Child Fatality Report

Report Identification Number: NY-21-013

Prepared by: New York City Regional Office

Issue Date: Aug 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: 6 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 02/06/2021
Initial Date OCFS Notified: 02/06/2021

Presenting Information

On 2/4/2021, the SM was co-sleeping with the SC on the bottom bunk bed. At about 9:00AM, the SM woke up to feed the SC and then fell back asleep. The SC rolled off the bed and fell approximately two feet to the floor. At about 9:40AM, the SM woke up and found the SC off the bed, face down on a laundry bag and unresponsive. The SM performed CPR on the SC. At about 10:16AM, a household member contacted EMS. The SC was taken to the hospital and at some point, his brain was not functioning. On 2/6/2021, the SC passed away from cardiac arrest. The SM's unsafe sleeping practice contributed to the SC's passing.

Executive Summary

On 2/4/2021, the mother fell asleep with the subject child in the bed with her. At about 9:40AM, the mother awoke and found the subject child, face down on a laundry bag next to the bed, and unresponsive. The mother performed CPR on the subject child as the 11-yo surviving sibling called 911. EMS responded to the home and transported the subject child to a hospital in the neighborhood. The subject child was then transported to a specialized hospital where the medical staff reported the subject child was experiencing seizures and had limited brain activity. A CAT scan of the subject child's head and chest/abdomen area was consistent with post cardiopulmonary arrest. On 2/6/2021, the subject child died. The autopsy report was pending; however, the ME's initial findings did not reveal any external injuries to the SC.

The father was at work when the incident occurred and did not witness the incident.

On 2/8/2021, 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 of the subject child. LE deemed the subject child's death an accident, and no arrests were made. The family and the pediatrician denied any preexisting medical condition for the subject child and there were no concerns reported for the care of the surviving sibling. Throughout the investigation, ACS assessed the surviving sibling through home and virtual visits, interviews with the family, school staff, and medical providers, and deemed him safe.

ACS initially removed the surviving sibling from the home and attempted to file an Article 10 Petition of Neglect in Family Court. ACS's Family Court Legal Services decided not to file the case due to lack of information. ACS returned the surviving sibling to the family and referred the family for bereavement counseling services. Throughout the investigation, ACS utilized language services to engage the parents who had limited proficiency in English language.

At the time of completing this report, ACS had not determined the CPS investigation. The family declined ACS's offer of services. The surviving sibling received school-based services.

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?** N/A

- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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 had not determined the CPS investigation.

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: 02/06/2021 **Time of Death:** 04:05 PM

Date of fatal incident, if different than date of death: 02/04/2021
Time of fatal incident, if different than time of death: 09:40 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 10:12 AM
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?

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Impaired by illness
- ☐ Impaired by disability

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	6 Month(s)
Deceased Child's Household	Father	No Role	Male	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)

LDSS Response

On 2/8/2021, the hospital staff stated the SC's hospital record indicated on 2/5/21, the brain death testing was performed on the SC. The clinical exam and the apnea test were consistent with brain death. There were no brainstem reflexes, no responses to pain and no spontaneous breathing. The test was repeated on 2/6/21, and at 4:05PM, the SC was declared brain dead.

On 2/8/2021, ACS visited the case address. The family reported the SC was fine the day prior and did not display any unusual behavior or medical condition. ACS discussed bereavement counseling services with the family, but the parents declined services and stated the SS would receive therapy in school. The family requested burial assistance from ACS. ACS assessed the SS and deemed him safe in the home. The home was free of any health or safety hazards.

ACS then assessed the family's friend home to be safe of any hazards. The home had ample supply of food. The family's friend did not report any concerns for the family.

On 2/8/2021, ACS conducted an emergency removal of the SS and placed him with the family's friend, who was the only means of support to the family.

On 2/9/2021, ACS held a child safety conference (CSC). The CSC decided to remand the SS.

On 2/10/2021, ACS attempted to file an Article 10 Petition in Family Court. The court rejected the case because there was no cause of action to file the case. ACS returned the SS to the parents' care and counseled the family to ensure that the SS was supervised. ACS also offered the family bereavement and individual counseling.

