Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-029

Prepared by: New York City Regional Office

Issue Date: Sep 20, 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: 3 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 03/21/2021
Initial Date OCFS Notified: 03/21/2021

Presenting Information

The SCR report alleged on 3/21/21, the SM fed and burped the SC between 9:00AM and 10:00AM. The SM then wrapped the SC in a baby blanket and placed the SC on her stomach in the SM's bed. Both the SM and SC subsequently fell asleep, together, in the bed. The SM woke up at 2:00PM and the SC was unresponsive. The SM called 911 and was advised to start CPR on the SC until the ambulance arrived. When EMS arrived, the SC did not have a pulse. EMS workers continued to work on the SC for 40 minutes and while en route to and after arriving at the hospital. The SC was pronounced dead at the hospital at 4:14PM. This was an otherwise healthy child and the SM had no explanation for why the SC passed away. The role of the father was unknown.

Executive Summary

The 3-month-old female subject child (SC) died on 3/21/21. The autopsy report listed the cause of death as unexplained sudden death (extrinsic factors identified) and the manner of death undetermined.

There were no surviving siblings or children in the home.

According to the ACS documentation, at about 9:00AM on 3/21/21, the SM fed the SC, burped her, and when the SC spit up, she changed her putting her in a clean onesie and then in a sleeping sac. SM said the SC had been having an issue spitting up after drinking her formula, but the SM would ensure the SC burped before putting her down for a nap. The SM placed the SC on her stomach on the SM’s full-size bed. The SM said she was aware of safe sleep, but preferred to co-sleep until the SC was asleep and then she would place the SC in the playpen. However, the SM did not do this the morning of 3/21/21 as she also fell asleep. When the SM awoke at about 2:00 PM, she saw that the SC was not responsive. She immediately called 911 and was instructed to perform CPR. The child was transported to the hospital where she was pronounced dead.

Throughout the investigation ACS maintained contact with the appropriate collaterals and followed up with information obtained. The Safety Assessments were adequate and accurately reflected case circumstances.

On 5/19/21, ACS substantiated the allegation of IG of the SC by the SM. During the investigation, it was learned the SM was educated concerning safe sleep. However, the SM admitted despite having a "Pack-n-Play" for the SC, she still placed the SC on the bed and engaged in bed sharing which led to the SC’s death.

ACS unsubstantiated the allegation on DOA/Fatality of the SC by the SM. The SM reported she fed the SC at 9:00AM and burped her. The SM placed the SC who was encased in a baby sleeping sack on her side on the bed on top of a fleece blanket. The SM fell asleep as well with the SC on the bed. The SM awoke at 2:00 PM to the SC unresponsive. The SM contacted 911 who instructed her to perform CPR while EMS and LE arrived on the scene and continued CPR. The SC was transported to the hospital and pronounced deceased at 4:14 PM. The ME reported the SC was unremarkable, no abnormalities, and no child abuse noted.

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 make determination for all allegations on the intake report.

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 SM had no children in her care.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The documentation did not reflect ACS interviewed EMS nor the EMS Liaison regarding the incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
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: 03/21/2021 **Time of Death:** 04:14 PM

Time of fatal incident, if different than time of death: 02:00 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 03:18 PM
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 was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	Female	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

On 3/21/21, LE said they received a 911 call indicating the SC was found unresponsive. SM was advised to perform CPR until EMS responded to the home. The SM disclosed she fed the SC about 9:00AM and the SC went to sleep on the full-size bed with her until about 2:00PM. She awoke and found the SC unresponsive. LE said the SM stated she placed the SC on her stomach. There were no physical signs of injuries. The apartment was sealed pending the autopsy.

On 3/22/21, ACS visited the apartment and LE advised the family was not present. LE said ACS could not interview the other tenants in the apartment at this time. ACS observed in the room where the incident occurred, a full-size bed with sheets and a comforter on the bed. Also, in the room was two nightstands and a dresser. Food was observed on the dresser. ACS did not observe a crib or "Pack-n-Play."

On 3/22/21, ACS visited the SM at a “drop-in center;” however, the Specialist was unable to meet with the mother.

On 3/22/21, ACS visited the PGGF who reported the BF was at his home on 3/21/21 when he received a phone call. The PGGF stated the BF was hysterical and screamed that his baby was dead. He transported the BF to the hospital. The PGGF said the parents stayed overnight and left in the morning. He did not know of their location. He said he did not observe any concerns with their ability to care for the SC. He stated the parents had resided in his home, but after they were involved in an argument, the SM relocated to the AirBnB. He said the BF resided with him and would visit the SM and SC.

