Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-048

Prepared by: New York City Regional Office

Issue Date: Oct 23, 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	

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 04/26/2021
Initial Date OCFS Notified: 04/26/2021

Presenting Information

The SCR report alleged that shortly before 3:00PM on 4/26/21, the SF helped the SC change his clothes while the SC stood on a futon. The futon was positioned very low to the ground. Once fully dressed, the SC jumped from the futon, and landed on the carpeted floor headfirst. Immediately, the SC was unresponsive and breathing heavily with his arms raised up above him. The SF brought the clothed SC into the shower for about five minutes while the SC continued to breathe irregularly. After removing the SC from the shower, the SF laid the SC down and put some ice on the SC's head. Around 3:05PM, the SF called the PGM in a panic, while the SC continued to lay unresponsive. After ending the phone call, the SF then called 911. Emergency responders arrived at the apartment around 3:25PM and found the SC laying unresponsive on the futon in the living room. The SC was wearing a dry set of diapers upon their arrival and no wet clothes were observed in the area.

Executive Summary

The 2-year-old male subject child (SC) died on 4/26/21. As of 10/1/21, NYCRO had not received a copy of the autopsy report.

The SC resided with his father. The BM and the 3-yo female SS did not reside in the home. The 3-yo SS's father resided outside NYS. The BM had a 10-yo male who also resided outside NYS.

ACS learned that the SC awoke at 2:00 PM. The SC climbed on the futon and began jumping. The child had a bad step when he jumped and he landed on the back of his head. The SF put the SC on the bed and thought he would regain consciousness. When the child did not quickly revive, the SF put the SC in the shower, then got ice and applied it to the SC's head; these attempts to revive the SC also did not work. The SC continued to gasp for air. The SF called the PGM and then called 911. The child was transported to the hospital where he was pronounced dead.

On 4/29/21, ACS convened separate conferences with the SF and BM. The outcome was for bereavement counseling and burial assistance.

On 4/29/21, the ME said SC did not have recent trauma to his body but had healing rib fractures. Several tests were conducted to determine the stages of the fractures. However, it was noted the fractures did not contribute to the death. More testing was being conducted to ascertain the cause of death.

On 5/11/21, ACS completed the burial assistance package for the family.

On 6/21/21, ACS unsubstantiated the allegations of DOA/Fatality, IG, and LMC of the SC by the SF. ACS documented there was no "concrete" evidence the SC's death was due to foul play by the SF. ACS also documented that as per the ME, the delay in calling 911 did not play a factor in the SC's death. LE said there were no charges related to the death.

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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
Since the ACS did not explore the cause and circumstances around healing rib fractures, the reviewer is unable to assess the appropriateness of the determination.

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 SS's or other CHN living with the SF.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 4/27/21 safety assessment was completed timely; however, it was not necessary as there were no other SSs or children in the home.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	During the interview with the SF on 4/26/21, the SF stated the SC's front teeth were knocked out over the summer. ACS should have elaborated on whether he chipped his teeth or they were completely knocked out. More detail should had been sought.
Legal Reference:	18 NYCRR 432.1 (o)
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.

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The documentation did not reflect that the primary care physician was interviewed regarding the SC.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
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.

Issue:	Overall Completeness and Adequacy of Investigations
Summary:	ACS did not explore the cause and circumstances around healing rib fractures, and did not sufficiently explore the injury the child had sustained in the summer.
Legal Reference:	SSL 424.6 and 18 NYCRR 432.2(b)(3)
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

Incident Information

Date of Death: 04/26/2021 **Time of Death:** 04:06 PM

Time of fatal incident, if different than time of death: 03:00 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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
- ☒ Playing
- ☐ Other
- ☐ Working
- ☐ Eating
- ☐ Driving / Vehicle occupant
- ☐ Unknown

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
- ☐ Asleep
- ☐ Absent
- ☒ Other: **SF asked the SC if he wanted to go outside.**

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	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	31 Year(s)
Other Household 1	Mother	No Role	Female	27 Year(s)
Other Household 1	Sibling	No Role	Female	3 Year(s)

LDSS Response

Upon the receipt of the report, ACS initiated the investigation and made the appropriate contacts. ACS also interviewed the father and other family members.

On 4/26/21, LE told ACS the SF said he and the SC got up at 2:00PM and were going to get food. The SC was active and jumped from the couch. He landed on his head and was unresponsive. SF picked him up and took him to the bathroom and put cold water on him. The SC calmed down and SF put him back on the floor. The ME looked at the SC's body and there were no signs of trauma. There were also no marks or bruises. Later, LE said there were no arrests relating to the death of the SC pending the receipt of the autopsy report.

On 4/26/21, SF described the SC as being active. SF said the SC fell at 3:00AM and went to sleep around 4:20AM. He said the SC looked fine. He stated that when the SC fell, he did not call the ambulance. The SF said the SC was going through therapy. Later, the SF denied knowing the SC had any rib fractures. He said he took the SC to the Dr. in the beginning of April 2021 and was not informed of any rib fractures.

On 4/26/21, EMS said that upon arrival at the case address, the SC was lying on the floor next to the futon. The SF said the SC was jumping around and fell. The SC was not conscious but had a faint pulse. Both the SF and SC were dry at that time.

On 4/27/21, ACS visited the case address and was informed by LE that they were waiting for a warrant to search the apartment.

On 4/27/21, the hospital social worker (SW) indicated the SF's home had carpet and the futon/sofa was low to the ground.

