Child Fatality Report

Report Identification Number: NY-22-024

Prepared by: New York State Office of Children & Family Services

Issue Date: Sep 07, 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: 7 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 04/06/2022
Initial Date OCFS Notified: 04/06/2022

Presenting Information

An SCR report alleged on 4/6/22, at an unknown time, the father and 7-month-old female subject child were lying in the bed together. The father put the child on his chest and they both fell asleep. When the father woke up, he found the child on the bed, under a pillow. The child was unresponsive and was purple. The grandmother called 911 at 10:48 AM. EMS took so long that the father and grandmother hailed a cab and transported the child to the hospital. The doctors and nurses worked on the child for a couple of minutes and the child was pronounced deceased at 11:21 AM. The cause of the child's death was asphyxiation due to the co-sleeping environment. The child had no visible injuries. The roles of the mother and the grandmother were unknown. A duplicate report was received on 4/6/22.

Executive Summary

This report concerns the death of the 7-month-old subject child who died on 4/6/22. Two reports were made to the SCR on the same day that alleged the child passed away after the father discovered her unresponsive next to him while they were bedsharing. At the time of the child's death, she resided with her parents, maternal grandmother, and 8-year-old maternal uncle. The uncle was deemed safe in the care of the grandmother.

The Administration for Children Services (ACS) coordinated investigative efforts with law enforcement upon receipt of the SCR reports. An autopsy was performed; however, the final autopsy report was not yet received at the time this report was written. The medical examiner noted it was probable the child's death was a result of an unsafe sleeping environment in which included blankets, pillows, and a loose-fitting sheet. The criminal investigation remained open as the final autopsy report was pending; however, law enforcement did not suspect criminality.

The father reported after feeding the child around 7:00 AM, he placed the child on her back next to him and they both fell asleep. When he awoke, the child was turned upside down and face-down on the mattress. He made the maternal grandmother aware of the child's condition and she called 911. The father and grandmother went outside and signaled a passing driver to stop. The family got in the car and was taken to the hospital where the child was pronounced deceased. At the time of the fatal incident, the mother was in Pennsylvania working and the uncle was at school.

ACS gathered information from collateral contacts including family members, the pediatrician, and Pennsylvania Children and Family Services as the family moved to the state after the death. Collateral contacts did not have concerns for the care the parents provided to the children.

ACS made home visits and documented thorough interviews. The record did not reflect attempts to notify or interview the maternal uncle's father. The Safety Assessments were completed timely and accurately. The family was offered services in response to the death, including bereavement counseling and burial services; however, the family declined as they relocated to another state.

The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the father. ACS noted that the allegations were unsubstantiated as there were no criminal charges and collateral contacts stated the father prioritized the needs of the child. However, the investigation revealed the father regularly co-slept with the child, which created an unsafe sleeping environment. Additionally, ACS gathered information that although the ME did not find signs of trauma to the child's body, the child's death was likely a result of the unsafe sleeping environment created by the father. The ME

noted the child was found face-down on the bed and was up against the wall. There were aggravating factors as the father co-slept with the child on the bed with pillows, a loose fitted sheet, and blankets.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** No

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:

Casework activity was not commensurate with case circumstances as the father of the uncle was not interviewed or provided with written notice of the SCR report. The allegations were determined inaccurately.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The information ACS gathered from the ME and case documentation of the child's unsafe sleeping environment (including photographs) met a fair preponderance of evidence to substantiate the allegations.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The record did not reflect attempts to contact the maternal uncle's father with regard to the SCR report.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.
Issue:	Failure to provide notice of report
Summary:	Although the parents and grandmother were provided with written notice of the SCR report, the record did not reflect the maternal uncle's father was notified of the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/06/2022 **Time of Death:** 11:21 AM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 10:48 AM
Did EMS respond to the scene? Unknown
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
How long before incident was the child last seen by caretaker? 4 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	Aunt/Uncle	No Role	Male	8 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	7 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Mother	No Role	Female	20 Year(s)

LDSS Response

Within the first 24 hours of the investigation, ACS coordinated investigative efforts with LE, contacted the sources, and completed a CPS history check. The ME and district attorney's offices were made aware of the death and the safety of the MU was assessed.

