Child Fatality Report

Report Identification Number: NY-19-134

Prepared by: New York City Regional Office

Issue Date: May 23, 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: 4 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 12/30/2019
Initial Date OCFS Notified: 12/30/2019

Presenting Information

The 12/30/19 report alleged the SM and MGF were the only caretakers for the SC and on 12/30/19, the SM was reportedly sleeping on the couch, while the SC slept on a different couch. At about 3:30 AM, the SM awoke and found the SC not breathing. She called 911, and was directed to start CPR. The SM moved the SC from the couch and placed the SC onto the counter. When the paramedics and LE arrived, the SC was in cardiac arrest while the SM was performing CPR. The SC was still alive when she was transported by paramedics to the hospital. Hospital staff made several unsuccessful attempts to revive the SC, and she was pronounced dead at 5:13 AM. The SC had no known pre-existing medical condition or issues and was an otherwise healthy child prior to her death. The SM and MGF had no explanation as to why the SC was found unresponsive and not breathing.

Executive Summary

The 4-month-old female child (SC) died on 12/30/19. NYCRO had not yet received a copy of the autopsy report at the time of issuance of this fatality report.

There were two reports registered on 12/30/19 regarding the incident. The initial report had allegations of IG of the SC by the SM and MGF. The allegations of the subsequent 12/30/19 report were DOA/Fatality and IG of the SC by the SM and MGF.

ACS learned, on 12/30/19 the SM gave the SC her last bottle and burped her. The SM placed a blanket on the couch and placed the SC on her back to sleep. The SM sat next to the SC on the couch and she fell asleep in a seated position next to the SC. The SM awoke at about 3:45 AM to check the SC, and observed the SC was not moving. The SM saw milk seeping from the SC's nose and mouth, and woke the MGF who initiated CPR on the SC. The SM contacted 911, and the operator instructed her to perform CPR. LE and EMS arrived shortly thereafter and transported her, the MGF, and the SC to the hospital. There was no car seat, crib, or bassinet in the home. According to the SM, the couch was a pull-out bed; however, she did not pull the couch out the night of 12/29/19 and instead, sat on top with the SC. The medical records showed the SC was born one month premature and received physical therapy and nurse visits weekly. There were no SS or other CHN residing in the home.

On 12/30/19, the ME informed ACS the only concern was the lack of proper bedding for the SC, and the SM co-sleeping with the SC while having knowledge of the SC's past medical health issues.

On 1/13/20, LE told ACS the case was pending. Later, LE informed ACS that the ME usually required approximately four months to finalize the death certificate and death determination.

ACS obtained clinical health and medical consultations for the family. Referrals were recommended but the MGF said the family would seek family therapy through an organization of their choosing. The SM opted to seek bereavement services through the same organization. The family arranged burial services for the SC.

The MGF said he was awakened by the SM who said the SC was not breathing. When he saw the SC, she was discolored, not breathing, and milk was seeping from her nose and mouth. He attempted CPR while the SM contacted 911. During the interview with the MGF, he said the SC's aunt resided in the home. The interview did not reflect that ACS obtained additional information about the aunt. The investigation conclusion narrative of the 12/30/19 fatality report did not include

an explanation for the allegations of DOA/Fatality and IG for the MGF, who was a subject of the report, neither did the DOA/Fatality allegation of the SM. Neither the 24-Hour Child Fatality Summary Report nor the 30-Day Child Fatality Summary Report was completed timely. ACS did not provide the Notice of Existence for one of the reports registered on 12/30/19. Although there were two reports registered on 12/30/19, the case record reflected there were only two Notice of Existence provided to the subjects.

On 2/27/20, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SM and MGF. The allegation of IG was unsubstantiated as there was no evidence to support that the SM was negligent. After a thorough investigation, making significant collateral contacts with physicians, LE, neighbors, and family members it was concluded that the report would be unfounded. ACS did not link the unsafe sleeping arrangements to the child's death or to the allegation of IG.

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:
Sufficient information was gathered to determine all 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:
There were no surviving children in the household.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Supervisor Review
Summary:	The investigation conclusion narrative of the 12/20/19 report did not include an explanation for the unsubstantiated allegations of DOA/Fatality and IG for the MGF who was a subject of the report, and the DOA/Fatality allegation of the SM.

