Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-017

Prepared by: New York City Regional Office

Issue Date: Aug 26, 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: Bronx
Gender: Male
Date of Death: 03/03/2021
Initial Date OCFS Notified: 03/03/2021

Presenting Information

An SCR report was received which alleged that on 3/3/21, the parents put the three-month-old child down to sleep at 12:30AM, and at 6:30AM, they discovered the child not breathing. Emergency services were called and responded to the home. The child was unable to be revived and pronounced deceased at the hospital. The child was otherwise healthy and none of the adults in the home, which included two grandparents, could provide an explanation for the child's death. Therefore, all adults were named as subjects in the report.

Executive Summary

This fatality report concerns the death of a three-month-old male subject child that occurred on 3/3/21. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother, father, maternal grandmother, and maternal great grandmother. The New York City Administration for Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; however, the official cause and manner of death had not yet been released at the time of this writing. Preliminary results noted the child had no outward signs of abuse or trauma but tested positive for a virus; however, at this time, it is unknown if this was a contributing factor to the child's death.

Prior to 2/24/21, the child resided with his mother, maternal grandmother, and two maternal uncles, one of whom was 13 years old. The father lived in a separate residence. The investigation revealed that the subject child began staying with his maternal great-grandmother on 2/24/21 due to the mother, father and adult maternal uncle contracting a virus. Information surrounding what occurred leading up to the fatality was limited due to the maternal great-grandmother retaining legal counsel and declining to be interviewed; however, it was discovered the maternal great-grandmother had been caring for the subject child and an 11-month-old cousin at the time of the fatality. The 11-month-old child was spending the night at the maternal great-grandmother's when the incident occurred. The maternal great-grandmother last fed each child around 12:30AM on 3/3/21, and then she and both children went to sleep: the subject child was put to sleep in a car seat next to the maternal great-grandmother's bed, and the cousin was placed to sleep in a bassinet. The maternal great-grandmother woke around 6:30AM and found the subject child unresponsive. She immediately called emergency services, who transported the child to a local hospital. The child could not be revived and was pronounced deceased at 7:16AM on 3/3/21.

From the time the investigation began to the time of its closure, ACS gathered information surrounding the fatality from the mother, father, and collateral sources, which included law enforcement, medical staff, and relatives. Diligent efforts were made to interview the maternal great-grandmother but were unsuccessful. All collateral contacts denied any concerns surrounding the maternal great-grandmother's ability to care for the subject child, and there were no criminal charges brought against her regarding the death. ACS offered the family services in response to the fatality. Details surrounding the child's sleeping environment, sleeping position, and the maternal great-grandmother's knowledge surrounding safe sleep practices remained unknown. ACS found no evidence to support the allegations in the report, and the case was unfounded and closed.

The adult and 13-year-old maternal uncles were not added to the case composition; however, both resided in the mother and subject child's home. The record did not reflect any attempts were made to interview the 13-year-old maternal uncle. The safety assessments documented in Connections were inaccurate as they did not address the safety of the 13-year-old maternal uncle, and specifically noted the maternal grandmother had no minor children in her care.

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?** No
  - **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 information to determine the allegations and assessed the safety of the other children in the households.

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:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	It was determined SM and SC resided with MGM in MGM's home, where a 13yo MU also lived. The record did not reflect that child was interviewed.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)

Action:	The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including all children in the home or children named in the report.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	Although the MGM was named as a subject in the report, the safety assessment did not reflect the safety of the 13-year-old maternal uncle that resided in the home.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/03/2021 **Time of Death:** 07:16 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? N/A
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 6 Hours
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	Aunt/Uncle	No Role	Male	13 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	26 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	24 Year(s)
Other Household 2	Grandparent	Alleged Perpetrator	Female	66 Year(s)

LDSS Response

On 3/3/21, ACS received the SCR report regarding the death of SC. On that same date, a subsequent report was received with additional information that MGGM was the caretaker of SC at the time of his death, and that report was consolidated with the initial report. ACS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACS established there were no SSs, nor were there any other CHN residing in MGGM's home, where the fatal incident occurred.

