Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-009

Prepared by: New York City Regional Office

Issue Date: Jul 30, 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: 4 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 01/28/2021
Initial Date OCFS Notified: 01/28/2021

Presenting Information

The SCR report alleged on 1/28/21, the 4-month-old SC died while in the care of the BM, the BF, and the two grandparents. At 7:30AM, the BM fed the SC and then placed the SC on her back, in the bed, between herself and the BF. At 9:30AM, the BM attempted to feed the SC, but the SC did not cry or stare. The BM noticed that the SC's feet were purple and there was milk on the SC's face. The BM screamed and police were called by a neighbor. The BM attempted CPR, but milk was coming from the SC's nose. EMS responded to the home, where they found the SC pulseless; however, they still initiated CPR. The SC was transported to the emergency room, where medical staff pronounced the SC dead. The SC was an otherwise healthy child.

Executive Summary

The four-month-old female SC, who was an otherwise healthy child died on 1/28/21 while in the care of her parents. On 1/28/2021, ACS received the report and initiated the investigation within the mandated timeframe. The allegations of the report were DOA/Fatality and Inadequate Guardianship of the subject child by the parents, the MGM, the MGGM and the MGGF, and Inadequate Guardianship of the three-year-old SS by the father. The final autopsy report was pending; however, the ME's preliminary findings did not reveal any trauma to the SC.

At the time of the fatality, the SC, the SS, and the BM resided with the MGM at the maternal great grandparents' home. The MGM's 14-yo son, the 17-yo daughter and an adult daughter also resided in the home. The BF lived with his parents in the same building as the subject family. The SS's father resided at a different address and was involved with the SS.

ACS case documentation reflected the SC was co-sleeping with her parents in the same bed when the BM found the SC unresponsive. The parents administered CPR and a neighbor called 911. EMS arrived on the scene, administered Basic Life Support on the SC, and then transported her to the hospital where medical staff pronounced her dead at 10:46AM.

ACS obtained information from the family and relevant collaterals such as hospital staff, the ME, LE, medical provider, and agency staff. The information did not reveal any concerns of abuse or maltreatment to the SC and there were no safety concerns for the SS. LE did not suspect any criminality and did not make any arrests.

ACS held a child safety conference (CSC) and the outcome was that the family would be referred to PPRS services. The family agreed and signed up for services to assist with child parent psychotherapy, bereavement counseling, parenting skills, educational services, and community-based referrals.

On 3/14/2021, the SCR registered a subsequent report due to the SS's father taking the SS and refusing to return her to the BM. The BM contacted the police to have the SS returned to her as the father became aggressive towards the BM. The father was arrested and charged with menacing, harassment and endangering the welfare of a child. The charges were later dropped by the DA. ACS appropriately merged the subsequent report with the ongoing fatality investigation.

On 3/17/21, ACS held an updated CSC. The CSC decided to seek Family Court intervention due to DV concerns between the BM and the SS's father. Consequently, ACS filed an Article 10 Petition in Family Court. The SS's father was the respondent in the petition. The court released the SS to the BM with COS and granted an OP against the father protecting the BM and SS. The court also granted supervised visits for the father and referrals to PPRS services.

Throughout the investigation, ACS assessed the SS and the MGM's children for safety during home and virtual visits, interviews with relatives, service providers, school staff, and deemed them safe. ACS ordered a bed for the SS. ACS observed adequate safety and sleeping provisions in the home.

On 3/3/2021, the adult MA gave birth to a baby girl. ACS assessed the MA's new home via video. There was adequate provisions in the home for the baby. ACS discussed safe sleep with the MA and observed the baby to be well.

On 3/30/2021, ACS substantiated the allegation IG of the SS by the father on the basis of some credible evidence. On 3/11/2021, the father was arrested by police for aggressively charging at the BM and the SS; he later released.

ACS unsubstantiated the allegations DOA/FATL and IG of the SC by the BM, the BF, the MGM, the MGGM and the MGGF due to lack of credible evidence. The ME reported the cause and manner of death were pending; however, there were no signs of trauma to the SC's body. At the time of the incident, the family acted appropriately and contacted EMS.

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?** Yes

Explain:
Sufficient information was gathered to determine all allegations.

Was the decision to close the case appropriate? N/A

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:
The level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion was commensurate with the case circumstances. The case remained open for services.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	ACS failed to contact/interview the SS's father.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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: 01/28/2021 **Time of Death:** 10:46 AM

Time of fatal incident, if different than time of death: 09:30 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 10:11 AM
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	Aunt/Uncle	No Role	Female	17 Year(s)

Deceased Child's Household	Aunt/Uncle	No Role	Female	19 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	14 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	71 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	63 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Other Household 1	Other - Father of surviving sibling	Alleged Perpetrator	Male	23 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	26 Year(s)

LDSS Response

On 1/28/21, the ER Dr. reported there were no marks and or bruises on the SC.

