



Report Identification Number: NY-20-007

Prepared by: New York State Office of Children & Family Services

Issue Date: Jun 29, 2020

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: 14 day(s)

Jurisdiction: Bronx
Gender: Female

Date of Death: 01/13/2020
Initial Date OCFS Notified: 01/14/2020

Presenting Information

An SCR report was received on 1/14/20 with concerns the mother was co-sleeping with the 14-day-old child in a full size bed on 1/13/20, when she awoke around 6:00AM and found the child unresponsive. The mother last saw the child alive around 2:00AM, and there was no explanation as to how the child died.

Executive Summary

This fatality report concerns the death of a 14-day-old female subject child (SC) that occurred on 1/13/20. A report was made to the SCR on 1/14/20 with allegations of Inadequate Guardianship and DOA/Fatality against the child’s mother (SM). The Administration for Children’s Services (ACS) received the report and investigated the child’s death. An autopsy was completed; however, the final report remained pending at the time of this writing. ACS spoke with the Medical Examiner’s Office and was advised there were no signs of trauma to the child and opined the mother may have rolled onto the child while sleeping.

At the time of the child’s death, she resided with her mother and six paternal relatives: five adults and a 16-year-old child. The child’s biological father resided in another state, and the mother had planned on moving to that state with the child. The investigation revealed at approximately 2:00AM on 1/13/20, the mother changed and fed the child, and then laid the child back in bed with her to sleep. The mother placed the child on the side of the bed closest to the wall, on her back and with a small blanket. The mother also placed another small blanket under the child’s head as a pillow. The mother fell asleep beside the child and awoke again at approximately 6:00AM. The mother used the restroom and wondered why the child had not yet awoken for her next feeding. The mother checked on the child and found her to be unresponsive. A family member called emergency services, but the mother and two of the relatives attempted to drive the child to the hospital, as the mother felt it would be quicker than waiting for an ambulance. When they were en route and experienced traffic, a relative called emergency services from the car. Police and an ambulance responded to the call and transported the child to the hospital. The child was pronounced deceased at 8:07AM.

From the time the investigation began to the time of its closure, ACS met with family members and interviewed pertinent collateral sources. The mother and father relocated to a different state soon after the child’s death. It was determined the mother had been educated surrounding safe sleep practices and placed the child at risk by choosing to co-sleep. ACS substantiated the allegations in the report and closed their case.

PIP Requirement

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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:

ACS gathered sufficient information to appropriately determine the allegations. There were no surviving siblings; however, the safety of the 16yo relative was assessed.

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	Although the safety of the 16yo relative was assessed and documented in a progress note, the Initial Safety Assessment in Connections did not reflect this.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	Prior to making a determination, the investigation conducted by the child protective service shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment in the form and manner provided by OCFS.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	SM and SC resided with six relatives at the time of SC's death; however, ACS only interviewed three of the six.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.



Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/13/2020

Time of Death: 08:07 AM

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

Unknown

County where fatality incident occurred:

Bronx

Was 911 or local emergency number called?

Yes

Time of Call:

Unknown

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
- Playing
- Other

- Working
- Eating

- Driving / Vehicle occupant
- Unknown

Did child have supervision at time of incident leading to death? Yes

How long before incident was the child last seen by caretaker? 4 Hours

At time of incident supervisor was:

- Drug Impaired
- Alcohol Impaired
- Distracted
- Impaired by disability
- Absent
- Asleep
- Impaired by illness
- 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	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	14 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Other - Cousin	No Role	Male	18 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	16 Year(s)
Other Household 1	Father	No Role	Male	32 Year(s)

LDSS Response



On 1/14/20, ACS received the SCR report regarding the death of SC, which occurred on 1/13/20. ACS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACS learned SC was an only child and promptly began gathering information surrounding her death.

On 1/14/20, ACS completed a home visit to where BM and SC had been staying. ACS utilized translator services to interview BM, as she was non-English speaking. BM explained SC was born prematurely via c-section while she was visiting BF in another state. She stated she and SC had to go back to NY because that was where her insurance covered. SM explained she was staying with BF's family upon returning as they offered to help her with SC as she healed from her surgery. ACS observed there were no appropriate sleeping arrangements in the home for SC. SM reported she last fed SC around 2:00AM on 1/13/20, and then laid her in the full-size bed where SM and SC co-slept. SM explained she placed SC on the side of the bed closest to the wall, covered her with a small blanket and folded a small blanket under her head as a pillow. SM explained she placed SC on her back to sleep. SM recalled she awoke around 6:00AM and used the bathroom, then wondered why SC had not awoken for her feeding; she typically wanted to be fed every 2 hours. SM tried to rouse SC and discovered SC was not breathing. SM said she called out for family members, and they started to drive SC to the hospital. SM stated there was traffic, so they called 911 from the car, and EMS went to their location. SM reported SC was last seen at the doctor on 1/7/20 and was healthy but had a runny nose; the pediatrician provided SM with a bulb syringe. SM said SC still had a runny nose at the time of her death. SC's next doctor's appointment was scheduled for 1/14/20. ACS observed the home and found no safety concerns.

On 1/15/20, ACS interviewed BF and three of his six family members who resided in the home. Of these family members, there was a 16yo CH, who was assessed to be safe. BF reported he resides out of state and was not present the night of the incident. He explained he received a phone call around 7:00AM on 1/13/20 and was informed to go to the hospital where SC was taken. BF stated by the time he got there, SC was already pronounced dead. BF had no further information and denied any concerns for SC when with SM. A paternal uncle was not at the home at the time SC was found unresponsive, and the other family members were asleep when the incident took place. SM woke a paternal aunt, who then woke a paternal uncle and the three of them tried to drive SC to the hospital. The 16yo CH reported SM and SC slept in bed together and that there was no crib in the house for SC. There were no other concerns disclosed during this home visit.

Early on in this investigation, SM and BF relocated to another state. ACS contacted that state's CPS and arranged for a home visit and to link the family with any needed services in their new community. There were no concerns noted by that agency regarding SM and BF's home. ACS received medical records that noted SM last received safe sleep information from SC's pediatrician on 1/7/20.

Throughout the investigation, ACS spoke with numerous collateral sources and some family members; however, ACS did not interview all of the individuals who lived at the residence. The initial and 7-Day safety assessments did not reflect the safety of the 16yo relative that resided in the home. LE found no criminality on behalf of SM regarding SC's death. ACS found some credible evidence that SM's failure to provide a safe sleeping environment for SC placed SC in imminent risk of harm, therefore, ACS indicated and closed their case.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Unknown

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No

Comments: This investigation adhered to previously approved protocols for joint investigation.



Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054263 - Deceased Child, Female, 14 Days	054264 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
054263 - Deceased Child, Female, 14 Days	054264 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

ACS did not interview all household members. Appropriate collateral sources were contacted. Progress notes and other documentation were completed and entered timely.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				



Child Fatality Report

Within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain as necessary:

The 16yo relative did not need to be removed as a result of this fatality report.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:
 ACS offered the family appropriate services; however, the family relocated to another state during the investigation.

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 record did not reflect any services were offered to the 16yo relative.

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

Explain:
 ACS provided the parents with information on community resources; however, the parents relocated to a different state during the investigation.

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 fetal alcohol effects or syndrome



With neither of the issues listed noted in case record

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 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