Child Fatality Report

Report Identification Number: NY-21-090

Prepared by: New York City Regional Office

Issue Date: Jan 24, 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	

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 08/21/2021
Initial Date OCFS Notified: 08/21/2021

Presenting Information

The 8/21/21 SCR report alleged, the SC suffered from a mild cold with nasal congestion for two days prior to his death. At about 12:00AM, on 8/21/21, the SM administered nasal spray and his condition improved. At about 4:00AM, the SM fed the SC and put him in the crib to sleep and at about 9:00AM, the SM found the SC in the crib with some blood in his nose. The SM brought the SC to the hospital for medical care and arrived at the hospital around 9:30AM. The report alleged the SC died before he arrived at the hospital and rigor mortis had set in when examined in the hospital. The sleeping arrangements for the SC were unknown and the SC had no visible injuries about his body. It was also unknown exactly what time the SC died while in the SM's care. The SC was an otherwise healthy and at the time of this report there was no explanation for the SC's death.

Executive Summary

The 1-month-old male child (SC) died on 8/21/21. As of 1/24/22, NYCRO had not received a copy of the final autopsy report from the ME.

At the time of his death, the SC resided with his mother. There were no surviving children in the home.

ACS learned the SC had a cold and nasal congestion. The SC’s doctor had provided him with a medical device which ACS observed, and had instructed the SM on its use. The SM denied that she used a nasal spray on the SC as was reported and said at about 1:30AM she used the medical device to suction mucus from the SC's nose. The SM put the SC to bed in the bassinet. At about 4:00 AM the SC awoke. The SM fed him and put him back to sleep in the bassinet on his back on top of a blanket in the bassinet. At 9:00 AM, when the SM awoke, she found the SC still on his back on top of the blanket in the bassinet. There was blood on the SC’s nose and mouth, and some blood on the blanket. The SM’s stepfather who resided out of state and was visiting performed CPR on the SC, but he remained unresponsive. The SM grabbed the SC and ran to the hospital which was two blocks away, as she felt calling 911 for EMS would take too long. The MGM, SM’s partner, MU and another relative ran with them to the hospital. The MGM said she called 911 while they were running to the hospital. The child was pronounced dead on arrival.

ACS contacted LE and learned a visit was conducted to the home with the assigned ME Investigator. LE interviewed the SM who said she found the SC unresponsive, and she rushed the SC to the hospital where he was pronounced dead. No arrest had been made as LE deemed the SC's death non-suspicious. LE closed their investigation pending the final autopsy report.

The ME reported there were no injuries or any signs of trauma to the SC's body. However, the SC had a hole in his heart that would have been hard to detect during routine medical visits and there were signs of a slight infection that could have contributed to the SC's difficulty in breathing.

ACS held a safety conference which the SM attended. ACS supplied the SM and family with community-based organization information regarding bereavement counseling and services. Later, ACS submitted burial assistance documentation and referrals to service providers who could assist in addressing the family's rental arrears.

On 10/20/21, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SM due to a lack of credible evidence. ACS based their decision on the ME's preliminary information that the SC was observed with no signs of

external and internal injuries, and the SC's death was most likely due to natural causes as a medical condition was detected and determined to be unknown by the SC's primary care physician.

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?** 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

Explain:
There are no surviving children.

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 are no surviving children.

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: 08/21/2021 **Time of Death:** 09:28 AM

Time of fatal incident, if different than time of death: 09:00 AM

County where fatality incident occurred: Kings

Was 911 or local emergency number called? Yes

Time of Call: Unknown

Did EMS respond to the scene? No
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 was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ Other: **N/A**

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	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Female	20 Year(s)

LDSS Response

On 8/21/21, the hospital social worker (SW) said the SM brought the SC to the hospital at about 9:30 AM, but the SC was already deceased. The SC had a cold and nasal congestion for two days prior to his death. At about 12:00AM the SM used a nasal spray on the SC. The SM fed the SC at 4:00AM and put him back to sleep. When the SM awoke at 9:00AM, there was blood on the SC's nose, and he was not responding. The SW stated that according to the SM, the SC did not have any known medical conditions.

On 8/21/21, the ER physician told ACS the SC's face was blue and rigor mortis set in. The physician said the SM stated she awoke at 9:00AM and found the SC face down in the crib. The Dr. said there was "frothing mucous, blood, secretions" from the SC's nose and mouth. ACS contacted the ME regarding the information they obtained from the physician. The ME reported the child's death appeared to be from natural causes as a result of a preexisting medical condition.

On 8/21/21, the SM said the SC's last checkup was on 7/11/21 at the hospital. The SC was diagnosed and prescribed medication. The SM said she gave the medication as prescribed, and his condition improved. ACS observed the discharge summary. The SM said during the last checkup, the Dr. said the SC sounded congested, but he was fine.

The SM and her partner said everything seemed fine with the SC. However, about two days before the SC was congested and they tried to clear his congestion with steam from running the hot water shower. The SM did not contact the SC's Dr.

as she had an upcoming appointment on 9/3/21. The SM said she placed the SC on his back in the bassinet with the blanket under the pad. There were no other objects in the bassinet. The next time she awoke was about 9:00AM and at that time she saw blood coming from the SC's nose. The SC was still on his back. The SM denied any substance abuse. ACS referred the SM to a local funeral home and offered the SM burial assistance.

The MGM resided out of state but was visiting. She opted to remain with the SM for a longer time.

On 8/23/21, the stepfather said the day before the SC was playing but he was congested. The stepfather said about 9:00AM the SM screamed and brought the SC into the living room. The stepfather said he attempted CPR and told them to run to the hospital, which they did. The MGM said she called LE but told them the SM was running to the hospital and LE said to find the SM and then call back. By the time the MGM got to the hospital, LE was there and she did not make a second call to 911. The time of her call was not recorded.

ACS interviewed the MU who said someone knocked on his door and when he left his room he saw the SC bleeding from his nose. He said he and the other adults began running to the hospital. The MA said she too was awakened by the SM screaming. She said everyone got up, got dressed, and ran to the hospital.

On 8/23/21, the SC's Dr. said the SM was engaged with visiting nurse services. The SM received two visits with the first one on 7/7/21 and no concerns were noted.

ACS completed safety and risk assessments that adequately reflected case circumstances and on 10/20/21, ACS unsubstantiated the allegations of the report due to a lack of credible evidence.

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: 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
059363 - Deceased Child, Male, 1 Mons	059364 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
059363 - Deceased Child, Male, 1 Mons	059364 - Mother, Female, 20 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The documentation reflected ACS provided referrals to service providers who could assist in addressing the family's rent arrears.

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 are no surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS submitted a request for burial assistance on behalf of the family. The documentation reflected ACS provided bereavement referrals and referrals to service providers who could assist in addressing the family's rent arrears.

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 fetal alcohol effects or syndrome

☒ With neither of the issues listed noted in case record

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