On 3/22/21, ACS received a call from the BF who denied clinical health issues and substance abuse. He denied marijuana possession charges and having a court hearing on May 2021. He again stated he did not misuse drugs. The BF explained he was not at the case address when the SM found the SC unresponsive. He did not know what occurred. He confirmed he stopped by the case address between 4:00AM and 5:00AM to drop some things off and both the SM and SC were sleeping. He said they awoke when he entered the apartment. The SC was not ill or fussy, and seemed fine. Soon after, the SC and SM went back to sleep and he left the address.

The SM informed ACS she was not willing to meet or speak with ACS in person. The SM stated she did not have any history of substance use. She said the SC was born full term and did not have any medical concerns at birth. The SC's last wellness check was in February 2021 where she spoke with the Dr. about the SC constantly spitting up. The Dr. recommended a formula change. ACS offered the SM and BF services and bereavement information, and both declined. The SM said she had support from family and friends.

The Specialist interviewed LE and the information the mother shared with LE was consistent with the account she provided to ACS.

On 3/22/21, the ME identified co-sleeping as a risk factor. The ME stated the SC was "unremarkable" with no anatomic abnormalities. There were no findings, and the final report would be completed when all test results were received. The ME told ACS the SC had was a small scrape on her toe but could not determine how it occurred.

On 3/23/21, the DA informed ACS the ME stated there were no suspicions of child abuse. The DA said the ME explained they were waiting for the results of the toxicology which takes up to six/seven months. Currently, there are no charges against the parents. The DA would provide ACS an update if there are any new developments.

On 4/21/21, the SM told ACS she was no longer staying in the AirBnB and had no plans of entering Prevention Assistance Temporary Housing (PATH). The parents refused services.

ACS indicated the report.

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 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
057841 - Deceased Child, Female, 3 Mons	057842 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated

057841 - Deceased Child, Female, 3 Mons	057842 - Mother, Female, 23 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 documentation reflected the SM and BF were interviewed by phone. The documentation reflected ACS could not speak to the pediatrician as the SM did not meet with ACS and sign the Health Insurance Portability and Accountability Act document.

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 documentation reflected the SM and BF did not want any assistance from ACS.							

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 other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The documentation reflected the SM did not want any assistance from ACS.

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? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/15/2018	Sibling, Female, 24 Days	Mother, Female, 20 Years	Choking / Twisting / Shaking	Unsubstantiated	Yes
	Sibling, Female, 24 Days	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 24 Days	Mother, Female, 20 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The 3/15/18 report alleged the SM was unable to provide the 3-week old SS with adequate care. She did not feed the SS according to medical instructions. She did not give the SS medications and did not comply with the SS's medical appointments. The SM also shook the SS for unknown reasons. On 3/12/18, the SM left the home without making any plans for the SS's care. The SM had another child who had been removed from her due to neglect.

Report Determination: Indicated **Date of Determination:** 04/25/2018

Basis for Determination:
It was reported the SM left the SS with the MA for several days and her whereabouts were unknown. In addition, the SM had a Termination of Parental Rights (TPR) pending, in which she did not comply with the recommendations and referrals of the courts. The SM had a history of clinical health, substance abuse, and homelessness.

The allegations of C/T/S and LMC were unsubstantiated. The hospital reported there was no evidence of trauma for the SS. The MA and SM denied the allegation. According to the physician, the SM brought the SS to her scheduled appointments.

OCFS Review Results:
The report was initiated in a timely manner. The LDSS followed up on information received and maintained contact with the appropriate collaterals.

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

Issue:
Confidentiality of reporters

Summary:
ACS was assigned a secondary role in the investigation. The documentation reflected that on 3/19/18, ACS identified the name of the source of the report.

Legal Reference:
SSL 422(4)(A); 05-OCFS-ADM-02

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.

[redacted]

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

The SM was known to the SCR and Westchester County DSS (WCDSS) as a subject in one report dated 8/9/16. The allegations of the report were IF/C/S, IG, and LMC of the 4-yo male sibling by the SM and the father of the child. On 10/7/16, WCDSS substantiated the allegations.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Foster Care Placement History

The documentation reflected the two SSs, (4-yo male and 3-yo female) were removed from the SM's care in Westchester County. The SM's parental rights were terminated. The 4-yo was freed for adoption on 6/12/18 and on 9/19/19, the 3-yo was also freed.

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