Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-039

Prepared by: New York City Regional Office

Issue Date: Oct 06, 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: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 04/05/2021
Initial Date OCFS Notified: 04/06/2021

Presenting Information

On 4/6/2021, the SCR registered multiple reports regarding the death of the 1-month-old SC. The narrative of the reports alleged at approximately 10:00PM on 4/5/2021, the BF arrived home and went to check the BM and the SC. The BM and the SC were side by side in the BM's bed. The SC was unresponsive, with blood coming from his nose and mouth. The BF called EMS and attempted to perform CPR on the SC; however, the SC remained unresponsive. EMS responded to the home and they also attempted to perform CPR on the SC, but the SC was unable to be revived. EMS then transported the SC to the hospital. At 11:45PM, the SC passed away, with the cause of death being cardiac arrest. The SC was an otherwise healthy child. The BM did not have any explanation for the SC's death.

Executive Summary

On 4/6/2021, the BF found the SC unresponsive in the home with blood coming out of his mouth. The BM was bed sharing with the SC in the lower bunk bed at the time. The BF called 911 and initiated CPR on the SC as directed over the phone by the 911 operator. EMS responded to the home minutes later, continued efforts to revive the SC and then transported the SC to the hospital. The hospital staff continued resuscitation efforts on the SC until they pronounced him deceased at 11:45PM. The ME’s preliminary tests did not reveal any trauma to the SC. At the time of writing this report, the cause and manner of death were undetermined pending the toxicology results.

The BM and the children resided with the maternal family. The BF resided at a different address. He was the BF of the SC only; however, he was actively involved with the two SSs. The BM did not have contact with the SSs’ fathers, and the fathers were not involved with the SSs.

On 4/6/2021, ACS initiated the CPS investigation in a timely manner. ACS obtained information from the family and relevant collaterals such as the medical providers, the ME, LE and the school staff. The medical staff ruled out abuse to the SC. LE did not suspect any criminality regarding the SC’s death and no arrests were made. The family denied any concerns about the BM or her ability to care for her children. The family and the pediatrician denied any pre-existing medical condition for the SC and there were no concerns reported for the care of the SSs.

ACS held a child safety conference, and the decision was not to seek judicial intervention for the family. The family was also interviewed at the Child Advocacy Center and there were no disclosures or criminal findings for arrest. The family was referred for PPRS services. The BM and the SSs actively participated in family counseling/bereavement services, but the BF declined services.

Throughout the investigation, ACS maintained bi-weekly contacts with the family, and ongoing collateral contacts with the school staff, service, and medical providers to assess the safety and wellbeing of the SSs. ACS deemed them safe as the family was meeting their basic needs. ACS discussed the concerns regarding bed sharing. The BM acknowledged being aware of Safe Sleep practice; however, she denied she rolled over on the SC. The BM and SSs had the support of the maternal family and were coping with their loss. The service provider provided the family with assistance regarding the SSs’ educational needs.

On 6/6/2021, ACS UNSUB the allegations DOA/FATL, and IG of the SC by the parents due to lack of sufficient evidence. ACS based its decision on the ME’s report which stated there was no trauma to the SC’s body and that the cause and manner of death were undetermined pending the toxicology results. Additionally, ACS obtained credible evidence

during the investigation that the parents provided a minimum degree of care or more for the children's basic needs. ACS observed ample provisions for the SC in the home.

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

Was the decision to close the case appropriate? N/A

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:
ACS kept the case open for service.

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: 04/05/2021 **Time of Death:** 11:45 PM

Time of fatal incident, if different than time of death: 10:50 PM

County where fatality incident occurred: Kings

Was 911 or local emergency number called? Yes
Time of Call: 10:56 PM
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
- ☐ 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? Unknown if they were 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	22 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	23 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Grandparent	No Role	Male	65 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	14 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	44 Year(s)

LDSS Response

On 4/6/2021, ACS contacted LE, the ER Dr., and the ME. LE did not suspect any criminality and no arrests were made; however, the criminal investigation was ongoing pending the autopsy. The ER Dr. and the ME stated initial findings did not reveal any internal or external wounds to the SC.

On 4/6/2021, ACS visited the family. The family provided an account of events that led to the incident which was consistent with the information that was already known. They reported that it was routine for the BM and the SC to co-sleep on the same bed even though there was a bassinet in the home. The BM denied the SC had any known medical condition. The family did not have any concerns about the BM or her ability to care for her children. ACS assessed the two SSs to be free of any marks/bruises. The family was receptive to ACS' offer of referrals for bereavement counseling. The home conditions did not pose any safety or health hazards. The family had a dog in the cage and three puppies in the MU's room. ACS completed the assessment for animals in the home. No concerns were noted.

Other collaterals did not report any concerns about the care the BM gave to her children; however, police had been called to the home multiple times due to the loud noise from frequent parties by the adults in the home. The building staff did not report any concerns for the family.

On 4/7/2021, the two SSs were forensically interviewed at the Child Advocacy Center and they did not make any disclosures of any wrongdoing by the family.

On 4/8/2021, LE reported that the criminal investigation had been submitted for closing pending the final autopsy report.

On 4/8/2021, the responding police officer denied the parents were observed to be under the influence of any substance.

