Child Fatality Report

Report Identification Number: NY-22-023

Prepared by: New York City Regional Office

Issue Date: Sep 09, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 04/05/2022
Initial Date OCFS Notified: 04/05/2022

Presenting Information

On 4/5/22, two reports were registered with the SCR regarding the death of the 5-month-old subject child, one as an initial and the second as a subsequent. The SCR reports alleged that the mother and father napped with the subject child on a Tempurpedic mattress that was delivered to the home the same day and was not fully expanded. The mother checked on the child and discovered him unresponsive. The father called 911 and the child was transported to the hospital.

Executive Summary

On 4/5/22, the New York City Administration for Children's Services (ACS) received SCR reports regarding the death of the 5-month-old male subject child. The reports alleged DOA/Fatality and Inadequate Guardianship against the parents. The child resided with his mother, father and maternal grandmother. There were no surviving siblings or other children residing in the home.

Through a joint investigation with law enforcement it was learned that on 4/5/22, the subject child was home with the mother and father. The father left the home briefly and returned at approximately 10:20AM. The mother took an online test between 12:30PM and 1:30PM. The parents reported being tired from getting little sleep the night prior and at approximately 2:00PM they decided to take a nap. The child was initially in his crib and began to fuss, so the parents placed him in the bed with them. The mother woke up around 5:00PM and discovered the child had rolled off the bed onto a piece of exposed bed frame. The child was cold and limp. The mother woke the father and then attempted to perform cardiopulmonary resuscitation. The father called 911 and emergency medical services responded to the home. The child was pronounced deceased upon arrival to the hospital.

An autopsy was performed; however, the final report was pending further testing at the time this report was written. The preliminary examination showed there were no indicators of trauma, abuse, injuries and no fractures. The Medical Examiner did not provide a preliminary cause of death. Law enforcement's investigation revealed no criminality related to the death.

ACS interviewed the parents and several collaterals, including law enforcement, neighbors, hospital staff and the child's pediatrician. ACS determined there was a fair preponderance of evidence to substantiate the allegations of DOA/Fatality and Inadequate Guardianship against the mother and father, as it was determined the parents co-slept with the child which resulted in his death. ACS referred the investigation for a mental health and medical consultation. As a result of the consultations, it was recommended ACS offer and discuss services regarding grief counseling, mental health counseling and substance use. ACS offered the parents information on grief counseling and funeral assistance. The record did not reflect a further discussion with the family regarding substance use or mental health counseling. The investigation was indicated and closed on 6/7/22.

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?** N/A

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:
There were no surviving siblings or children in the home; therefore, the completion of the safety assessment tools was not required. ACS gathered sufficient information to determine the allegations.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The record reflected several detailed supervisory consultations throughout the investigation. It was not documented that notice of existence and notice of indication letters were provided to all required adults for each investigation, and the grandmother was not interviewed.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	Although the mother and father were notified of the SCR report in writing, the record did not reflect the grandmother, who resided in the home, was provided with a notice of existence letter for the initial investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.
Issue:	Failure to Provide Notice of Indication
Summary:	Although the mother and father were notified of the SCR report in writing, the record did not reflect the grandmother was provided with a notice of indication letter for the initial investigation.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	If a report is indicated, ACS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Although ACS had face-to-face contact with the grandmother on 4/6/22, the record did not reflect attempts were made to interview her regarding the SCR report and overall safety and risk.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/05/2022 **Time of Death:** 05:46 PM

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: 05:03 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
How long before incident was the child last seen by caretaker? 3 Hours
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	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	56 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

Upon receipt of the SCR report on 4/5/22, ACS initiated their investigation and coordinated efforts with law enforcement, notified the District Attorney, contacted the Medical Examiner, interviewed the parents and necessary collaterals, completed a home visit, and offered services regarding the fatality.

ACS completed an interview with the father. The father reported that on 4/5/22, the parents had a new queen-size Tempurpedic mattress delivered to the home at 9:30AM. The father left the home to get a haircut and the subject child was home with the mother. Upon the father's return to the home, the child was sleeping in his crib. The mother was taking a test online and afterward they decided to take a nap. The child started to cry and the father picked up the child from his crib and placed him on the bed. The bed was against the wall and the father slept near the wall, the mother in the middle and the child on the outside. The child was placed on his back and the mother gave the child a bottle. The father went back to sleep and was woken up by the mother, who stated the child was not breathing. The father made multiple attempts to call 911 and got through to dispatch at 5:04PM.

The mother was interviewed by ACS and she confirmed that on 4/5/22, she was home with the subject child while the father was getting his haircut. The mother took a test online for school that ended at 1:30PM. The mother fed the child two ounces of milk and burped him at 2:00PM. When the father returned home, the parents took a nap on the bed because they were tired from not getting any sleep the night before due to being up making space for the bed delivery. The mother placed blankets near the edge of the bed and pushed the crib up against the edge of the bed to prevent the child from falling. There was an exposed piece of wood from the bed frame in the space between the bed and crib and the mother placed a blanket on top of it. When the mother woke up, she found the child on the slab of wood and facing her. The child was unresponsive so the mother started CPR. EMS arrived and the child was transported to the hospital and the mother followed behind in law enforcement's vehicle.

The parents were asked about safe sleep practices and the father reported no prior knowledge of it. The father stated it was typical for the parents to co-sleep with the child and they normally placed him on the outer part of the bed. The pediatrician reported safe sleep guidance was discussed with the parents during each visit. The parents reported marijuana use the morning of the death and denied any other substance use. The parents stated they had their new bed delivered the morning of the death. The delivery service informed them the bed would take 24-hours to fully inflate. After the bed delivery, the parents realized the bed was not properly assembled and had called the company to have them fix it, which had not occurred prior to the parents and child sleeping on it.

Law enforcement reported no concerns for abuse or maltreatment by the parents. It was further stated the home was spotless and the parents were cooperative. The emergency room doctor reported the child arrived to the hospital without a heartbeat and was unable to be revived. The doctor reported the child was well-nourished, appropriate weight and height, and had no marks or bruises on his body. The child's pediatrician reported there were no concerns for the child's health or well being, he had no pre-existing medical concerns, and he was up to date on immunizations and appointments.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060921 - Deceased Child, Male, 5 Mons	060922 - Mother, Female, 24 Year(s)	DOA / Fatality	Substantiated
060921 - Deceased Child, Male, 5 Mons	060923 - Father, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
060921 - Deceased Child, Male, 5 Mons	060923 - Father, Male, 27 Year(s)	DOA / Fatality	Substantiated
060921 - Deceased Child, Male, 5 Mons	060922 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The record did not reflect the grandmother was interviewed.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
A mental health consultation was completed, which recommended that substance use be discussed with the parents and grandmother due to the parents' marijuana use and concerns for the grandmother's substance misuse. In addition, it was recommended the mother be referred to mental health services; however, the record did not reflect these discussions or referrals were completed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered grief counseling and funeral assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☒ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

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