Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-035

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

Issue Date: Nov 10, 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
Jurisdiction: Queens
Date of Death: 05/16/2022
Age: 6 month(s)
Gender: Female
Initial Date OCFS Notified: 05/16/2022

Presenting Information

An SCR report alleged that on 5/16/22, at 2:50AM, the mother and father went to check on the subject child in her crib, and she was breathing. At 3:05AM, the mother and father went back to check on the subject child and realized she was not breathing. The mother and father performed cardiopulmonary resuscitation. The mother and father left the subject child unsupervised and went to the police station for help. Law enforcement followed the mother and father back to the home and performed cardiopulmonary resuscitation until EMS arrived and took over. EMS performed cardiopulmonary resuscitation on the subject child, but were unsuccessful. The subject child was cold to the touch.

Executive Summary

This fatality report concerns the death of a 6-month-old female subject child that occurred on 5/16/22. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and father. At the time of her death, the subject child resided with the father in a shared apartment with the father’s roommate. The mother resided nearby with the maternal grandmother. There were no surviving siblings.

New York City Administration for Children's Services (ACS) completed collateral and casework contacts and learned that on the evening of 5/15/22, the father put the subject child to bed in her crib around 11:00PM. Sometime between 2:30AM and 2:50AM on 5/16/22, the father went to check on the subject child and observed her breathing and well. The father checked on the subject child again around 3:05AM and noticed she was unresponsive. The father picked the subject child up and noted that she was stiff, pale and her lips were black and blue. The father attempted CPR and ran to the police station across the street for help. The mother who was present in the home and distraught when the subject child was found unresponsive, followed the father to the police station, leaving the subject child in the home. Multiple law enforcement officials followed the parents back to the residence where they continued to attempt life-saving measures until emergency medical services arrived and took over. Resuscitation efforts were unsuccessful, and the subject child was pronounced deceased at the home.

An autopsy was performed, and the final cause and manner of death were pending at the time of case closure. There were no criminal charges filed pertaining to the subject child’s death, as law enforcement and the district attorney’s office did not find evidence of criminality at the scene.

The parents were offered bereavement services following the subject child’s death, and though the mother expressed feeling the need to speak to a counselor, it is unknown if the parents were engaged with services. The allegations against the mother and father were unsubstantiated, as ACS did not find there was a fair preponderance of evidence to support that the parents failed to meet minimal standards of care for the subject child. The report was unfounded and closed on 7/18/22.

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?** N/A

Determination:

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

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 case circumstances. There were no surviving siblings and therefore completion of the Safety Assessment was not required.

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:	The 24-hour Fatality Report was completed two months late, on 7/15/22.
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. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/16/2022 **Time of Death:** 03:35 AM

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

County where fatality incident occurred: Queens

Was 911 or local emergency number called? No
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:

- [x] 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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Other Household 1	Mother	Alleged Perpetrator	Female	28 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their investigation with law enforcement, notified the district attorney's office, spoke with collateral sources, interviewed the father, and offered services regarding the fatality.

ACS interviewed the father on 5/16/22; however, were unable to interview the mother at that time as she was distraught and crying for the duration of the interview. The father reported that he put the subject child to sleep on her back and in her crib with a pacifier in her mouth. The father stated that he and the mother were downstairs cooking, when he went upstairs to check on the subject child. The father reported that the first time he went to check on the subject child, she was observed to be breathing and well; however, the father went to check on the subject child around 3:05AM and observed the child had rolled to her side and the pacifier was out of her mouth. At this time, the father noticed the subject child was unresponsive and the mother came upstairs. The father began CPR on the subject child, but at some point, put the subject child down and reported asking his roommate to use his phone or call 911. There were discrepancies pertaining to if the father's phone was dead and if the roommate did call 911. The father ran across the street to a police station for help and the mother followed the father. When asked if the subject child was left home alone during this time, the father reported the subject child was in the home with the roommate, though the roommate reported in his interview that he was not home at the time of the incident. Law enforcement followed the parents back to the home and resumed life-saving measures until EMS arrived and took over. The subject child was not able to be resuscitated and was pronounced deceased at the home. In a later interview, the mother corroborated the father's version of events.

The father reported that the subject child co-slept in his queen-sized bed approximately 50% of the time but would otherwise sleep in her crib. The father reported there being stuffed animals and toys at the foot of the crib, away from the child's head, at the time of the incident. Law enforcement also reported observing a blanket in the crib. The record did not reflect if the parents were aware of safe sleep guidelines.

The investigation revealed that on 5/14/22, there was a domestic violence incident in which the father contacted law enforcement due to the mother threatening him. The mother was removed from the father's home, arrested, and an Order

of Protection was put in place in favor of the father. The mother returned to the father's home on the evening of 5/15/22 around 9:00PM. The record did not specify the stipulations of the Order of Protection, but did note that the mother was in violation of the order upon returning to the father's home. In addition to grief services, ACS offered the parents services regarding domestic violence.

ACS learned that the subject child was born underweight and with multiple birth defects, but the parents reported the condition would resolve with age. The father denied the subject child being on any medication for these conditions or seeing any specialist doctors; however, did note that there was an at-home procedure that was to be regularly conducted to improve the condition, which both parents stated they were not completing. ACS attempted to obtain medical records from the subject child's pediatrician but were unsuccessful due to the pediatrician having a different date of birth for the child.

ACS completed the 24-hour Fatality Report two months late, on 7/15/22.

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: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061619 - Deceased Child, Female, 6 Mons	061620 - Father, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
061619 - Deceased Child, Female, 6 Mons	061620 - Father, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
061619 - Deceased Child, Female, 6 Mons	061621 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
061619 - Deceased Child, Female, 6 Mons	061621 - Mother, Female, 28 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:

ACS contacted the SC's pediatrician and were able to confirm the SC had been seen at that office; however, were unable to obtain medical records due to the pediatrician having a different date of birth for 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.

Have any Orders of Protection been issued? No

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:
ACS offered the mother and father resources pertaining to domestic violence, as the parents had a history of domestic violence dating back 10 years with both the mother and father as the perpetrator during various incidents reported to police.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the parents following the subject child's death. Both parents were in agreement with attending counseling, as the mother was distraught over the loss of the subject child and felt she needed to speak to a counselor, though it is unknown if at the time of case closure the parents were engaged in any services.

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 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?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 05/14/2022	**To:** Unknown

Explain:
There was a domestic violence incident on 5/14/22 in which the mother threatened the father, and the father called LE. LE responded, resulting in the mother being removed from the home and an Order of Protection being issued in favor of the father. Though the record did not reflect the conditions of the Order of Protection, the mother was present at the father's home at the time of the subject child's death, which ACS noted was a violation of the order.

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