On 1/28/21, LE stated the information obtained from the family and the medical staff indicated the incident appeared to be a "roll over."

On 1/28/21, ACS visited the case address. The MGM stated the family was grieving and did not speak with ACS. ACS did not document any concerns for the children in the home. ACS contacted the BM over the phone. She gave an account of the incident which was consistent with the information contained in the intake narrative. The family's neighbors did not report any concerns for the family. ACS then visited the BF's home and did not observe any health or safety hazards in the home.

On 1/29/21, the ME reported the cause of death was pending.

On 2/1/21, ACS held a child safety conference and the outcome was that the family would be referred for PPRS services.

On 2/4/21, ACS visited the family. There were no concerns for the children in the home. The family denied the SC was ill or displayed any unusual behavior in the days prior to her death.

On 2/16/21, the property staff at the case address did not report any concerns for the family.

On 2/19/21, the pediatrician stated the SC was seen when she was 8 days old. The SS's immunizations were not current. The BM appeared caring to her two children.

On 2/19/21, ACS visited the family and did not document any concerns for the family. There was a new toddler bed in the home for the SS.

On 2/22/21, the PPRS worker provided the BM with information about the PRRS services. The BM accepted services.

On 3/6/21, the adult MA reported that the SS's father came to the home and left with the SS.

On 3/8/21, the BM stated the SS's father had not returned the SS to her care since 3/6/21. ACS advised the BM to call the police and file a missing person's report if the SS did not return to the home within 24 hours.

On 3/11/21, the BM reported that the SS's father was aggressive towards her and the MGU as they attempted to get the SS

back. She stated the SS was back in her care through the help of the police.

On 3/11/21, school staff did not report any behavioral concerns for the MU.

On 3/12/21, ACS visited the family. The family was well, and the home appeared safe.

On 3/14/21, the SCR registered a subsequent report due to DV concerns between the SS's father and the BM.

ACS visited the family. The family denied ever seeing any fights between the BM and the SS's father. ACS observed the children to be well in the home.

On 3/16/2021, LE confirmed the incident between the SS's father and the BM on 3/11/21. The father was arrested and charged with menacing, harassment and endangering the welfare of a child. The charges were later dropped by the DA. The DA stated there was no court order barring the father from having the SS in his home. In addition, the MGU left the scene and did not provide any information to the police about the incident. The case would not proceed without the MGU giving a statement about the incident to LE.

On 3/17/21, ACS held a CSC. ACS decided to seek judicial intervention for the family and on 3/18/2021, ACS filed an Article 10 Petition in Family Court against the SS's father. The court released the SS to the BM with COS and granted an OP against the father for the BM and SS. The court also granted agency supervised visits for the father.

On 3/24/2021, the service provider stated the SS's father would not accept services until he spoke with his lawyer.

Between 3/24/2021 and 3/27/2021, ACS made casework contacts with the family, LE and the ME. There was no new information about the fatality. The SS remained safe in the care of her BM and had received her vaccines. Also, there were no safety concerns for the MU, and the minor MA. ACS made virtual contact with the adult MA who gave birth to a baby girl on 3/3/21. ACS assessed her home to be safe and observed the baby to be well. ACS discussed safe sleep with the MA.

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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056281 - Deceased Child, Female, 4 Mons	056287 - Grandparent, Male, 71 Year(s)	DOA / Fatality	Unsubstantiated
056281 - Deceased Child, Female, 4 Mons	056287 - Grandparent, Male, 71 Year(s)	Inadequate Guardianship	Unsubstantiated

056281 - Deceased Child, Female, 4 Mons	056282 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
056281 - Deceased Child, Female, 4 Mons	056282 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
056281 - Deceased Child, Female, 4 Mons	056283 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
056281 - Deceased Child, Female, 4 Mons	056283 - Father, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
056281 - Deceased Child, Female, 4 Mons	056286 - Grandparent, Female, 39 Year(s)	DOA / Fatality	Unsubstantiated
056281 - Deceased Child, Female, 4 Mons	056286 - Grandparent, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
057798 - Sibling, Female, 3 Year(s)	057738 - Other - Father of surviving sibling, Male, 23 Year(s)	Inadequate Guardianship	Substantiated

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 case documentation did not reflect ACS contacted the SS's father.

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: Appropriate services were offered to the family.				

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: There was an adequate assessment of impending or immediate danger to the children named in the report and no removal was necessary.				

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	☐	☐	☐	☐	☐	☒	☐

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?	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 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