Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-096

Prepared by: New York City Regional Office

Issue Date: Mar 09, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 09/25/2020
Initial Date OCFS Notified: 10/02/2020

Presenting Information

The SCR report alleged on 9/25/20, at an unknown time, the mother put the 1-month-old male child in bed to sleep. At approximately 4:30 pm, the mother went to check the child and found him in the bed, unresponsive, and with blood coming out of his nose. It was unknown if the blood was dried or in liquid form when the mother found him. It was unknown in what position the child was found on the bed, the size the bed, or if there was bedding present while the child was asleep. The mother called 911 and police responded to the home. The child was transported to the hospital where he was pronounced dead on 9/25/20, at an unknown time. It was unknown if emergency medical services, another agency, or an individual transported the child to the hospital, or if the child had been resuscitated at any point. The child was an otherwise healthy child at the time of his death. The mother had no explanation for the child's death.

Executive Summary

This fatality report concerns the death of a one-month-old male child that occurred on 9/25/20. A report was made to the SCR on 10/2/20 with allegations of DOA/Fatality and Inadequate Guardianship of the child by the mother. The Administration for Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; however, the final report remained pending at the time of the writing of this report.

At the time of the child's death, he resided with his parents in a studio apartment in the Bronx. ACS's investigation revealed at about 6:18PM on 9/25/20, the child was discovered on a futon bed unresponsive. The parents stated they fed the child before putting the child down for a nap at around 4:30PM. They also went to sleep and when they woke up, they observed the child with blood coming from his nose and mouth. They attempted CPR on the child and called 911 at around 6:18PM. The ambulance arrived within minutes of the call and the child was transported to the hospital where he was pronounced dead at 6:52PM.

The parents said they and the child had been sharing a futon. Law enforcement indicated on the futon was a comforter, adult size pillows, and two baby blankets. The death scene investigator from the ME's office also reported there was a newborn drawstring nightgown which the child had worn over his onesie. There were blood stains around the collar. Also, there were canisters of Enfamil and strawberry flavored milkshake drink. Law enforcement did not suspect any criminality relating to the death of the child. They confirmed the child was the only child for the parents.

On 12/7/20, ACS unsubstantiated the allegations of the report. ACS documented there was no credible evidence to support that the parents were inappropriate with providing adequate care and supervision of the child.

The report was unfounded.

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:
The safety decision was #1 (No safety factors noted).

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 level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion was commensurate with the case circumstances. There was documentation of supervisory consultation during the investigation and the decision to close the case was appropriate.

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: 09/25/2020 **Time of Death:** 06:52 PM

Time of fatal incident, if different than time of death: 06:10 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 06:10 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 supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

ACS initiated the investigation of the report with a Heightened Oversight protocol conference, given the age of the child and the allegations of the report. The Investigative Consultant and the CPS Team discussed the case and noted the family had no prior history. The team learned the child was pronounced dead at the hospital; however, the time of death was not immediately known. The mother stated that she checked the infant at 4:30PM on 9/25/2020 and found him unresponsive. The team also learned the autopsy was delayed due to high case volume related to COVID-19. However, the child's body had no signs of trauma or injury, neither were there any medical concerns.

Attempts to make face-to-face contact with the parents on 10/2/20 were not successful. However, on 10/3/20 the mother contacted ACS staff via telephone and confirmed the child was their first and only child. The mother was not available for a face-to-face visit.

On 10/3/20, the Specialist contacted the Medical Examiner and learned that the autopsy was completed; the preliminary cause and the manner of death were pending.

On the same date, the Specialist contacted law enforcement and learned no arrest had been made. The autopsy was completed; however, the toxicology report was still pending. The detective reported that both parents were present at the hospital and stated that the child was fed and was placed to sleep on the futon. The position in which the child was placed was not ascertained. The mother later checked the child and found him unresponsive with blood coming out of his nose. EMS was immediately summoned, and the child was transported to the hospital where he was pronounced dead; no timeline was provided. The child's body did not present any signs of trauma and there was no suspicion of foul play.

Between 10/3/20 and 10/5/20, the Specialist continued to make attempts to visit the family's home. These attempts were also unsuccessful.

On 10/5/20, the Child Protective Manager (CPM) contacted the Medical Examiner's Office to inquire about any findings as it related to the child's death. The CPM learned the autopsy was completed on 9/26/20, but the cause of death was still

pending.

The Specialist also contacted EMS personnel who reported upon arrival to the scene on 9/25/20, they met firefighters from the FDNY performing CPR on the one-month-old male child who had presented with cyanosis in his face and hands. The child was immediately placed in the ambulance and CPR was continued by firefighters and EMT until the child arrived at the hospital. EMS technicians said the child's body was still warm and CPR continued until 6:52PM when the child was pronounced dead. EMS reported there were no signs of trauma found on the child. According to EMS, the mother said the child woke up, ate like he normally did, and did not display any signs of distress. The family took a nap and when they woke up, they found the one-month-old child with vomit or mucus and blood in mouth and nose. The father cleared the vomitus and began CPR while mother called 911. The documentation did not reflect the Specialist asked about the condition of the home at the time emergency services technicians were there.

