Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-048

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

Issue Date: Nov 28, 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 06/25/2022
Initial Date OCFS Notified: 06/25/2022

Presenting Information

Two SCR reports alleged the godmother put the child down for a nap around 7:00PM. Around 7:30PM, the godmother found the child unresponsive, called 911 and began CPR on the child. EMS arrived at the home and the child appeared cyanotic and her extremities were cold to the touch. EMS took over resuscitative measures and transported the child to the hospital. Upon arrival hospital staff continued to perform life saving measures but were unsuccessful and the child was pronounced deceased. The godmother had no explanation for the death of the child and the mother and father had unknown roles.

Executive Summary

This fatality report concerns the death of a 3-year-old female child. New York City Administration for Children's Services (ACS) received two SCR reports regarding the child's death on 6/25/22. At the time of the child's death, she resided with her mother and father. There were no surviving siblings or other children residing in the parents' home. At the time of the fatal incident, the child was being watched by the godmother, at her home, while the mother was at work. The child had a developmental disability, was nonverbal and had a history of chronic medical conditions.

The investigation revealed the child took a nap in the godmother's bedroom in the afternoon. The child awoke around 3:45PM and was making noises, the godmother checked on the child, rubbed her back and the child went back to sleep. Sometime around 7:30PM, the godmother went into the bedroom to check on the child and found her to be unresponsive. The godmother called 911 and began CPR on the child. First responders arrived, took over resuscitative measures and transported the child to the hospital. Hospital staff continued life saving measures but were unsuccessful and the child was pronounced deceased at 8:50PM.

ACS contacted the medical examiner's office, and an autopsy was performed; however, the final report was pending further testing at the time this report was written. The preliminary examination showed there were no indicators of trauma, abuse, injuries, and no fractures. The medical examiner did not provide a preliminary cause of death. Law enforcement investigated the incident, and no criminal charges were filed at the writing of this report; however, the criminal case remained open.

ACS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the godmother regarding the death of the child. ACS found no preponderance of evidence that the godmother caused or contributed to the death. ACS offered the parents grief counseling, mental health counseling and burial assistance, and they declined the services. The godmother was referred for grief counseling, but it was unknown if she engaged in the services.

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:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
ACS made an appropriate determination based on the evidence obtained throughout the investigation and there were no surviving siblings.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was commensurate with the case circumstances; however, the 24-hour fatality report and the 24-hour safety assessment were not completed in a timely manner.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	A 24-hour Fatality Report was not documented and approved in Connections within 24 hours of receipt of the report alleging the death of a child as a result of abuse or maltreatment. The 24-hour Fatality Report was approved in Connections on 8/23/22.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour safety assessment was not approved within the required time frame and was approved one day past the due date.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	A safety assessment will be documented and approved by a supervisor within 24 hours of a report if such report contains the allegation of DOA/Fatality, as required.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/25/2022 **Time of Death:** 08:50 PM

County where fatality incident occurred:	New York
Was 911 or local emergency number called?	Yes
Time of Call:	07:32 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

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	Female	3 Year(s)
Deceased Child's Household	Father	No Role	Male	43 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)
Other Household 1	Other Adult - Godmother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

On 6/25/22, ACS received two reports regarding the death of the subject child. ACS initiated their investigation within 24 hours and spoke with LE regarding the investigation. ACS contacted the sources of the reports, completed a CPS history check regarding the family and godmother, and informed the DA of the fatality. There were no surviving siblings; however, ACS did assess the safety of the godmother's 2-year-old child.

ACS interviewed the mother, father, and godmother regarding the events prior to the child's death. The mother and father reported the child was not sick or having any respiratory distress prior to the godmother picking up the child from the parents' home. The child had a medical condition that required medication as needed and the mother provided the medication to the godmother. The mother packed the child's prescription medications in the bag the godmother was to take when she picked up the child. The godmother picked up the child from the parents' home around 7:00AM and took the

child to her home for the weekend while the mother worked. The mother and father exchanged texts with the godmother throughout the day regarding the child and how she was doing, and the godmother reported the child was active and playing with the other child. Sometime around 3:00PM the child took a nap on the godmother's bed; around 3:47PM the godmother texted the mother that the child woke up and was yelling in her sleep. The mother replied that the child may have had a bad dream. The godmother informed the mother that she rubbed the child's back and the child calmed down and was okay. The godmother made the mother aware that she offered the child various food throughout the day and the child was not eating. Around 7:00PM the godmother reported the child was getting sleepy and the godmother left the child in the bedroom and went to make food within the home. Around 7:30PM, the godmother went to check on the child and found her unresponsive.

ACS learned that the child was born premature, at 29 weeks, and was born with complex medical complications. The child had a developmental disability and was non-verbal, had a history of seizures and a chronic respiratory condition and was taking prescribed medication. The child had an allergy to cats and there were cats in the godmother's home.

The medical examiner reported the child's preliminary autopsy was unremarkable; there were no physical signs of trauma to the child and the medical examiner could not say whether the child's medical conditions affected her death. The medical examiner reported the child had no evidence of Anaphylactic shock and no swelling. The final autopsy and toxicology reports were pending at the writing of this report.

ACS interviewed several collaterals, including LE, EMS, neighbors, hospital staff and the child's medical providers. When the child arrived at the hospital her jaw was clenched shut as if rigor mortis had set in and the child's temperature was at 95 degrees. Hospital staff and EMS reported to ACS because of the child's jaw being locked and the child's temperature, the child may have been deceased longer than the godmother reported. The medical examiner stated the jaw lock could have occurred if the child had a seizure and that the child's temperature could have been so low because she was lying in front of the air conditioner. LE said that they had no concerns about the timeline given after they read the text messages between the godmother and mother.

ACS spoke with medical collaterals that reported that the child's medical needs were being addressed by the mother. The child was last seen at the hospital regarding respiratory concerns on 5/30/22. ACS spoke with family members that were in the godmother's home the day of the fatal incident that reported no concerns for the child or the godmother's care of the child. At the close of the investigation the godmother's child was assessed to be safe in the godmother's care.

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: Manhattan County does not have a Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

060835 - Deceased Child, Female, 3 Yrs	060846 - Other Adult - Godmother, Female, 26 Year(s)	DOA / Fatality	Pending
060835 - Deceased Child, Female, 3 Yrs	060846 - Other Adult - Godmother, Female, 26 Year(s)	Inadequate Guardianship	Pending

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS offered the parents services and they declined. The godmother was referred to 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? N/A
Was the child acutely ill during the two weeks before death? No

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

In 2012, the father was indicated for Lack of Medical Care, regarding another child.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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