An LE officer noted the SF put the SC on his chest and fell asleep. The SF awoke, the SC was not on his chest, and she was under a pillow. He yelled to the MGM and 911 was called. The adults ran outside and flagged down the driver of a passing car and they were taken to the hospital where the SC died. The SF was distraught and suicidal. LE planned to deem the death accidental as there were no signs of trauma to the SC's body, per the ME. Another officer said the SF slept next to the SC, who was on her back when they fell asleep. The SC fell asleep with her head pointed toward the head of the bed; however, when the SF awoke, the SC's head was facing the foot of the bed. The record was unclear where LE obtained their information.

Hospital staff reported the SF was distraught; he and the MGM screamed the SC was not breathing upon their arrival. The SF gave the SC rescue breaths to no avail.

The ME did not find signs of trauma to the SC's body. The ME interviewed the SF, who did not disclose that the SC was under a pillow, yet stated the SC was at his side and positioned on her back when they fell asleep, but she was face-down when he woke up. The ME stated the bed had pillows on it, along with blankets and a loose fitted sheet. The ME noted the SF was sedated at the hospital as he was frantic and was admitted to the mental health unit.

On 4/6/22, ACS completed a video call with the MGM and the safety of the MU was assessed. ACS contacted Buck's County Children and Youth Social Services Agency in Pennsylvania as the family was there. Buck's County interviewed MGM, BM and MU on 4/7/22. The MGM said on 4/6/22, she took the MU to school and returned home. She heard the SF scream and saw him holding the SC who was purple. The MGM called 911, but the operator could not understand her, so the adults ran outside and hailed a ride to the hospital. The SF told the MGM he fed the SC and they both fell asleep and when he woke up the SC was unresponsive. The SF did not normally co-sleep with the SC, and she slept in a bassinet. The MGM believed the SC suffocated as a result of the sleeping environment. The MU and BM were not home at the time of the fatal incident and did not have additional information about the fatal incident. The BM was aware of safe sleeping practices as the hospital educated her at the time the SC was born. The BM stated the family followed safe sleeping recommendations and that the SC had started to roll over.

On 4/11/22, ACS was able to interview the SF in a mental health unit. The SF recalled feeding the SC at 7:00 AM on 4/6/22 and then placed her on her back next to him and fell asleep. Around 10:45 AM, the SF found the SC unresponsive. He screamed for the MGM, and she called 911. The SF said the 911 operator repeated the same questions several times and the SF became frustrated and went outside with the SC and they were taken to the hospital by an unknown passerby. The SF said he and the SC co-slept the entirety of the night and that he found her face-down with her head pointing toward his feet. He stated it was typical for him to co-sleep with the SC while the BM was away. The SF was aware of safe sleep recommendations and stated the SC's airway was not obstructed.

ACS contacted the MU's school staff and there were no concerns for his safety. The school offered to provide bereavement services to the MU. The pediatrician did not have concerns for the care the parents provided to the SC and stated they did a "really good job as parents."

The family provided information that they were staying in Pennsylvania and would not be returning to New York. It was unknown if the family engaged in services in Pennsylvania, in response to the fatality.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061218 - Deceased Child, Female, 7 Mons	061220 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated
061218 - Deceased Child, Female, 7 Mons	061220 - Father, Male, 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?	☒	☐	☐	☐

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?	☒	☐	☐	☐

Additional information:
The record did not reflect attempts to contact the father of the uncle.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
The family did not accept services from ACS as they relocated out-of-state.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The uncle did not need to be removed as a result of the fatality investigation.				

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? Unable to Determine
Explain:
Although the uncle's school offered bereavement services, he did not return to that school. It remained unknown if he engaged in services in response to the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
It remained unknown if the adults utilized bereavement services or funeral assistance as they relocated to another state.

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 New York.

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