On 2/10/2021, LE reported the ME did not find any trauma to the SC and deemed the death non-suspicious. The criminal investigation would be concluded with a finding of accidental.

On 2/11/2021, the ME reported that the SC was clean and appeared well cared for. There was no external or internal trauma to the SC. There was no abuse or maltreatment found and that LE could close the criminal investigation. The ME stated the toxicology results were pending.

On 3/1/2021, ACS visited the family and assessed the home to be safe for the SS. The family reported they were doing well. The SS did not have any visible marks/bruises on his body. He stated that he was able to speak with school staff if he needed to.

On 3/10/2021, the school staff did not report any concerns for the SS. The SS was in receipt of school-based counseling services.

On 3/23/2021, the pediatrician reported the SC was born with an “innocent heart condition” and was discharged from the hospital with visiting nurse services. The pediatrician did not have any concerns regarding the SC.

On 3/23/2021, ACS visited the case address and did not document any concerns for the family. The family reported they were not interested in any counseling at the time but would prefer the SS received services at the school. The family sought burial assistance from ACS. ACS assessed the SS to be doing well. The SS stated he was happy to be back in school.

On 4/1/2021, ACS visited the family. There were no safety or health hazards in the home. The family reported they were doing well. The SS did not have any marks/bruises on his body.

On 4/5/2021, the ME reported the autopsy was pending the results of other studies.

On 4/23/2021, ACS visited the SS’s school. The school staff stated the SS would benefit from outside counseling as the school counselor was not trained to offer trauma/grief counseling services. The school did not report any concerns for the SS.

Between 5/4/2021 and 7/16/2021, ACS made multiple casework contacts with the family and other collaterals. There was no new information regarding the fatality. The SS remained safe in the care of the parents. During home and virtual visits, the SS appeared comfortable and happy in the home. ACS observed the family home to be neat and clean with no safety concerns.

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 reviewed by 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
057908 - Deceased Child, Male, 6 Mons	057909 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending
057908 - Deceased Child, Male, 6 Mons	057909 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending

CPS Fatality Casework/Investigative Activities

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

Fatality Safety Assessment Activities

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

Explain as necessary:
ACS conducted and emergency removal of the SS from the home and placed him with a neighbor. ACS then attempted to file an Article 10 Petition in Family Court. The court rejected the case due to lack of enough information to file the case. Consequently, ACS returned the SS to his BM's care.

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 sent in a request for burial assistance on behalf of the family but the case documentation did not reflect the request had been approved at the time of completing this report.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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 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)
02/04/2021	Deceased Child, Male, 6 Months	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 6 Months	Mother, Female, 35 Years	Lack of Supervision	Substantiated	

Report Summary:
There was a concern that on 2/4/21, the SM fell asleep with the SC in the bed with her. At about 9:40AM, the SM was awakened by a phone call and did not see the SC in the bed with her. The SM assumed that the SC was with the SS who was in the living room at the time on a zoom classroom. The SM later found the SC on a laundry bag face down and unresponsive. The SM administered CPR as the SS called 911.

Report Determination: Indicated | **Date of Determination:** 04/20/2021

Basis for Determination:
The SM confirmed that she fell asleep with the SC on her bed. When the SM awoke, she did not see the SC on the bed and assumed the SC was with the 11-yo child who at the time was in the living room for zoom learning. The SM did not immediately check on the children. She later found the SC unresponsive face down on a laundry bag. The SC was taken to an area hospital and then transferred to a specialized children hospital. The SC was hospitalized and in critical condition with severe anoxic brain injury and cardiac arrest. On 2/6/21, the SC was declared brain dead.

OCFS Review Results:
ACS initiated the investigation in a timely manner and contacted the hospital staff, school staff, and LE. ACS visited the home and interviewed the family. ACS also reviewed the CPS, and medical records. The family did not have any CPS or criminal history prior to the investigation. The hospital staff did not report any trauma to the SC. LE deemed the incident accidental and did not make any arrest.

ACS initially removed the SS from the home and attempted to file an Article 10 Neglect Petition Family Court. ACS Family Court Legal Services decided that the case would not be filed and returned the SS to the family.

ACS referred the family for bereavement counseling services.

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

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

The family did not have any known CPS history outside of New York State.

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