Child Fatality Report

Report Identification Number: NY-19-132

Prepared by: New York City Regional Office

Issue Date: Jun 11, 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: 5 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/21/2019
Initial Date OCFS Notified: 12/21/2019

Presenting Information

The 12/21/19 SCR report alleged, on an unknown date, the SC (5 months) fell from a bed, and was found, by an unknown person, wedged between the bed and the wall. The report also alleged the SC was unresponsive at the time. As a result of the fall, the SC sustained a skull fracture. The SC was transported by Emergency Medical Services to a local hospital, and later the SC was transferred to another hospital. On 12/21/19, the SC was pronounced dead. The report alleged an unknown adult was the sole care provider of the SC at the time of the incident and was therefore made an alleged subject.

Executive Summary

This 5-month-old SC died on 12/21/19. NYCRO had not yet received a copy of the autopsy report at the time this report was issued.

The SCR registered a report of the SC's death on 12/21/19. The allegations of the 12/21/19 report were DOA/Fatality, Fractures, II and IG of the SC. The SCR report listed the BM as having an unknown role although the BM was the SC's sole caretaker.

At the time of the SC's death, the family had two open investigations that began on 11/20/19 and 11/27/19. ACS initiated these investigations and found that on 11/20/19, at an unidentified time between 3:00 PM and 4:00 PM, the BM and SC were in a family friend's home when the BM placed the SC face down in the friend's bed (queen size) to sleep. The SC was found wedged between the bed and wall. The family described the SC's position as being wedged where his nose and mouth were covered. The SC sustained serious brain injuries that required hospitalization.

ACS verified that, on 11/20/19, after the SC was found wedged between the bed and wall, the BM initiated CPR, 911 was contacted and an adult cousin continued CPR until EMS responded to the friend's home. At approximately 3:50 PM, EMS transported the SC to the local hospital. The SC was then transported to another hospital for additional treatment. During his hospitalization, medical professionals diagnosed him with serious damage to his lungs as a result of loss of oxygen, and a skull fracture to the back of his head. His condition initially improved, and he was expected to be discharged to the BM with hospice nursing care. However, his condition deteriorated on 12/19/19 and he remained hospitalized until he was pronounced dead on 12/21/19.

The SC had no surviving siblings and there were no other children in the BM's care. The SC was born out of New York state and relocated on 10/28/19 when the BM accompanied him to the MGGM's home in the Bronx. The BM resided in the MGGM's home with the MGM and two minor MA's who were 17 and 12 years old. ACS interviewed and observed the BM, MGM, and MAs, observed household conditions and determined the MA's received a minimum degree of care. The BF did not reside with the BM and SC and he was at work at the time of the incident. He supported the family although the BM no longer had a relationship with him. ACS provided burial assistance and referral for bereavement.

ACS interviewed LE on 3/24/20. Per LE's account, the ME's preliminary findings showed the SC was not intentionally harmed while in the care of the BM. The SC's death was listed as accidental. LE informed ACS there were no arrests pending the ME's final report.

ACS had not yet determined the 12/21/19 investigation at the time this report was issued.

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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
ACS had not yet completed the investigation at the time this report was issued.

Was the decision to close the case appropriate? N/A

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 investigation remained open at the time this report was issued.

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 report was dated 12/21/19 and ACS did not complete/approve the 30-Day Fatality Report until 1/31/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations 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

Child Fatality Report

Incident Information

Date of Death: 12/21/2019 **Time of Death:** 07:16 AM

Date of fatal incident, if different than date of death: 11/20/2019
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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
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	5 Month(s)
Deceased Child's Household	Mother	No Role	Female	19 Year(s)
Other Household 1	Father	No Role	Male	19 Year(s)
Other Household 2	Other - Unknown	Alleged Perpetrator	Unknown	19 Year(s)

LDSS Response

Following the SC's death, ACS interviewed the BM in the MGGM's home on 12/21/19. According to the BM's account, on 11/20/19, she took the SC, accompanied by the MGM and MAs to visit the MGM friend's home in the Bronx. A female adult cousin, and the friend and her two female children were also in the home. Between 3:00 and 4:00 PM, the MGM fed and burped the SC. The SC fell asleep, and then the BM placed him in the middle of the friend's bed, which was a queen size, located in a bedroom. The bed was situated on the side of the wall, and on the other side she placed pillows. The bed was 2 feet in height from the floor. The door to the bedroom was open, and the bedroom was next to the living room. The BM and other individuals were in the living room and kitchen. The BM checked the SC twice and then approximately three minutes after she checked him, the MA alerted her that he was not in the bed. The BM went into the bedroom and found the SC in an upward position between the bed and the wall. He was not breathing, his lips were blue, and his wrists were discolored. The BM placed him on the bed, initiated CPR, and saw pinkish foam coming out of his nose. The family contacted 911, and the adult cousin continued CPR until EMS responded to the home.

ACS reviewed medical records that showed on 11/20/19, the SC's heart stopped beating for 20-30 minutes upon arrival in the hospital and prior to him being resuscitated and placed on life-sustaining machines. The records reflected the SC did not have a pre-existing heart condition but he sustained brain damage on 11/20/19. He experienced severe swelling due to a lack of oxygen and sugar, and his injury was consistent with asphyxiation.

