Child Fatality Report

Report Identification Number: NY-19-084

Prepared by: New York City Regional Office

Issue Date: Nov 06, 2019

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		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 07/10/2019
Initial Date OCFS Notified: 07/11/2019

Presenting Information

The 7/11/19 report alleged on 7/10/19, the SM was walking with the SC in his stroller. The SM observed the SC's arm was in an unusual position and checked him. At that time she observed he was unconscious and unresponsive. EMS was contacted, and the SC was taken to the hospital where he was pronounced dead. The cause of the SC's death was unknown.

Executive Summary

The 2-month-old male infant (SC) died on 7/10/19. NYCRO received a Report of External Examination from the New York City Office of Chief Medical Examiner (OCME). The ME listed the cause of death as Undetermined and the manner of death as Undetermined.

On 7/11/19, the SCR registered a report that included the allegations of DOA/Fatality and IG of the SC by the SM.

ACS findings showed that on 7/10/19, the SM dropped the SC off at the babysitter's home at approximately 9:30 AM. The babysitter was a family friend who cared for the SC when the MGM was not available. When the SM brought the SC to the babysitter's home, the SC was alert. The SM went to work, and then picked the SC up at the babysitter's home at 4:15 PM. The babysitter told her she fed the SC at 2:00 PM and at 2:30 PM he cried so, she put him to sleep. When the SM arrived at the babysitter's home, the SC was sleeping. He was sleeping on his stomach and his head tilted to the side when she checked him prior to leaving the babysitter's home. When she was approximately five minutes away from the babysitter's home, she observed the SC's arms were stretched up. The SM then took the SC in her hands and observed he was pale and unconscious. He did not seem to be breathing. The SM called EMS who transported the SC to the hospital. After contacting EMS, the SM called the BF. The BF was at work at the time of the incident.

The babysitter said that before 12:00 PM, the SC awoke, and she fed him. She said the SM told her to feed the SC every 2-2 ½ hours. She burped him and then placed him in his carriage where he was alert. At 2:00 PM, she fed him again and burped him. At 3:00 PM, the SC fell asleep. She checked him while he slept, and there were no concerns. The SM arrived at approximately 4:00 PM to pick up the SC. A neighbor was at her door at the time, so she did not speak with the SM. The SM took the carriage and left the home. The SC was still sleeping when the SM arrived.

On 7/12/19, ACS visited the hospital and met with an attending physician. ACS learned that the SC was already dead when he was brought by EMS to the hospital. The SC was well nourished and there were no marks or bruises on his body. The physician said the SM provided an account that showed the SC was born full term and did not have any medical conditions.

On 8/7/19, the family physician reported the SC was healthy and there were no medical concerns.

On 8/8/19, the ME informed ACS that since an autopsy was not performed the exact cause of death could not be provided. The ME listed the death as undetermined. The ME noted the SC was clean and well nourished.

On 8/8/19, the SM said she and the BF received support through associates. Other resources were discussed with the SM, but she declined services. ACS provided the babysitter with information for community-based services to address safe sleep practices and CPR.

On 8/27/19, ACS provided the SM with information for a community-based organization regarding bereavement support service.

On 9/10/19, ACS Unsub the allegations of DOA/Fatality and IG of the SC by the SM. ACS based the determination on finding of no credible evidence. The ME's final cause and manner of death for the SC was undetermined. ACS learned that the SM acted appropriately as she called 911 when she observed the SC was unconscious.

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

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:
There were no SS and no surviving CHN in the household.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS documentation did not reflect EMS was interviewed regarding the incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/10/2019 **Time of Death:** 05:09 PM

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

County where fatality incident occurred: Kings
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
At time of incident supervisor was: Not impaired.

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	2 Month(s)
Deceased Child's Household	Father	No Role	Male	20 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Other Adult - Friend	No Role	Female	66 Year(s)

LDSS Response

On 7/11/19, LE said the SM left the SC at a friend's home for a few hours. The friend was not a full-time babysitter for the SC. LE stated the SC was fed at 2:00 PM and was placed for a nap at 3:00 PM. The SM picked up the SC at 4:00 PM from the babysitter's home while he slept in his stroller bed. LE said the SM stated she did not take the SC out of the stroller. The SM and SC resided a few blocks away. The SM looked at the SC and saw the SC's arm was in an awkward position. When she tended to the SC, she observed the SC was unresponsive. The SC had no trauma and no bruises. Later, LE said the SC was dropped off at the babysitter's at 10:00 AM and was fine.

On 7/15/19, the babysitter's spouse said he was not present at the time the SC was in his home. He said the friend did a favor for the SM, but she did not normally babysit.

The same day, the babysitter said the MGM asked her to care for the SC at times. According to the babysitter's account, she supervised the SC a few times before 7/10/19. The SM brought the SC to her home at 10:00 AM. The SC was asleep at

the time. The carriage was flat. There were no soft toys or pillows in the carriage. She placed a diaper in the carriage to make the SC comfortable. (ACS observed the diaper and noted it was a swaddling cloth.) She usually placed infants on their side, but on 7/10/19, she placed the SC on his stomach and put his head on his side. She observed the SC turn his head as she placed him on his stomach and his head was on his left side, when the SM arrived his head was turned to the right. Safe sleep practices were discussed with the babysitter. She said she was the only one in the home when the SC was present. The babysitter had seven CHN; all were adults and subsequently, the babysitter said she babysat two of her daughter's CHN. The babysitter denied alcohol and drug use.

In a follow-up interview with ACS, the babysitter said the SC slept on his stomach while his head was placed on the side, and noted she always placed the SC in such position to sleep. She stated that prior to leaving her home, the SM asked her about the SC, and she responded indicating there were no concerns. The babysitter said the SM dropped the SC off at around 9:30 AM. She checked the SC every 20 minutes while he slept.

On 7/17/19, the MGM said the SM went to get the SC after 4:00 PM. The SM asked the babysitter about the SC's behavior. The SC cried and he was fussy. He was fed at 2:30 PM, burped, and then placed to sleep on his stomach with his head turned to the side. The MGM said the SC was normally placed on his stomach, and he would turn on his side throughout his sleep. The SC was asleep by the time the SM picked him up from the babysitter. While pushing the stroller the SM realized the SC was not crying or moving. The SM picked him up and observed he was lifeless and silent.

On 7/17/19, the SM said the SC had a well child visit on 7/8/19 and the physician said the SC was healthy. The SM brought the SC to the MGM's home, but the MGM was busy, and could not stay with the SC so the SM left the SC at the babysitter's home. The SM said the carriage included a bassinet. ACS asked to observe the carriage; but the SM said she gave it away. Later, the SM said prior to leaving the babysitter's home she asked the babysitter about the SC's behavior, and she checked the SC in the carriage. The SM did not see anything unusual. The SM said the SC was sleeping on his stomach and his head tilted to the side when she checked him prior to leaving the babysitter's home.

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)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051761 - Deceased Child, Male, 2 Mons	051762 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
051761 - Deceased Child, Male, 2 Mons	051762 - Mother, Female, 22 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The SM said she had a carriage with bassinet which ACS was not able to observe as the SM gave it to someone.

ACS documentation did not reflect EMS 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:
ACS referred the babysitter to community based services. Other resources were discussed with the SM, but she refused services.

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? N/A
Explain:
There were no surviving children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS provided information for community based services to discuss safe sleep practices and CPR. Other resources were discussed with the SM, but she refused services.

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 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

The SM was not known to the SCR or ACS.

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