Child Fatality Report

Report Identification Number: NY-21-111

Prepared by: New York City Regional Office

Issue Date: Apr 12, 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: 9 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 10/06/2021
Initial Date OCFS Notified: 10/13/2021

Presenting Information

The 10/13/21 SCR report alleged that on 10/2/21, the SM was bathing the male subject child (SC). The SC was sitting on a bath chair in the tub. The SM left the SC unsupervised for about five minutes. The SM went to get a towel and then began doing other things; she washed and fixed the SC's bottle, prepared his bag, and made his bed. The SM usually heard the SC playing in the water with his toys. When she did not hear the SC playing, she checked him and found him face down and unresponsive. The SM placed the SC on the bed, began CPR, and then called 911. The SC was transported to the hospital, and on 10/6/21 at 5:50 PM the SC was pronounced dead.

Executive Summary

The 9-month-old male child died on 10/6/21. As of 3/11/22, NYCRO had not received a copy of the autopsy report.

At the time of the SC's death, the family had an open ACS investigation that was registered on 10/2/21 with allegations of Inadequate Guardianship and Lack of Supervision of the child by the mother stemming from the incident. ACS was in the process of investigating the report when the SCR registered a report on 10/13/21 that included allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision of the child by the mother. There were no surviving siblings in the home.

ACS' investigation revealed on 10/2/21 the mother placed the child in the tub for a bath and left him unsupervised while she went for a towel. In the process of getting the towel the mother stopped to do other tasks, including packing the child's bag, fixing his crib and sheets, and preparing his bottles as she would be leaving the home. The mother denied she was on the phone at the time and permitted ACS to check her call log. ACS did not observe any calls during the time the incident occurred. The mother did not check the child during this period. After a while, the mother entered the bathroom and saw the child face down in the water. The child was unresponsive. The mother picked up the child, placed him on the bed, and initiated CPR. The mother also called 911. The child was transported to the hospital where he was stabilized and then transferred to another medical facility for a higher level of care. The child died on 10/6/21.

ACS coordinated investigative efforts with law enforcement upon receipt of the SCR report. ACS also contacted family members and first responders. ACS offered bereavement services.

ACS' Family Court Legal Services determined there was no basis to file an Article 10 Petition in family court as there was no surviving children in the home but noted the facts as presented, appear to indicate an accidental death of the SC, and while there was "clearly very serious neglect, it did not rise to the level of abuse."

On 12/1/21, ACS unsubstantiated the allegation of DOA/Fatality of the child by the mother on the basis of no credible evidence to support that the mother's actions were intentional. To support the decision ACS documented the ME stated there were no marks or bruises on the child's body other than the brain injuries from the accident, and there were no signs of criminality. NYCRO does not agree with the determination as written.

ACS substantiated the allegations of Inadequate Guardianship and Lack of Supervision of the child by the mother on the basis of some credible evidence to substantiate the allegations. ACS documented the mother left the child in the bathtub unsupervised for several minutes while she attended to other matters in the household. The child was found face down and unresponsive by the mother.

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 were no SSs.

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:
There were no SSs.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Although ACS indicated the report, ACS inappropriately unsubstantiated the allegation of DOA/Fatality. ACS documented there was not enough evidence to support the mother's actions were intentional. Intent, however, was not essential.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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

Child Fatality Report

Incident Information

Date of Death: 10/06/2021 **Time of Death:** 05:50 PM

Date of fatal incident, if different than date of death: 10/02/2021
Time of fatal incident, if different than time of death: 09:15 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 09:15 AM
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: Bathing

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: **packed the SC's bag, fixed the crib and sheets**

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	9 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Other Household 1	Father	No Role	Male	28 Year(s)

LDSS Response

On 10/13/21, ACS received the fatality report from the SCR. Within the first 24 hours of the investigation, ACS completed a CPS history check, contacted the source of the report and the hospital, notified the DA and ME's office of the death, and conducted a home visit.

On 10/13/21, ACS re-interviewed the mother who reported she was going to attend a party, so she bathed the child around 9:00AM, and got him ready to leave the home. The mother speculated the child may have fallen from the bath seat in the tub since she had placed a small toy basket ball in the tub and the child liked to chase balls. The mother denied substance use.

ACS notes reflected that some of the warning instructions included: not a safe device, babies have drowned while using bath seats, always stay within arm reach of your baby, product is suitable for babies able to sit up unassisted (approximately five months of age) and stop using when the baby begins pulling to a standing position (approximately 10 months of age).