On 4/27/21, ACS visited the BM's home which was a shelter. The BM's case manager (CM) did not have any concerns for the BM and 3-yo SS; the family was doing well in the shelter. Later, the BM informed ACS the PGM contacted her to tell her of the SC's death. ACS offered bereavement services, but she she was unable to talk. Later, she declined bereavement counseling.

On 4/28/21, ACS visited the BM and 3-yo SS at the shelter. The CM accompanied ACS to the apartment. BM declined to speak with ACS. BM agreed for ACS to observe the 3-yo which she was in the care of her PGM. The 3-yo was observed through the doorway waving at ACS. BM declined services from ACS.

On 4/30/21 the SC's PGM said that the day of the incident the SF was changing the SC. The SC was on the futon and the SF asked if he wanted something to eat and the SC nodded yes. The SF turned his head to the kitchen and when he turned

back around the SC was on the floor. The PGM said she could not recall the whole conversation as she was frantic when the SF called her and then called 911. The PGM said burial assistance would be helpful.

On 6/17/21, the DA's office told ACS the ex-paramour reported observing the SF being physical with the SC and doing acts that could had caused the fractures. The ex-paramour said that in the past the SF had been physical with the SC. The ex-paramour stated that on the day of the fatality the SF seemed to be agitated and angry (the reason was not disclosed).

ACS explored the allegations of the report and ultimately unsubstantiated them.

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 NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058113 - Deceased Child, Male, 2 Yrs	058114 - Father, Male, 31 Year(s)	DOA / Fatality	Unsubstantiated
058113 - Deceased Child, Male, 2 Yrs	058114 - Father, Male, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
058113 - Deceased Child, Male, 2 Yrs	058114 - Father, Male, 31 Year(s)	Lack of Medical Care	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 documentation did not reflect that the primary care physician was interviewed regarding the SC.

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 other CHN residing in the home of the SF.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided burial assistance to the family.

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?	Yes
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)
02/20/2021	Deceased Child, Male, 2 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 2 Years	Father, Male, 31 Years	Lack of Supervision	Substantiated	

Report Summary:
The 2/20/21 report alleged that on 2/20/21, the SF left the SC home alone. He had been gone at least 1.5 hours. His whereabouts were unknown, and he could not be reached. The SC was in need of intervention. Also, the SF left the SC unsupervised other times in the past. The role of the BM was unknown.

Report Determination: Indicated | **Date of Determination:** 04/21/2021

Basis for Determination:
There was some credible evidence to substantiate the allegations. The SF failed to exercise a minimum degree of care when he left the SC alone in the shelter unit for an extended period of time. There was no plan put in place in his absence and he failed to take accountability for his actions. Shelter staff documented the SC being left alone in the unit for about an hour. The SC was not of age or maturity where this was appropriate. The SF had an IND case from April 2020 for the same concerns and he still failed to ensure appropriate supervision was in place.

OCFS Review Results:
The investigation began timely. ACS explored the allegations of the report and contacted the appropriate collaterals. Notifications of the report and the outcome were provided to the alleged subjects.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:

The RAP reflected no reported housing issues; however, the family resided in a homeless shelter.

Legal Reference:

18 NYCRR 432.2(d)

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 investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Notes were not entered contemporaneously. For example, an event occurred on 3/1/20 but was not entered until 4/19/21.

Legal Reference:

18 NYCRR 428.5

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 investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:

Assessment as to need for Family Court Action

Summary:

Provided that the SF had history of a lack of supervision regarding the SC, ACS should had sought a legal consultation with Family Court Legal Service.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

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 investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/14/2020	Deceased Child, Male, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 1 Years	Father, Male, 30 Years	Lack of Supervision	Substantiated	

Report Summary:

The 2/14/21 report alleged that on 2/13/20, at about 11:11PM, the SF physically assaulted the BM in the presence of the SC. The SF grabbed the BM by her shirt forcefully. As a result, the SF ripped the SM's shirt and snatched her chain from around her neck. The BM sustained scratches around her neck. The SF became loud, irate, and belligerent in the presence of the SC. The SC did not sustain any physical injuries. The other CH was unknown.

Report Determination: Indicated | **Date of Determination:** 04/15/2020

Basis for Determination:

ACS documented there was credible evidence to support the allegations. The LE report and staff at the BM's shelter confirmed the SF physically assaulted the BM while in the presence of the SC. As a result of the SF's actions, he was arrested and charged. LE and shelter staff reported the SF had left the SC unattended in their shelter room on several occasions.

OCFS Review Results:
The investigation was timely. ACS interviewed the BM, PGM, LE, PGM of the 2-yo SS, SF shelter case manager (CM) and SF. Notifications were provided.

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 3/12/20 but was not entered until 4/13/20.
Legal Reference:
18 NYCRR 428.5
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 investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP reflected no reported housing issues; however, both parents according to the documentation resided in shelters.
Legal Reference:
18 NYCRR 432.2(d)
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 investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The 2/20/21 investigation reflected a supervisor review occurred on 4/13/21. The review reflected the SF had two reports from 1989 in the state of NJ. The documentation did not reflect whether he was a CH or a subject.

Foster Care Placement History

The BM had a 7-yo male CH and she surrendered her parental rights to the CH. The SM signed a conditional surrender for the FP to adopt the CH as of 6/23/17.

The BM also had a 10-yo male CH that resided outside of NYS with a godparent. The BM made arrangements with the godparent to care for him. At that time, she gave the godparent a notarized letter to care for the CH. The godparent was in the process of adopting the CH.

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