Legal Reference:	18 NYCRR 432.2(b)(3)(v)
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:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	During the MGF interview on 12/30/19, he stated his other adult daughter resided in the home. The interview did not reflect that ACS inquired about the adult daughter's name and contact information so she could be interviewed.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
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:	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 Child Fatality Summary Report was not completed timely as it was not completed until 1/10/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
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:	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 Child Fatality Summary Report was not completed timely as it was not completed until 2/4/20.
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.
Issue:	Failure to provide notice of report
Summary:	ACS did not provide the Notice of Existence for one of the reports registered on 12/30/19.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
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:	Failure to utilize an approved MDT

Child Fatality Report

Summary:	The case documentation did not reflect there was a MDT response to the fatality.
Legal Reference:	SSL 423(6); SSL 424 (5-a); 10-OCFS-LCM-09
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

Incident Information

Date of Death: 12/30/2019 **Time of Death:** 05:13 AM

Time of fatal incident, if different than time of death: 03:30 AM

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? 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
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	Female	4 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	54 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

On 12/30/19, ACS interviewed the MGM who reported at 4:12 AM, she learned of the incident when she received a phone call from the SM. According to the MGM, the SM said the SC was not breathing and milk was coming from her nose and

mouth. Later, the MGM informed ACS that at the time of the SC's birth the SC did not have any medical concerns although the SC was born prematurely. The SC had a crib at the MGM's home. According to the MGM, the SC was not prescribed medication. The MGM stated the family planned to obtain counseling and therapy for the SM.

ACS and LE interviewed the SM simultaneously. Per the SM's account, she was with the SC most of the day while the MGF worked. She gave the SC her last bottle and burped her. She then placed a blanket on the couch and placed the SC on her back to sleep. The SM said she sat next to the SC on the couch and she fell asleep in a seated position next to the SC. She said that at about 3:45 AM, she awoke and checked the SC. She saw the SC was not moving and observed milk flowing from her nose and mouth. She woke the MGF who began to perform CPR on the SC. She contacted 911 and an operator instructed her to perform CPR. There was no car seat, crib, or bassinet in the home. There was a crib at the MGM's home, but she did not pick it up. ACS counseled the SM regarding safe sleep practices.

Later, ACS interviewed the SM who said the night of the incident she was with a friend prior to returning home at about 1:00 AM. The SM left the SC in the care of the MGF. The MGF fed the SC at about 11:45 PM and when she arrived home, she took the SC from the MGF. She then fed the SC another bottle at 1:05 AM, and placed the SC on the couch which the family described as a queen size mattress. She went to sleep on the left side of the couch, sitting upright and placed the SC next to her facing up. They went to sleep at 1:30 AM. Between 1:00 AM and 1:30 AM, the SC cried but seemed well and when she saw the SM, she stopped crying and fell asleep. The SM said she awoke at 3:45 AM and the SC was in the same position but sideways. The SM touched her, and she was cold and limp. She pressed on the SC's chest and did not feel a heartbeat, and began CPR. The MGF then took the SC. The 911 operator directed the SM to move the SC to a flat service. The SM said milk exited the SC's nose. The SM denied substance abuse. The SM reported the BF had no contact with the SC.

According to the MGF, he was awakened by the SM who said the SC was not breathing. When he saw the SC, she was discolored, not breathing, and milk flowed from her nose and mouth. He attempted CPR while the SM contacted 911. Later, the MGF reported by phone that the family was out of state with relatives as they did not want to return to the case address. He said regarding the incident, the SC cried, and the SM fed her. They were on the couch and the MGF went to bed. He then heard the SM state the SC was not breathing. He was aware the SC was born prematurely. He had not witnessed nor observed medication prescribed for the SC. He said since her birth, at times, the SC breathed heavily.

On 12/30/19, LE informed ACS that the SM reported co-sleeping on the couch with the SC, who was face up next to her and when she awoke the SC was not responsive and was observed with spit on her. The SM called the MGF immediately and they began CPR. LE said there was no criminality suspected.

On 1/8/20, an attending physician, said the SC was brought to the ER with no pulse and was not breathing. There were no external findings of trauma, no bruises or suspicion. The physician recalled the SC did not have a crib in the MGF's home.

ACS unfounded the report.

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 case documentation did not reflect there was an MDT response.

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
053710 - Deceased Child, Female, 4 Mons	053711 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
053710 - Deceased Child, Female, 4 Mons	053711 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Unsubstantiated
053710 - Deceased Child, Female, 4 Mons	053712 - Grandparent, Male, 54 Year(s)	DOA / Fatality	Unsubstantiated
053710 - Deceased Child, Female, 4 Mons	053712 - Grandparent, Male, 54 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The SM said she planned to obtain bereavement counseling.

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 SS or other CHN in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The ACS documentation reflected that referrals for service for the family was recommended but the MGF said the family would seek family therapy.

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

The SM and MGF were not known as subjects in any CPS investigation that occurred more than three years before the fatality that involved the deceased child.

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