Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-101

Prepared by: New York City Regional Office

Issue Date: Mar 11, 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: 2 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 09/10/2021
Initial Date OCFS Notified: 09/10/2021

Presenting Information

The SCR report alleged on 9/10/21, sometime around 9:00 AM the mother discovered the subject child not breathing and unresponsive in her crib. The mother called 911, who responded to the home. The subject child was taken to the hospital by emergency personnel and was pronounced dead by the hospital staff at about 9:14 AM. The subject child was an otherwise healthy child and the mother had no explanation for the death. The roles of the other children in the home were unknown.

Executive Summary

The 2-month-old female subject child died on 9/10/21. As of 2/10/22, NYCRO had not received a copy of the ME's report.

At the time of her death, the subject child resided with the mother, a 15-yo male, and a 9-yo female SSs. The father resided in the same supportive housing building as the mother but in different apartments.

ACS learned that the mother and the subject child went to bed at about 12:00 AM on 9/10/21, on a full-size mattress. The mother and subject child were sleeping on opposite sides of the mattress. When the mother awoke, she saw the subject child next to her. The mother attempted to move the subject child, and realized the subject child was not breathing. The mother placed the child in a stroller, got dressed, and then took the subject child to the father's apartment. An adult sibling in the father's home opened the door and when the mother screamed that the subject child was not breathing, the adult sibling called 911 for emergency assistance. The time of the call was listed as 8:28AM. The operator provided instructions which the mother followed until EMS arrived. The subject child was transported to the hospital where she was pronounced dead on arrival at 9:14 AM.

The ME reported the subject child's cause and manner of death was listed as undetermined pending the result of additional tests. The ME suspected the subject child's death was the result of a rollover related to an unsafe sleep situation. The ME also stated the subject child's body was clean with no visible signs of trauma. The scene investigator's notes indicated the subject child was in an adult bed, lying face-up with an adult and that on the bed were four adult pillows and a baby blanket.

ACS offered the family burial assistance and on 11/30/21, ACS unsubstantiated the allegation of DOA/Fatality of the subject child by the mother as there was no evidence the subject child's death resulted from other than accidental means.

NYCRO does not agree with the determination to unsubstantiate the allegation of DOA/Fatality as written. The allegation of DOA/Fatality should have been indicated as the ME said the death was most likely the result of a rollover related to an unsafe sleep situation. There were bed sharing aggravating factors.

The allegation of IG was substantiated as the mother created an unsafe sleep environment when she bed shared with the subject on 9/9/21 into 9/10/21. The mother's action created a situation that placed the subject child at substantial risk of harm. ACS documented the mother received safe sleep counseling; thus, the mother was aware bed-sharing with the subject child created an unsafe sleep environment and placed the SC at substantial risk of harm.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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:
NA

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:
On 9/13/21, ACS opened a service case. It was closed on 2/9/22.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 9/11/21 safety assessment was inadequate. The safety assessment had comments that did not support the selected safety factor. The comment regarding the BF's health and SM's alleged clinical health condition did not reflect the negative impact.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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 Seven Day Assessment

Summary:	The 9/15/21 safety assessment was inadequate. Comments that did not support the selected safety factor. The comment the 15-yo SS had a history of a medical condition did not reflect the parent was unable and/or unwilling to provide adequate care.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
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:	Notes were not entered contemporaneously. For example an event occurred on 9/13/21 but was not entered until 11/19/21.
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.
Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment-Family Court)
Summary:	ACS substantiated the allegation of IG citing substantial risk of harm instead of applying the appropriate legal standard of some credible evidence.
Legal Reference:	SSL 412(1) and 412(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:	Appropriateness of allegation determination
Summary:	The allegation of DOA/Fatality should have been indicated as the ME said the death was most likely the result of a rollover related to an unsafe sleep situation. There were bed sharing aggravating factors.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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:	Appropriateness of allegation determination
Summary:	Although ACS listed the BF as having no role, case documentation reflected according to the adults, at 11:00PM on 9/9/21 the BF fed the SC and changed her diaper before propping the SC up on a pillow to sleep in bed with the SM.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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: 09/10/2021 **Time of Death:** 09:14 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:28 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
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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Other Household 1	Father	No Role	Male	51 Year(s)

