Child Fatality Report

Report Identification Number: NY-22-015

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

Issue Date: Jul 21, 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: 2 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 03/05/2022
Initial Date OCFS Notified: 03/08/2022

Presenting Information

An SCR report dated 3/8/2022 alleged that on 3/5/2022, the 2-year-old subject child (SC) had a fever of 103 degrees and was brought to the emergency room around 7 AM by the subject mother (SM). The SC was discharged from the hospital around 2 PM with pain/fever reducer medication. Sometime after 2 PM the SM noticed that the SC was in a daze and not alert, and the parents put the SC down for a nap. The subject father (SF) checked the SC sometime after 4 PM and the parents found the SC to be unresponsive, unconscious, and blue. The parents contacted 911 at 4:59 PM. EMS responded to the home, performed CPR, and transported the SC to the hospital where he was pronounced deceased at 5:39 PM. The SC was an otherwise healthy child aside from his fever. The parents had no other explanation for the SC's death. There was a 12yo surviving sibling (SS) residing in the home.

Executive Summary

This report concerns the death of the 2-year-old subject child that occurred on 3/5/2022. At the time of his death, the subject child resided with his mother, father, and 12-year-old sibling.

The investigation revealed the subject child had been ill with a fever on the morning of 3/5/2022 and was brought to the hospital by the mother around 9:00 AM. The subject child was treated for fever and discharged home with a fever reducer around 12:00 PM. Later that day, the parents found that the subject child was unresponsive. The parents contacted 911 at 4:59 PM and EMS transported the subject child to the hospital where he was pronounced dead at 5:39 PM.

The surviving sibling was seen and assessed to be safe in the care of his parents within 24 hours of ACS’s receipt of the SCR report.

During the initial home visit on 3/8/2022, and a follow-up visit on 3/9/2022, the home was observed to be cluttered with clothes and other items, to the extent that it was deemed a safety concern for the sibling. The record reflected supervisory direction that bi-weekly home visits be conducted to follow up with that concern, as well as to engage with the family and assess for their service needs, including bereavement and mental health services; however, the record did not reflect any such contact occurred. The record also contained supervisory direction to obtain medical releases for the subject child and surviving sibling to ascertain they were up to date with medical appointments, and to verify that the parents were following medical advice pertaining to the subject child’s first hospital visit on 3/5/2022; however, the record did not reflect that the parents were asked to sign medical releases and did not reflect that any such information was gathered. While ACS did contact the hospital to discuss the subject child’s initial visit on 3/5/2022, ACS did not discuss the subject child’s diagnosis or discharge instructions with medical staff.

ACS interviewed the parents, and both stated that the subject child was seen at the hospital for a fever on Saturday 3/5/2022, returned home that afternoon, and was found unresponsive when the parents woke on 3/6/2022. Information gathered from law enforcement and the medical examiner reflected that the parents contacted 911 on the afternoon of 3/5/2022. The record did not reflect that the date discrepancy was explored with the family, law enforcement, or medical staff.

ACS opened a preventive service case with the family on 3/15/2022; however, as of this writing, the record reflected no documented casework activity since 3/15/2022, and did not reflect if any services were offered or utilized. The initial Family Assessment Service Plan had not been completed and was overdue by more than 1 month.

The 30-day fatality report, as well as the 30-day safety assessment, were not completed until 59 days into the investigation.

On 5/9/2022, ACS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship for both parents regarding the subject child, citing no credible evidence found to support the allegations. The parents sought medical attention for the subject child when he had a fever and called EMS when he was later found unresponsive.

The investigation was closed on 5/9/2022 with the preventive services case remaining open.

PIP Requirement
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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

Explain:
There were documented concerns for the state of the home; however, the record does not reflect these concerns were addressed or mitigated prior to the closing of the CPS investigation.

