Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-130

Prepared by: New York City Regional Office

Issue Date: May 26, 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: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/04/2021
Initial Date OCFS Notified: 12/04/2021

Presenting Information

The 12/4/21 SCR report alleged on 12/3/21, at an unknown time the MGM placed the subject child (SC) down in his crib. At about 3:00PM the MGM went to check the SC and found him on his side, unresponsive, and with blood under his nose. The MGM called 911. When EMS responded to the home, they immediately initiated CPR. Lifesaving measures continued enroute to the hospital. The SC was stabilized in the emergency room and at about 7:35PM the SC was transported to the neonatal intensive care unit at another hospital for further treatment and observation. On 12/4/21 at 12:33AM the SC was pronounced dead. Neither the MGM nor the SM had any explanation for why the otherwise healthy SC died.

Executive Summary

The 1-month-old male child (SC) died on 12/4/21. The autopsy listed the cause of death as Sudden Unexplained Death in Infancy (extrinsic factor identified) and the manner of death was Undetermined.

At the time of the incident, the SM, SC, MGM, and an adult MU resided in the home. The BF resided outside of NYS. The MGM's 3-year-old grandchild was visiting the home. There were no surviving siblings.

According to the information obtained by ACS the SM went to work at 9:00 AM on 12/3/21 and left the SC with the MGM. Between 12:30PM and 1:00PM, the MGM fed and burped the SC. The SC remained alert for 30 minutes after being fed. When the SC fell asleep, the MGM placed him in his crib on his side because he was "gassy." At about 2:30 PM when the MGM checked the SC, he was fine. The MGM's three-year-old granddaughter was in the home and the MGM decided to cut the three-year-old child's hair while the SC was sleeping. At about 4:00PM, the MGM checked the SC and noticed the SC was not awake. When she checked further, she found he was unresponsive. The SC was face down in the crib. The MGM screamed and told the MU to call 911. The MGM also called the SM. The MU relayed the instructions on how to perform CPR from the operator to the MGM. When the MGM picked up the SC, turned him around, and patted his back, she heard the child gasp for air. When the MGM placed the SC on the bed, she noticed blood seeping from his nose. During this time the SM arrived home from work and called the MA, who worked as a nursing assistant. The MA went to the home and when EMS arrived, the MA and the SM traveled in the ambulance to the hospital. The MA left her 10-year-old male and the three-year-old female children with the MGM. At about 2:00AM on 12/4/21, the family was informed that the SC had died.

LE informed ACS they were awaiting the results of the autopsy; however, there did not appear to be any criminality associated with the SC's death based on the statements provided by the MGM. LE further stated no actions would be taken against the adults and LE's investigation would be closed once they received the SC's death certificate.

The ME reported there were no concerns of abuse or maltreatment. There were no noted abnormalities. The SC's body was not observed with any serious injury. The SC had bruising to the abdominal area which was because of resuscitation efforts by EMS and hospital staff.

ACS informed the family about services; however, the SM, BF, MA, and MU declined. The MGM sought and was engaged in services which she obtained on her own.

On 2/2/22, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the MGM and SM. ACS

documented that at the time of the incident the SM was not present; she was at work. To further support the decision ACS documented that LE and other collaterals indicated there was no evidence to support the MGM's actions or inactions cause the death of the SC.

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:
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:
NA

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: 12/04/2021 **Time of Death:** 12:33 AM

Date of fatal incident, if different than date of death: 12/03/2021
Time of fatal incident, if different than time of death: 03:05 PM

County where fatality incident occurred: Kings

Was 911 or local emergency number called? Yes
Time of Call: 03:05 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: **Giving her 3-yo visitng grandadaughter a hair cut.**

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	Male	20 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)

LDSS Response

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Official Manner and Cause of Death

Official Manner: Undetermined
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

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
060297 - Deceased Child, Male, 1 Mons	060298 - Mother, Female, 18 Year(s)	DOA / Fatality	Unsubstantiated
060297 - Deceased Child, Male, 1 Mons	060298 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
060297 - Deceased Child, Male, 1 Mons	060299 - Grandparent, Female, 58 Year(s)	DOA / Fatality	Unsubstantiated
060297 - Deceased Child, Male, 1 Mons	060299 - Grandparent, Female, 58 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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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 SSs or other minor CHN 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 MGM was receptive to bereavement services which she sought on her own. The SM, MU, and BF declined services 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? 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 was not known as a subject to the SCR and ACS more than three years prior to the fatality.

The MGM was known to the SCR and ACS as a subject in 5 reports dated: 7/16/04, 2/27/07, 5/21/12, 8/22/14, and 7/20/15. The allegations of the reports were a combination of EdN, IG, LS, IF/C/S, PD/AM L/B/W of the MGM's now adult children. Of the five reports, four were indicated and one was unfounded.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

The family received preventive services from 2004 until 6/23/08 and again from 2012 until 4/27/15 when it was determined the family met the goals. Services were in place to address the MGM's substance abuse. The service plan for the family included case management services, drug counseling treatment, and general preventive services.

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