ACS interviewed an assigned child abuse physician from the hospital on 12/27/19. ACS learned that due to the fact that no individual saw the SC fall from the bed, there were unanswered questions about what happened to SC. There were no concerns regarding causation of the fracture or incident, and without an explanation, it was not possible to speculate exactly how the SC fell and what position he was in. The physician was unable to conclude with certainty the incident was a result of abuse. Per the physician's account, the incident appeared to be a tragic accident, as it was doubtful someone intentionally hurt the SC.

Between 12/21/19 and 1/15/20, ACS monitored the family through home visits, face-to-face interviews and telephone contacts. The investigative findings showed the MAs had no developmental, mental health, or behavioral or academic concerns and appeared attached to the family. The BM and her family of origin had no history of mental health or substance abuse. The BM experienced conflicts with the BF, who did not reside with the family. ACS provided referrals for burial assistance, bereavement, and services to address the BM and BF's domestic conflict.

ACS did not attempt to contact the family between February and April of 2020, with the exception of a brief telephone contact with the BF on 4/7/20.

On 4/13/20, ACS attempted telephone contact with the ME, however there was no response.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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: 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053462 - Deceased Child, Male, 5 Mons	054142 - Other - Unknown, UNK, 19 Year(s)	DOA / Fatality	Pending
053462 - Deceased Child, Male, 5 Mons	054142 - Other - Unknown, UNK, 19 Year(s)	Fractures	Pending
053462 - Deceased Child, Male, 5 Mons	054142 - Other - Unknown, UNK, 19 Year(s)	Inadequate Guardianship	Pending
053462 - Deceased Child, Male, 5 Mons	054142 - Other - Unknown, UNK, 19 Year(s)	Internal Injuries	Pending

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?	☐	☒	☐	☐

Additional information:
The alleged subject of the report was listed as an unknown individual.

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: The family received community-based services.							

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 BM and BF's care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family received community-based services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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? Yes

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)
11/27/2019	Deceased Child, Male, 5 Months	Mother, Female, 19 Years	Lack of Supervision	Substantiated	No
	Deceased Child, Male, 5 Months	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The 11/27/19 report alleged on 11/20/19, the SM left the SC unsupervised for ten minutes on a bed. Another individual found the SC in cardiac arrest. The 911 operator was contacted and the SC was taken to the hospital. Cardiopulmonary resuscitation was required to keep the SC alive.

Report Determination: Indicated | **Date of Determination:** 02/20/2020

Basis for Determination:
ACS substantiated the allegations of the 11/27/19 report on the basis of credible evidence. ACS explained that the SM defied safe sleep practices when she placed the SC in the bed to sleep. The SM informed ACS that she was aware of safe sleep standards and education.

OCFS Review Results:
ACS interviewed household members and obtained information from LE and medical professionals. ACS verified the SM, SC, MGM and two MAs, resided out of New York State until 10/28/19 when they relocated to the Bronx. On 11/20/19, at approximately 3:30 PM, the family was visiting the MGM's friend when the friend found the SC unresponsive, wedged between the bed and wall. An adult female cousin, who was in the friend's home, contacted 911 for assistance, EMS responded and transported the SC to the hospital. The SC received medical care in the hospital until the time he was pronounced dead.

There were no SS or other children in the BM's care. The family received community-based services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/20/2019	Deceased Child, Male, 5 Months	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
The report alleged on 11/20/19, while in the care of the SM, the SC became wedged behind the bed for an unknown

length of time. When the SM found the SC he went into cardiac arrest and needed to be transported for medical care. He was resuscitated. The role of the BF was unknown.

Report Determination: Indicated | **Date of Determination:** 02/20/2020

Basis for Determination:
ACS substantiated the allegation of IG of the SC by the SM on the basis of credible evidence. ACS explained that the SM placed the SC in the family friend's bed to sleep. The SM placed pillows along the border as a protective barrier to prevent the SC from falling as she was aware the SC had the ability to roll off the bed. The SM "reported being aware of safe sleep standards and education."

OCFS Review Results:
ACS interviewed the SM, BF, MGM, MAs, and medical professionals. ACS found on 11/20/19 at approximately 3:30 PM, the SM placed the SC face down in the middle of a friend's queen sized bed to sleep. The SM and family periodically checked the SC until the friend informed the SM that the SC was not in the bed. The SM checked the room and found the SC was in a vertical position, head facing downwards, wedged between the bed and wall. The SM initiated CPR, a relative contacted 911 for assistance, and EMS responded and transported the SC to the hospital.

The BF was at work at the time of the incident. The BF, MGM and MAs did not have concerns about the care the BM provided the SC.

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

Issue:
Failure to Provide Notice of Indication

Summary:
ACS did not provide the Notice of Indication to the SM, who was the subject, and the BF who was identified in the 11/20/19 investigation.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations 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.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not enter progress notes contemporaneously, including events that occurred on 11/21/19, that were not entered until 1/13/20 and 1/16/20.

Legal Reference:
18 NYCRR 428.5

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations 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.

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS 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