Child Fatality Report

Report Identification Number: NY-21-088

Prepared by: New York City Regional Office

Issue Date: Jan 16, 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		
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: 3 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 08/18/2021
Initial Date OCFS Notified: 08/13/2021

Presenting Information

The SCR report alleged at 9:00PM on 8/17/2021, the BM put the 3-month-old subject child (SC) to bed in her crib on her back. When the BM woke up in the morning of 8/18/21, the SC was not breathing and had blood coming from the nose area. The BM called 911 and the SC was taken to the hospital. The SC was pronounced dead at the hospital. The BM did not have any explanation for the SC's death. The child was considered otherwise healthy.

Executive Summary

On 8/18/2021, the BM found the 3-month-old female SC unresponsive on a Boppy pillow on the BM's bed. The BM was co-sleeping with the SC at the time. The ME reported the autopsy was pending further tests; however, preliminary findings did not reveal any signs of trauma to the SC.

At the time of the fatality, the BM and the SC resided with the MGM and the MGM's 7 minor children. Three of the MGM's children were vacationing with their PA who resided out of state at the time. The BF resided at a different address but was involved his daughter. The parents did not have any other children.

On 8/18/2021, ACS received the report and commenced the CPS investigation. According to ACS' case documentation, at about 9:00PM on 8/17/2021, the BM placed the SC on a poppy pillow on the bed with her and they both fell asleep. At about 2:00AM, the BM awoke and noticed the SC had slipped off the pillow. The BM picked the SC up and placed the SC back on the Boppy pillow, both falling asleep again. At about 5:00AM, the BM awoke the second time and saw that the SC had again slipped off the pillow. The SC was unresponsive with blood coming from her nose. The BM alerted the MGM who called 911. The BM gave the SC CPR as was instructed by the 911 operator until EMS arrived. EMS arrived at the home minutes later, took over resuscitation efforts and then transported the SC to the hospital where medical officer pronounced the SC dead at 6:53AM.

During the investigation, ACS obtained information from the hospital staff, LE, medical provider, and the MGM. LE ruled out any criminality and deemed the fatality an accident pending the final autopsy. The medical provider did not report any concerns for the SC. The BM and the BF did not provide any explanation for the SC's death. They stated they took good care of the SC and denied any medical concerns for her. They declined ACS' offer of services and refused to take a drug screening. Following the incident, the BM moved out of the home and ACS could no longer reach her.

Prior to the fatality, the MGM had an active neglect case due to the 3-yo MU leaving the home unsupervised on multiple occasions. The BM and the SC did not have any role on the MGM's case. The MGM's 2 youngest children were removed from her care and placed with their father. The MGM requested a 1027 and 1028. The court ruled in the MGM's favor and the children were returned home with COS. ACS SUB the allegations of LS and IG against the MGM and referred the family to PPRS. ACS continued to assess the MGM's children and there were no concerns reported.

Although LE ruled the SC's death accidental, on 10/15/2021, ACS substantiated the allegations of the report against the BM. The BM admitted to co-sleeping in the same bed with the SC at the time she found her face down on the pillow and not breathing. Additionally, the SC had a crib/pack and play in the home, but the BM chose to co-sleep with the SC in the same bed. The BM's actions placed the SC in imminent danger resulting in the SC's death.

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

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:
ACS' decision to close the case was appropriate, as the parents did not have any other children.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/18/2021 **Time of Death:** 06:53 AM

Time of fatal incident, if different than time of death: 05:50 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 05:50 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
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☒ Asleep
- ☐ Absent
- ☐ 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	Aunt/Uncle	No Role	Female	8 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	9 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	12 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	14 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	17 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	3 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	17 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Other Household 1	Father	No Role	Male	21 Year(s)

LDSS Response

On 8/18/2021, LE stated the ME's preliminary assessment did not reveal any trauma to the SC. LE confirmed the SC had a crib and a Pack N' Play in the home.

On 8/18/2021, ACS conducted a virtual video call with the PA. The MGM's 3 children in the PA's care at the time appeared to be well cared for. ACS did not observe any health of safety hazards in the PA's home.

On 8/18/2021, ACS visited the family to assess the MGM's other 4 children. The children were free of suspicious marks or bruises. They appeared to be in good health and did not present with any obvious concerns. The MGM denied the SC had any medical issues/concerns. She stated the BM received prenatal care. The MGM declined services from ACS but requested assistance for the funeral arrangement. She also requested book bags for her children.

On 8/19/2021, the ME reported the cause of death had not been determined pending further tests. The ME stated that there were no signs of trauma to the SC.

On 8/19/2021, ACS interviewed the BM and the BF. They stated they took good care of the SC and denied the SC had any medical condition. The BF described the BM as a good mother. The BM confirmed she was co-sleeping in the bed with the SC at the time of the incident. The BM admitted to smoking marijuana but denied she was smoking on the night of the incident.

On 8/19/2021, the pediatrician reported the SC's vaccines were current. The SC was not on any type of medication and did not have any medical concerns.

On 8/23/2021, ACS held a family team meeting with both parents and offered them bereavement services and funeral assistance. They refused any services or any financial assistance from ACS.

On 8/27/2021, the BF declined to submit to submit to a drug screening.

On 8/31/2021, ACS visited the BF at the PGM's home. There was a bassinet in the home for the SC where she slept whenever she visited.

On 9/15/2021, the DA reported that the SC's death was ruled an accident and there was no criminality pending the final autopsy.

On 10/15/2021, ACS substantiated the allegations of the report against the BM and closed the fatality investigation. ACS transferred the MGM's FSS case to the Family Services Unit for ongoing monitoring and assessment.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical 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 referred to an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in New York City.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059352 - Deceased Child, Female, 3 Month(s)	059354 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
059352 - Deceased Child, Female, 3 Month(s)	059354 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated

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 MGM asked ACS not to interview her children regarding the SC's passing.

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	☐	☐	☐	☐	☐	☒	☐

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

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