On 4/8/2021, ACS held a child safety conference (CSC). The outcome of the CSC was not to seek legal action against the family. The family agreed to accept service and was referred for early engagement preventive services.

On 4/14/2021, ACS and the service provider visited the family. The BM signed up for service. ACS assessed the SSs; they did not have any suspicious marks or bruises on their bodies. ACS did not document any safety or health concerns for the home.

On 4/15/2021, the pediatrician reported the SSs were medically evaluated on 4/14/21 and they did not have any medical diagnosis that needed follow up attention. Their immunizations were current.

On 4/29/2021, LE stated based on the ME's initial report, there would be no criminal charges against the family pending the toxicology report.

On 4/30/2021, the responding EMS reported the SC was observed with blood in his airway. He was revived in the home and then taken to the hospital. The hospital staff continued to resuscitate the SC until he was pronounced deceased.

On 4/30/2021, ACS visited the family. ACS assessed the SSs to be free of any suspicious marks/bruises. The home did not pose any health or safety hazards. The BF declined ACS' offer of grief counselling services.

On 5/4/2021, the school staff did not report any behavioral concerns for the SSs; however, there was a concern that the 9-yo SS's promotion to a new grade was in doubt. The BM agreed to seek help from her PPRS worker to contact the school to address the 9-yo SS's promotion.

On 5/5/2021, the ME reported the cause of death was pending the toxicology report.

On 5/5/2021, the DA reported the criminal investigation would be kept open pending the autopsy report.

Between 5/6/2021 and 6/3/2021, ACS made casework contacts with the family, and other collaterals. There was no new update regarding the fatality. The family continued to engage in PPRS services, and the service provider reported the BM was compliant with services.

On 6/6/2021, ACS unsubstantiated the allegations DOA/FATL, and IG of the SC by the parents.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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 reviewed by an OCFS approved Child Fatality Review Team? No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058454 - Deceased Child, Male, 1 Mons	058455 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
058454 - Deceased Child, Male, 1 Mons	058455 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
058454 - Deceased Child, Male, 1 Mons	058461 - Father, Male, 44 Year(s)	DOA / Fatality	Unsubstantiated
058454 - Deceased Child, Male, 1 Mons	058461 - Father, Male, 44 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:
The MGF declined an interview by ACS.

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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
☐ Had heavy alcohol use
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Used illicit drugs
☒ Was not noted in the case record to have any of the issues listed

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/30/2019	Sibling, Male, 12 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 12 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 12 Years	Aunt/Uncle, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 12 Years	Aunt/Uncle, Male, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 7 Years	Aunt/Uncle, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Aunt/Uncle, Male, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
On multiple occasions the BM failed to pick up the now 9, and 14-yo SSs from school in a timely manner. On 4/29/2019, multiple calls were made to the BM for her to pick the SSs up with no answer. The BM was repeatedly failed to arrange for the pickup of the children.

On 6/8/2019, the SCR registered a subsequent report with a concern that on an ongoing basis the BM smoked marijuana and drank alcohol to the point of intoxication. As a result of that, the BM became aggressive and engaged in physical altercations in the community while her children were present. On 6/7/2019, the BM became aggressive with an unknown person after her older son pushed another child while playing.

Report Determination: Unfounded | **Date of Determination:** 06/28/2019

Basis for Determination:
The BM did not neglect her children when they were picked up late from school. This situation occurred twice. Once, the BM was running late due to work and the second time, there was a miscommunication. The MA was responsible to collect children. The BM's children were not in the vicinity when she had conflict with neighbors. The BM denied she had a weapon. In addition, the BM was providing the SSs with their basic needs and she had extended family support. The MU did not have any care taking responsibility for the SSs.

OCFS Review Results:
ACS appropriately closed the 6/8/2019 report as a duplicate, and merged the with the initial investigation. Based on the case documentation, NYCRO agrees with the determination of the investigation.

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

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

The family first became known to the SCR in two reports dated 6/29/16 and 12/11/17. The patterns and themes of the reports centered around DV, IG, and PD/AM of the two SSs by their father. According to the reports, the father smoked marijuana and abused alcohol to the point of intoxication and impairment. While impaired, the father became violent and engaged in physical altercations with the BM in the presence of the children. The father's violence towards the BM placed the children in immediate danger of serious harm as his marijuana and alcohol misuse impacted his ability to protect and supervise the children adequately. The reports were subsequently indicated.

The BM and her children moved into a shelter. The BM was no longer in a relationship with the father. Due to the prior incidents of DV, the father was unable to enter the shelter with the BM and the children. The father continued to live with the PGM. ACS referred the BM for PPRS services to stabilize the family. The BM accepted services.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Preventive Services History

On 7/21/2016, an FSS Stage was opened to document the family's engagement with PPRS services. The BM engaged in random drug and alcohol screenings, parenting skills classes, DV counseling, child play therapy, and educational assessment for the children.

On 7/17/2018, the provider agency closed the BM's case. During home visits and casework contacts, the CP assessed positive interactions between BM and her two children. The BM did not exhibit any concerning behavior. She showed diligent efforts to improve the children's school attendance with the aid of her siblings. She ensured that the children received the educational services that supported their learning. The BM's home appeared clean with no safety or health hazards. Consequently, the CP determined there were no safety factors that compromised the BM's children.

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