On 10/5/20, the Specialist contacted the MGM who provided background information regarding the mother's interaction with the child; the MGM hinted at possible drug use by the mother.

On 10/7/20, law enforcement reported they reported to the hospital on the day the child was pronounced dead. The attending physician reported that there was no trauma to the child's body and the Medical Examiner confirmed there was no evidence of trauma to the child. Law enforcement reported that there was no criminality on the case; however, the investigation would remain open until the toxicology report was returned and autopsy report was finalized.

When asked if they were able to meet and speak with the parents, detectives reported that they spoke with the parents both at the hospital and at the home. The parents reported that they fed the child before putting the baby down for a nap at around 4:30PM. The parents said they also went to sleep and when they woke up, they observed the child with blood coming from his nose and mouth. They attempted CPR on the child and called 911 at around 6:18PM. The parents said they and the child had been sharing a futon in the studio apartment. The detectives stated the parents had been co-sleeping although they had a 'Pack-n-Play' for the child. The detectives described the 'Pack-n-Play' as being "filled with junk" and that a crib that was still in a box. The detectives further reported the parents said they fed the child breast milk and Enfamil and had also given the child strawberry Pediasure "as a treat." The detectives added the case did not seem criminal, but rather it appeared to be an accident. The detective also stated the child also had a preexisting medical condition. Law enforcement's investigation would remain open pending the finalized autopsy report.

On 10/8/20, the CPM contacted the Medical Examiner and asked about the death scene investigation. The Medical Examiner reported the child was discovered on the futon bed unresponsive. On the futon bed was a comforter, an adult sized pillow, a baby blanket, and a knitted baby receiving blanket. The Medical Examiner's Scene Investigator observed a newborn drawstring nightgown which the subject child was wore over his onesie. There were dried blood stains around the collar. It was also noted that there were canisters of Enfamil, Strawberry flavored milkshake drink, Zap-A-Roach-Ant Killer Spray, and a free-standing air conditioner unit in the room which was on because it was warm. There were many flies in the apartment but no roaches. No pets or peeling paint were observed. The Medical Examiner also shared some of the child's medical history.

On 10/9/20, the Specialist made a successful home visit and documented there were adequate provisions in the home. At the time of the visit no unsafe conditions were observed. However, there were clothes in a cart in the front entrance and around the home; the home was disorganized. There was a functioning carbon monoxide detector and there were window guards installed. The Specialist observed the futon where the child and the parents slept on the day the child died. The father explained that child usually slept in a rocker. The Specialist documented that the child's 'Pack-n-Play' was filled with clothes, bags, and paperwork. The parents explained that the child did not usually sleep in the 'Pack-n-Play' hence the condition. The Specialist observed the family to have Enfamil and Pediasure Strawberry drink.

On 10/26/20, the Specialist received medical information from the hospital which showed the parents had received in room counseling at the time of the child's death. According to the medical record the mother had received prenatal care and had

stopped using marijuana once she became pregnant. Also, according to the medical report the parents accepted social work contact number and verbalized consent for outreach telephone calls regarding burial, coping, and for bereavement counseling.

On 11/26/20, ACS received more detailed information from medical personnel which showed the child was brought for evaluation by the paramedics with CPR in progress with no vital signs on arrival. EMS reports no vital signs at the scene. The child was sleeping in bed between the parents. The parents stated they had gone to bed around 4:00 PM and at about 6:00PM when they awoke, they noted blood on the infant face, and he was not breathing. It was not known how long the child was in the bed and not breathing or unresponsive. Paramedics arrived on scene and took child to the Emergency Room. The ambulance arrived at the hospital at 6:25PM. The child was, cold, clammy, mottled, cyanotic, and limp. CPR was resumed, and the child was intubated immediately on arrival. Body secretions were noted in the oropharynx, but no foreign body. There was dried blood on the child's nose and forehead. There was no swelling or hematoma. The child was pronounced dead at 6:52 PM.

On 10/5/20, 10/9/20, 10/30/20, and 12/1/20, ACS completed safety assessments which reflected there were no safety factors in the home as there were no surviving children. The safety decision was appropriate.

On 12/7/20, ACS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship of the child by the mother. ACS did not add any allegations against the father although he was present in the home and at the time of the child's death. ACS documented there was no credible evidence to support that the parents were inappropriate with providing adequate care and supervision of the child.

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: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056474 - Deceased Child, Male, 1 Mons	056476 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
056474 - Deceased Child, Male, 1 Mons	056476 - Father, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
056474 - Deceased Child, Male, 1 Mons	056475 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
056474 - Deceased Child, Male, 1 Mons	056475 - Mother, Female, 26 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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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 siblings or children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Referrals for grief counseling and burial assistance were made; however, the parents refused the 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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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