Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-015

Prepared by: New York City Regional Office

Issue Date: Aug 12, 2021

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: Richmond
Gender: Male
Date of Death: 02/20/2021
Initial Date OCFS Notified: 02/20/2021

Presenting Information

An SCR report was received which alleged that on 2/20/21, the five-month-old subject child died while in the care of his father. The child was otherwise healthy, and there was no plausible explanation for his death. At 7:45AM on 2/20/21, the child was actively moving around in his crib when the father checked on him. At 9:30AM, the father went back to the room to feed the child and found him face up and unresponsive. The father picked the child up and began cardiopulmonary resuscitation. The child remained unresponsive, so the father placed the child in a baby swing and called emergency services. The role of the mother was unknown.

Executive Summary

This fatality report concerns the death of a five-month-old male subject child that occurred on 2/20/21. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's father. The New York City Administration for Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; however, the final report had not yet been released at the time of this writing. Preliminary findings noted the child died from an infection caused by intussusception, and the manner of death was natural.

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 on the afternoon of 2/19/21, the mother went out of town for a special event, and left the child in the care of his father. The father tended to the child as normal and reported nothing out of the ordinary occurred. The father put the child to sleep in his crib at 9:30PM and checked on him frequently throughout the night via baby monitor. At 8:30AM on 2/20/21, the father felt the child had been asleep too long, so he prepared a bottle and went into the child's room to wake him. The father found the child to be unresponsive and warm, and attempted to rouse him with cold water. When this was unsuccessful, the father called emergency services. An ambulance arrived at the home and transported the child to a local hospital, but he could not be revived. The child was pronounced deceased at 10:16AM on 2/20/21.

From the time the investigation began to the time of its closure, ACS interviewed family members and collateral sources. Law enforcement found no criminality regarding the death of the child, and providers noted no concerns surrounding the child's care leading up to the incident. The medical examiner explained the intussusception most likely caused an infection in the child's blood, which would result in the child's condition to deteriorate rapidly. At the time of this writing, test results to identify the specific infection remained pending. ACS found no evidence of abuse or maltreatment regarding the death of the subject child, and the investigation was unfounded and closed.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
ACS gathered information to determine the allegations. There were no surviving siblings or other children in the household.

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/20/2021 **Time of Death:** 10:16 AM

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

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: 09:37 AM
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

How long before incident was the child last seen by caretaker? 1 Hours
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	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)

LDSS Response

On 2/20/21, ACS received the SCR report regarding the death of SC. ACS initiated their investigation within 24 hours and coordinated their efforts with their MDT. ACS learned there were no SS or other CHN that resided in the household, and the family had no CPS history.

On 2/21/21, ACS interviewed BM and SF via phone, as they declined to meet face to face. SF explained that on 2/19/21, BM left to go out of town around 4:00PM, and he was alone with SC for the night. SF stated he had a friend (OA) come over for a few hours, and during that time, SC was fed and changed on several occasions and there was nothing out of the ordinary. SF reported he last fed SC around 8:45PM and put him to bed at 9:30PM. SF said SC woke a few times during the night, but he could not recall the times. He stated at 7:45AM on 2/20/21, he checked the baby monitor and assumed SC was still asleep as he was not moving. SF reported around 8:30AM, he realized SC had been asleep too long, so he made him a bottle and went to wake him. SF reported when he went to rouse SC, he was unresponsive, so he picked SC up and placed him in a baby swing, then called 911; SF reported he was “in shock” and not thinking clearly, and was unsure why he placed SC in the swing. SF denied SC had a fever or showed any signs of illness prior to his death. Both parents reported SC had acid reflux which caused him to spit up after eating; however, he was not taking any medications at the time of his death. SF stated SC is typically placed to sleep on his stomach due to the reflux, per recommendation by SC's doctor. Also in the crib were blankets, stuffed animals and a burp cloth which was placed under SC's head in case he spit up. BM reiterated she was out of town when the incident occurred and had no further information surrounding the events.

On 2/22/21, ACS met with SF and BM face-to-face at a relative’s home to clarify information. SF said he was informed by medical staff that SC’s body temperature was 104 degrees at the hospital. SF reported he noticed SC felt hot when he found him in his crib, so he put some cold water on him to try to cool him down. SF stated SC was previously on medication for the acid reflux, but the reflux had improved, and he no longer needed it. BM denied anything unusual occurred prior to leaving on 2/19/21, and denied any concerns in general regarding SF’s ability to care for SC.

On 2/23/21, ACS spoke with OA. OA explained he went to SF’s home around 3PM on 2/19/21 to play video games, and he went to sleep in the living around 2:00AM on 2/20/21. OA said SF was attentive to SC, and after SF put SC to bed, SF checked on SC often through the baby monitor; SC appeared to be well throughout the night. OA stated he awoke around 9:00AM and heard SF screaming that SC was not breathing. OA had no further information surrounding the incident and

denied any concerns regarding SF or his care of SC.

Throughout the investigation, ACS spoke with the ME, LE, and SC's medical providers, including the specialist who was treating SC's acid reflux. ACS was informed by the specialist that it was typical for parents to cease recommended medications upon improvement of the condition. Further, he explained the preliminary cause of death had no correlation to acid reflux. The record did not reflect ACS inquired about recommending SC be placed to sleep on his stomach, or if BM and SF were previously educated surrounding safe sleep practices. There were no criminal charges brought against SF regarding the fatality. A home visit was completed and there were no safety hazards observed. There were no concerns expressed by family members or collateral sources regarding the care of SC. ACS provided the family with burial assistance information and referrals for grief and bereavement counseling. There was no evidence gathered to support that SF's actions or inaction led to the death of SC, and therefore, ACS unsubstantiated the allegations and closed the case.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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
Comments: This fatality investigation was conducted by the ACS MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The New York City 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
057801 - Deceased Child, Male, 5 Mons	057802 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
057801 - Deceased Child, Male, 5 Mons	057802 - Father, Male, 30 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:
ACS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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 bereavement counseling referrals and information on assistance with funeral costs.

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? Yes
Explain:
ACS provided grief and bereavement referrals to the parents and other family members affected by the child's death.

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.

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