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

Was the decision to close the case appropriate? N/A
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:
Supervisory direction was documented throughout the case, identifying safety concerns and service needs to be addressed with the family; however, there was no documentation of these concerns or needs being addressed.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-day safety assessment was not completed until day 59 of the investigation.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS will document and approve a 30-day safety assessment within 30 days of receipt of the fatality report.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-day fatality report was not completed until day 59 of the investigation.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS will document and approve a 30-day fatality report within 30 days of receipt of the fatality investigation.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The 7-day-safety assessment reflected a safety plan was established; however, the record reflected no monitoring of the plan.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS will document all applicable actions and considerations with respect to safety planning, including but not limited to: including all family members when devising the plan; adequately monitoring the plan; and, consulting the legal department if there is reason to believe the safety plan may not be sufficient to protect the child(ren).
Issue:	Adequacy of services following the fatality
Summary:	Service needs were identified for the mental health of the parents as well as grief counseling for the SS; however, the record did not reflect those services were discussed with, offered, or provided to the family.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	ACS will explore areas of potential service needs with all family members with whom they are involved. ACS will appropriately respond to changing circumstances, and if service needs are identified, ACS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect an attempt to speak with medical providers to gather information regarding the SC and SS.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/05/2022 **Time of Death:** 05:39 PM

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: 04:59 PM
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
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	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	46 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)

LDSS Response

Upon receipt of the report on 3/8/2022, ACS initiated an investigation by contacting LE, who had investigated the subject child's death on 3/5/2022. ACS also interviewed the mother, father, surviving sibling, hospital staff, and medical examiner. ACS learned the subject child had been ill with a fever in the days leading up to his death and was brought to the hospital by the mother on the morning of 3/5/2022, where he was treated for a fever and discharged with a fever

reducer. On the afternoon of 3/5/2022, the parents noticed the subject child was not acting normal and had become unresponsive. The parents contacted 911 and EMS responded to the home and transported the subject child to the hospital where he was pronounced dead.

Through contact with LE, ACS learned LE responded to the home during the initial EMS response, as well as later with the ME. LE noted no suspicion for criminality related to the subject child's death and noted no concerns for the surviving sibling. The record documented the ACS last had contact with LE on 3/10/22, and it was unclear if their investigation remained open.

ACS spoke with the ME who stated the autopsy was completed on 3/6/2022; however, the final autopsy report would not be available for 6-8 months. The ME was unable to provide an official cause of death but stated there were no signs of trauma found during the autopsy and both parents provided a consistent account of the days leading up to the subject child's death.

The 12yo sibling was interviewed and was distraught over the death of his brother. The sibling was unable to provide any specific details regarding the subject child's death. The sibling reported no concerns for his safety or for the safety of the subject child.

Supervisory guidance is documented throughout the case as well as consultations with medical and mental health specialists.

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: The NYC area does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059961 - Deceased Child, Male, 2 Yrs	059962 - Mother, Female, 46 Year(s)	DOA / Fatality	Unsubstantiated
059961 - Deceased Child, Male, 2 Yrs	059962 - Mother, Female, 46 Year(s)	Inadequate Guardianship	Unsubstantiated
059961 - Deceased Child, Male, 2 Yrs	059963 - Father, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
059961 - Deceased Child, Male, 2 Yrs	059963 - Father, Male, 36 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:
ACS did not speak with staff at the hospital where the SC was pronounced dead, nor did they contact the SC's pediatrician.

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?	☒	☐	☐	☐
Explain: There were documented concerns for the state of the home; however, the record did not reflect these concerns were addressed or mitigated prior to the closing of the CPS investigation.				
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?				
Explain: The 30-day safety assessment was completed late at 59 days.				

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: Service needs were identified for the parents and for the SS, however were not offered as of the time of this writing.				

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?	☐	☒	☐	☐

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:
Bereavement information was provided for the parents; however, a need for bereavement services was also identified for the SS but not provided. Service needs were identified for the SM's mental heath but not offered. Service needs were identified for house cleaning services but not offered.

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? No
Explain:
Service needs were identified for the SS, however no services were provided.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were referred for grief counseling.

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? No
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was known 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