On 10/13/21, the MU said he believed the child's death was an accident. He explained he had weekly contact with the SC. He had no concerns regarding the mother's parenting.

The father was interviewed prior to the fatality report during the initial investigation. He stated he recently became involved in the child's life and not having a relationship with the mother made visitation difficult. He said he was notified by one of the mother's family members that the child was in the hospital. He added he rarely had contact with the child but was devastated by what occurred. He denied drug or alcohol use.

On 10/14/21, the ME reported the child's body looked good, healthy, and "well cared for." There were no marks or bruises on his body other than the brain injuries from the accident. The ME explained the autopsy was not fully completed as the results of a few tests were outstanding; preliminarily, the death was deemed an accident.

On 10/15/21, LE told ACS there was no criminality based on their investigation. LE stated that the events that led to the SC's death appeared to be accidental; therefore, the criminal investigation was closed.

On 10/21/21, ACS contacted the shelter where the mother and child had resided. The shelter's case manager said the mother did not return to the shelter following the incident.

On 11/4/21, ACS conducted a visit to the MGM's home and spoke with the mother who said she needed therapy to cope with the child's death. ACS provided the mother a referral for bereavement counseling. The mother declined burial assistance and informed ACS she would remain at the MGM's home.

On 12/1/21, ACS unsubstantiated the allegation of DOA/Fatality and substantiated the allegations of Inadequate Guardianship and Lack of Supervision of the child by the mother.

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
059862 - Deceased Child, Male, 9 Month(s)	059863 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated

059862 - Deceased Child, Male, 9 Month(s)	059863 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
059862 - Deceased Child, Male, 9 Month(s)	059863 - Mother, Female, 32 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

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:
On 11/4/21, the family was referred for bereavement counseling. The mother declined burial assistance.

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 SSs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
On 11/4/21, ACS provided the mother a referral for bereavement counseling. The mother declined burial assistance.

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? 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/02/2021	Deceased Child, Male, 9 Months	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 9 Months	Mother, Female, 32 Years	Lack of Supervision	Substantiated	

Report Summary:
The 10/2/21 SCR report alleged that between 9:00 AM and 9:30 AM, on 10/2/21, the SM was bathing the SC. The SC sat in a baby chair in the water. The SM left the bathroom to get a towel and another baby item and upon returning the SC was face down in the water. The SC was unconscious. The SM called the ambulance and began CPR. When the ambulance arrived, they continued CPR and rushed the SC to the hospital. The SC was revived. There was no visible bruising on the SC.

Report Determination: Indicated | **Date of Determination:** 12/01/2021

Basis for Determination:
There was credible evidence to substantiate the allegations. The SM left the SC in the bathtub unsupervised for several minutes while she attended to other matters in the household.

OCFS Review Results:
The investigation was initiated timely, and a home visit was made. The source of the report was contacted. A CPS history check, and 7-day Safety Assessment was completed timely. Notice of Existence letters were provided timely. There was evidence of supervisory involvement and the report was appropriately indicated.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/08/2020	Deceased Child, Male, 1 Days	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 1 Days	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The 12/8/20 report alleged that the SM gave birth and delivered her first child, the SC. The SM then tested positive for marijuana. The role of the aunt was unknown.

Report Determination: Unfounded | **Date of Determination:** 02/05/2021

Basis for Determination:
The allegations were unsubstantiated due to a lack of credible evidence that the SC was placed at risk of harm due to her actions.

OCFS Review Results:
The investigation was initiated timely, and a home visit was made. The source of the report was contacted. A CPS history check, and 7-day Safety Assessment was completed timely. Notice of Existence letters were provided timely. Safe sleeping recommendations were provided. The investigation revealed no credible evidence to support the substantiation of the allegation; however, there was no documentation of a Plan of Safe Care.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
Notes were not entered contemporaneously. For example, an event occurred on 12/15/20 but was not entered until 2/4/21.
Legal Reference:
18 NYCRR 428.5
Action:
SCDSS will adhere to the following regulation: 18 NYCRR 428.5

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
Although the SM denied having a clinical health issue, the social worker notes reflected that the SM had a history of a clinical health issue and drug use. The SCDSS did not fully explore the SM's clinical health.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
SCDSS will adhere to the following regulation: SSL 424.6 and 18 NYCRR432.2(b)(3)

Issue:
Failure to complete, document, and monitor a Plan of Safe Care
Summary:
SCDSS did not document a Plan of Safe Care for the infant or family.
Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06
Action:
SCDSS will complete and document or request a Plan of Safe Care for applicable reports.

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.

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