LDSS Response

Upon receipt of the report, ACS contacted LE and learned EMS responded to a call that was received at 8:28AM on 9/10/21. LE said the SM reported she woke up and did not observe the SC moving and called 911. The SC was in the bed with her. LE reported that according to the adults, at 11:00PM on 9/9/21 the BF fed the SC and changed her diaper before

propping the SC up on a pillow to sleep in bed with the SM. The parents said the bed was pushed up against a wall in the room. A second pillow was used to separate the SC from the wall on the bed. Shortly after 8:00 AM the SM awoke and found the SC in bed next to her, but her stomach and chest were not moving. The SM picked up the SC and attempted to shake her a couple of times believing she would respond. When the SC did not react, the SM panicked, placed the SC in the stroller, got dressed, and ran to the BF's unit for help. Three calls were made to 911. LE indicated the accounts provided by the adults were consistent. LE said the SC was clean with no visible signs of trauma. Additionally, there was no suspicion of drug/alcohol use, no arrests were made, and no criminality was associated with the child's death.

On 9/10/21, ACS met with staff of the supportive housing facility and learned the family had never been mentioned with any concerns. It was reported the SM had a history of substance abuse. The staff reported the parents had received information regarding Safe sleep information. The staff also made referrals to community-based organizations for counseling for the family.

On 9/10/21, ACS visited the case address and spoke with the SM. ACS informed the SM about services such as counseling, and burial assistance.

ACS interviewed the SSs in the SM's home. The 15-yo SS said he woke up at about 8:24AM to get ready for school and heard the SM scream. The SM told him the SC was not breathing. He walked over to the stroller and saw the SC's lips and body looked purple. He said he tried to push the stroller to see if the SC would move, he tapped her and moved her arm, but she did not respond. The 15-yo SS said he called a school staff member and said he would not be attending for the day. He said when they arrived at the hospital, the SM was crying, and then they were told the SC was dead. He said the 9-yo SS stayed in the BF's home with the adult sibling until the MGM arrived. The 15-yo said he did not need counseling.

The 9-yo SS said when she awoke, she asked what was occurring and the adult sibling and his paramour told her what occurred. She said there were LE officers in her home. The 9-yo said she went to the BF's home with her adult sibling and his paramour until the MGM arrived.

On ACS interviewed medical personnel and learned on arrival the SC had no cardiac activity and was not breathing. Additionally, there were no visible signs of abuse or neglect.

On 9/13/21, ACS met with the SM, who once again repeated her account of the incident. ACS was informed the children's school had offered them counseling. The SM declined the need for counseling services for herself but indicated she would consider the service for the children. The BF also declined services. The BF explained the SC slept on her back in her crib; the SC would take naps during the day. The BF said the SM would often keep the SC in bed with her as the SC often "spat up."

On 9/14/21, the ME reported the SC's death was listed as undetermined pending the outcome of tests.

On 9/29/21, a Child Safety Conference was convened. The BF denied the use of substances and stated the alcohol observed in the home belonged to the MGM or people who visited the home. ACS and the family agreed to the safety plan of having the family's case manager visit the SM twice weekly and other staff would speak with the SM on a daily basis. ACS would complete routine checks on the SSs during the investigation.

On 10/1/21, ACS addressed alcohol use in the home, which the SM denied. ACS offered the family services and IND 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 referred to an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059553 - Deceased Child, Female, 2 Mons	059554 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
059553 - Deceased Child, Female, 2 Mons	059554 - Mother, Female, 36 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:
Notes were not entered contemporaneously. For example an event occurred on 9/13/21 but was not entered until 11/19/21.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐

Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: On 9/13/21, ACS opened a service case. However, it was closed on 2/9/22.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The two SSs were not taken into protective custody. The 9/11/21 safety assessment reflected that there was a safety plan implemented by the family and was in place prior to the involvement of ACS. The safety plan included the MGM				

visiting the home and staying with the family on weekends. The family also resided in supportive Housing, and the on duty staff member would check in with the family. ACS also provided the family with information for Crisis Services.

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 accepted burial 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? No
Explain:
The family declined bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
The SM accepted burial 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?	No
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 was listed as having no role in a report registered on 2/27/13. The SM was known to the SCR and ACS as a subject in one report dated 1/8/14. The allegations of the 1/8/14 report was IG of the now 15-yo SS by the SM. On 2/25/14, ACS UNF the report with no services required.

The now 15-yo SS was known as a non-confirmed maltreated CH in a report registered with the SCR and ACS on 2/27/13. The allegations of the 2/27/13 report were XCP and L/B/W of the now 15-yo by the uncle. On 4/26/13, ACS UNF the report. It was closed and referred to community based services.

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