Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-128

Prepared by: New York City Regional Office

Issue Date: May 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 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 11/26/2021
Initial Date OCFS Notified: 11/26/2021

Presenting Information

The SCR report alleged on 11/26/21, the mother awoke at 3:30AM to feed the one-year-old male subject child and found him unresponsive, but still warm. The mother contacted 911 for medical assistance and initiated CPR as instructed by the operator. The subject child was transported to the emergency room where he was pronounced dead on the same day. The mother had no explanation for the subject child's death.

Executive Summary

This fatality report concerns the death of a one-year-old male subject child who died on 11/26/21. The ME listed the cause of death as asphyxia due to neck compression by entanglement in feeding tube (infant with bronchopulmonary dysplasia and intubation related trachoma due to consequences of premature birth) and the manner of death as accident.

The SC had no siblings. The mother declined to disclose information regarding the subject child's father as he had not been involved in the care of the subject child.

ACS's investigation revealed the subject child was born at 25 weeks gestation, and was diagnosed with multiple medical conditions that required ongoing care and medication. The SC also received early intervention services such as physical, speech, and occupational therapy. He had weekly medical appointments with his pediatrician to which the mother was compliant. On 11/25/21 at about 9:00PM the mother was supervising the subject child's feeding through his feeding tube. During the process, the mother mother fell asleep and when she awoke she found the feeding tube around the subject child's neck. The mother called 911 at 4:22AM on 11/26/21 for emergency medical assistance. EMS responded to the home and transported the subject child to the hospital were he was pronounced dead at 6:34AM.

EMS reported upon arrival, they observed the mother administering compressions on the subject child as instructed by the dispatch operator. The attending doctor reported no visible injuries were found around the subject child's neck or elsewhere on his body and his temperature was warm.

Law enforcement personnel reported there was no criminality suspected in relation to the subject child's death. Other collaterals had no concerns regarding the mother's care of the SC. They reported no incidents associated with the mother.

The pediatrician reported the mother was compliant with the subject child's medication regiments, medical appointments and safe sleep was discussed. The subject child was placed on a feeding tube two months prior to his death and was last seen on 10/1/21. The subject child was up to date with immunizations and physicals. Additionally, the mother had been provided safe sleep training.

The mother declined a referral to parenting skill class as she had received seven months of training as an Neonatal Intensive Care Unit mother. The mother denied drug or alcohol use and no recent domestic violence concerns as she was no longer in a relationship. The mother also refused burial assistance. ACS mailed resources for bereavement counseling and mental health services to the mother.

On 1/5/22, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the mother on the basis of some credible evidence; however, the case documentation did not support this decision.

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?** No

Explain:
Sufficient information was gathered throughout the investigation; however, the allegation determination was incorrect.

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 casework activities, which included contact with the family and others from the receipt of the report through case conclusion; however, the determination of the allegations of the report was incorrect.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS' documentation throughout the investigation reflected the mother provided a minimum degree of care to the SC and yet ACS substantiated the IG allegation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report.
Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment-Family Court)
Summary:	ACS did not separate the allegations in the determination and apply appropriate legal standards to support them individually.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/26/2021 **Time of Death:** 06:34 AM

Time of fatal incident, if different than time of death: 04:00 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 04:22 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
How long before incident was the child last seen by caretaker? 8 Hours
At time of incident was supervisor impaired? Not impaired.
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	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)

LDSS Response

Upon receipt of the subsequent SCR report, ACS contacted hospital staff who reported the SC was transported to the ER via ambulance on 11/26/21. The doctor reported the SC was found with a stiff jaw and no visible marks around his neck. He was pronounced dead at 6:34AM the same day.

ACS learned the SC was born at 25 weeks gestation, and was diagnosed with multiple medical conditions. The SC received physical, speech, and occupational therapy. He had weekly medical appointments with his pediatrician to which

the mother was compliant. The mother was also provided safe sleep training.

On 11/26/21, ACS interviewed LE who reported the mother said she fed the SC at approximately 9:00PM; however, she and the SC fell asleep. She awoke at approximately 4:00AM and found the tube around the SC's neck. LE found no criminality and closed their case.

ACS interviewed the ME's investigator on 11/26/21 and learned that the mother stated she placed the subject child down to sleep at 9:00PM, after connecting the feeding tube. At approximately 4:00AM, she found the feeding tube wrapped around the subject child's neck and he was unresponsive. The ME's investigator reported the feeding tube had food in it, which confirmed the subject child was being fed. The investigator reported the home had "lots of food" and the medical equipment was very organized; the mother was visibly distraught and forthcoming with information surrounding the incident.

The mother declined a referral to parenting skills classes as she had received seven months of training as an NICU mother. The mother denied drug or alcohol use and no recent DV as she was no longer in a relationship. The mother declined to disclose information regarding the subject child's father as he had not been involved in the care of the SC.

Despite the information obtained throughout the course of the investigation, on 1/5/22 ACS substantiated the allegation of DOA/Fatality. ACS wrote the subject child was medically fragile and was being fed through a G-Tube. The mother started feeding the child and went to sleep while the tube was still being used. The SC appeared to have rolled over and the tube wrapped around the subject child's neck and he died as a result. ACS also documented the death was ruled an accident; however, the mother did not exercise minimum degree of care by sleeping while the child was still being fed.

NYCRO disagrees with the decision.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
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 the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060461 - Deceased Child, Male, 1 Yrs	060462 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated
060461 - Deceased Child, Male, 1 Yrs	060462 - Mother, Female, 25 Year(s)	Inadequate Guardianship	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:
The mother refused all service referrals from ACS.

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 other children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother declined all services from ACS.

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

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)
10/29/2021	Deceased Child, Male, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	No

	Deceased Child, Male, 1 Years	Mother, Female, 25 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
According to the SCR narrative, the 1-year-old subject child had a number of medical conditions, and was dependent on oxygen. On 10/28/21, the SC turned red and stopped breathing for less than a minute. The SM failed to follow through with the recommendation to seek medical treatment for the subject child.

ACS investigation revealed the SC was triaged at 12:06AM on 10/28/21 and the SM left the ER on 10/29/21 at 4:02PM. The SM and SC were in the ER waiting room for 16 hours. The Dr. had wanted to admit the SC for observation; however, they were no beds available. The mother left the ER and contacted the SC's pediatrician. ACS received confirmation the mother contacted the pediatrician.

Report Determination: Indicated | **Date of Determination:** 12/28/2021

Basis for Determination:
ACS substantiated the allegation of IG of the subject child by the mother citing the subject child died during the investigation. ACS documented the subject child was medically fragile due to his medical diagnosis and the mother went to sleep while the tube was in use. ACS believed the subject child rolled over and the tube wrapped around his neck resulting in his death. ACS wrote that although the ME ruled the death an accident, the mother did not exercise minimum degree of care by sleeping while the subject child was being fed.

ACS unsubstantiated the allegation of Lack of Medical Care and cited a lack of credible evidence to support the substantiation.

OCFS Review Results:
NYCRO does not agree with the substantiated allegation of IG. The documentation throughout the case reflected the SM provided a minimum degree of care and met all the subject child's needs. Information from collaterals also indicated the same.

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

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