the timeline of events leading to the child's hospitalization. The parents were questioned regarding safe sleep practices and reported they were aware of

safe sleep practices and normally placed the child to sleep in his crib. The mother reported she had left the child on the adult bed on the morning of 5/21/2022 so as not to disturb him and reported she had placed the pillows around the child as he had recently begun to turn himself over. The mother reported she had lest checked on the child around 6:40 AM on 5/21/2022, and noted the child appeared well at that time. The parents were questioned regarding substance use, domestic violence, and mental health concerns and denied any issues for themselves or their family.

Appropriate collateral interviews were completed with hospital staff, law enforcement, the medical examiner, and the child's primary care physician. Through contact with the hospital and with law enforcement, ACS learned the parents had provided both agencies a similar timeline of events regarding the morning of 5/21/2022. A hospital emergency room physician stated the death appeared to be the result of accidental suffocation; however, the medical examiner stated it was too soon to draw that conclusion as the final autopsy report was still pending and awaiting the results of necessary laboratory testing. The child's primary care physician reported the child appeared to have been well-cared-for by the parents. The pediatrician reported the child was brought to all necessary appointments and stated the parents were educated regarding safe-sleep practices during those visits.

ACS interviewed family members and friends of the family, all of whom denied any concerns for the parents' care of the child.

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: The NYC region does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061381 - Deceased Child, Male, 4 Month(s)	061544 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
061381 - Deceased Child, Male, 4 Month(s)	061544 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
061381 - Deceased Child, Male, 4 Month(s)	061545 - Father, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated
061381 - Deceased Child, Male, 4 Month(s)	061545 - Father, Male, 21 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?	☒	☐	☐	☐
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:
The 30-Day Fatality report was completed 26 days late.

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? No
Explain:
Bereavement services were offered to both parents but were declined.

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

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.

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