ACS learned that although the fatality occurred at the MGGM's home in the Bronx, SF, SC, and SM resided in Westchester County. Accordingly, ACS requested that Westchester County Department of Social Services (WCDSS) take on a secondary role to complete interviews and observe home environments. ACS and WCDSS made several attempts to meet with and interview MGGM, SM, and SF in their respective locations; however, they either could not be located or were uncooperative with the caseworkers. ACS was able to gather information concerning the fatality via statements the family made to LE and other collateral sources, including relatives. On 3/3/21, ACS spoke with LE for details surrounding the fatality. ACS was advised of MGGM's statement that she had been caring for SC and her other grandchild (11-month-old cousin to SC), and last gave each a bottle around 12:30AM on 3/3/21. LE explained MGGM stated she then put the cousin to sleep in a bassinet, and the SC to sleep in a car seat; MGGM then went to bed herself. LE said MGGM then awoke at 6:30AM, found SC unresponsive and called 911. There was no additional information surrounding SC's sleeping environment, what position he was placed in to sleep nor his position when he was found by MGGM.

ACS discovered SC and SM resided with SM's mother (MGM) in Westchester County. Also living in that home were two MUs, one of whom was 13-years old. On 3/5/21, ACS spoke with MGM via phone, who stated that on 2/9/21 and 2/10/21, the adult MU and SM tested positive for a virus, so SM brought SC to stay with SF at his home as a safety precaution. MGM explained that on 2/24/21, SF also tested positive for a virus, so he brought SC to stay with MGGM at her home in the Bronx, as SC had not yet tested positive for the virus at that time. MGGM regularly provided care to the 11-month-old cousin, who was present the date of the incident. ACS assessed the safety of this child, and no safety concerns were noted.

On 3/15/21, ACS conducted an unannounced home visit to MGGM's residence and attempted to interview her; however, MGGM stated she retained counsel and was advised by her attorney not to speak with anyone regarding SC's death. ACS provided MGGM with resources for grief and bereavement counseling, which MGGM accepted. ACS also obtained contact information for MGGM's attorney. ACS attempted to schedule an interview with MGGM via the attorney; however, the attorney advised MGGM would not participate.

On 3/22/21, WCDSS spoke briefly with SM and SF face-to-face. Both parents reported SC was brought to MGGM's because they did not want him to contract the virus since they both had tested positive. Neither parent had any details surrounding the incident as they were not present; however, both denied any concerns regarding MGGM or her ability to care for SC. Further, SM denied SC had any health concerns prior to his death.

Throughout the investigation, ACS and WCDSS spoke with family members and collateral sources. LE found no criminality regarding the death of SC. The ME explained SC was positive for a virus but appeared to be a healthy child with no signs of abuse or trauma. There was suspicion that SC's death was due to the virus; however, additional testing and toxicology screenings to confirm this remained pending at the time of this writing. There was no evidence gathered to support any of the caregivers' actions or inaction led to the death of SC, therefore, ACS unfounded and closed the investigation.

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
Comments: This fatality investigation was conducted by the New York City MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057901 - Deceased Child, Male, 3 Mons	057902 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
057901 - Deceased Child, Male, 3 Mons	057902 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
057901 - Deceased Child, Male, 3 Mons	057903 - Grandparent, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated
057901 - Deceased Child, Male, 3 Mons	057903 - Grandparent, Female, 43 Year(s)	Inadequate Guardianship	Unsubstantiated
057901 - Deceased Child, Male, 3 Mons	057904 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
057901 - Deceased Child, Male, 3 Mons	057904 - Father, Male, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
057901 - Deceased Child, Male, 3 Mons	057905 - Grandparent, Female, 66 Year(s)	DOA / Fatality	Unsubstantiated
057901 - Deceased Child, Male, 3 Mons	057905 - Grandparent, Female, 66 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐

When appropriate, children were interviewed?	☐	☒	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☐	☒	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS interviewed some family members and collateral sources; however, were unable to interview MGGM. The source of the subsequent report could not be contacted. The record did not reflect that the 13-year-old maternal uncle was interviewed. Progress notes and other documentation were completed within the required timeframes.

Fatality Safety Assessment Activities

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

Explain:
ACS made attempts to assess the safety of the 11-month-old cousin within 24 hours; however, the family could not be located. ACS was able to observe the 13-year-old maternal uncle on 3/4/21 and no concerns were noted.

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: The parents had no other children, and by the close of the investigation they were living in a new location together, with no other children in their household. ACS offered the family services in response to the child's death.				

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: There were no children that were 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	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐

Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS provided the family with bereavement counseling referrals, as well as information on assistance with funeral costs.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
Service referrals were provided to the maternal grandmother for the 13-year-old maternal uncle that resided in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Service referrals were provided to the parents, grandparents, and other adult relatives in response to the fatality.

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 investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No