Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-022

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

Issue Date: Aug 11, 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: 6 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 04/03/2022
Initial Date OCFS Notified: 04/04/2022

Presenting Information

On 4/3/2022, two SCR reports were received alleging the death of the 6-month-old subject child which occurred that day. Around 9:00 PM on 4/3/2022, the subject mother was bathing the subject child and left her unattended to go to a different part of the home to retrieve a towel. Upon her return, the subject mother found the subject child on her side, submerged in the bathwater and unresponsive. The subject mother contacted 911 and EMS responded to the home, provided CPR to the SC, and transported the SC to the hospital where she was pronounced dead at 10:00 PM.

Executive Summary

This report concerns the death of the 6-month-old subject child that occurred on 4/3/2022. At the time of her death, the subject child resided with the subject mother, biological father, paternal great-grandmother, and paternal uncle. A half-sibling resided outside of the home with her mother, had limited contact with the biological father, had never been to visit the family, and was unaware of the existence of the subject child. There were no other children residing in the home.

The investigation, conducted by New York City Administration for Children Services (ACS), revealed the subject mother was bathing the subject child on the evening of 4/3/2022, while they were the only people in the residence. The subject mother had placed the subject child in a small portable bathtub inside of the home's regular bathtub and filled both with water. The subject mother reported she had left the subject child unsupervised in the bathtub for less than 2 minutes, while she walked to the other end of the apartment to get a towel. When she returned, the portable bathtub had tipped sideways and the subject child was submerged in the bathwater and unresponsive. The subject mother reported she brought the subject child to a neighbor's apartment, as that neighbor worked at a hospital. The neighbor began CPR and directed the subject mother to contact 911. EMS responded to the home and transported the subject child to the hospital, where lifesaving efforts were continued; however, the child was pronounced dead shortly thereafter. The subject mother and paternal great-grandmother both reported the mother was the only adult home at the time of the incident. ACS made multiple attempts to contact and engage the biological father during the investigation, to no avail. The paternal uncle was identified as residing in the home; however, the case record reflected no attempt made to contact him or engage him during the investigation.

ACS substantiated the allegations of DOA / Fatality, Lack of Supervision, and Inadequate Guardianship against the subject mother regarding the death of the subject child. ACS determined the subject mother had left the 6-month-old subject child unsupervised while in a bathtub filled with water when she left the room to get a towel. The subject mother had reported to law enforcement that she had been gone from the bathroom for less than 2 minutes. ACS noted in the record that the walk from the bathroom to the room where the towels were kept was about 7 seconds. ACS noted that the lack of supervision led to the death of the subject child. The investigation was appropriately closed on 6/1/2022 as there were no surviving siblings or other children residing in the home.

Supervisory documentation was evident throughout the case record, as well as consultation with medical and mental health specialists. The 24-hour and 30-day fatality reports were completed timely and accurately. ACS appropriately assessed for the safety of the half-sibling, despite that child having no contact with the subject mother and not visiting the home where the fatality occurred.

ACS made referrals for bereavement services for the subject mother and biological father and provided the family with

burial assistance. The paternal great-grandmother was identified as having a need for bereavement services; however, the record did not reflect any services provided.

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 regarding the allegations given the evidence obtained during the investigation.

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:
A paternal uncle was identified as residing in the home at the time of the fatality; however, the record did not reflect an attempt was made to contact him or engage him with the investigation.

Required Actions Related to the Fatality

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

Issue:	Adequacy of services following the fatality
Summary:	The paternal great-grandmother disclosed a need for bereavement services after the death of the subject child; however, the record reflected bereavement services were provided for the subject mother and biological father only.
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:	ACS identified a paternal uncle as residing in the family's home when the fatality occurred. The paternal uncle was added to the case composition as a collateral contact; however, the record reflected no attempt made to contact or interview him.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/03/2022 **Time of Death:** 10:00 PM

Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 09:05 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: Bathing

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	Male	30 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	6 Month(s)
Deceased Child's Household	Father	No Role	Male	22 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	54 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

Upon receipt of the report on 4/3/2022, ACS initiated an investigation into the death of the subject child. ACS interviewed the subject mother and paternal great-grandmother and made collateral contact with the maternal grandmother, law enforcement, and the medical examiner. ACS also consulted their agency's medical and mental health specialists.

ACS made contact with law enforcement and learned that the police responded to the home and to the hospital shortly after the fatal incident. Law enforcement reported there was an ongoing investigation regarding the incident; however, the death appeared to be accidental. ACS attempted to surmise the status of the police investigation prior to the closure of the CPS case through emails and phone calls to law enforcement; however, the record did not reflect that information was received.

Through contact with the medical examiner, ACS learned that an autopsy had been completed and that samples were sent for laboratory testing, which could take 4-6 months. The official cause and manner of death remained pending as of the closure of the CPS investigation.

ACS attempted to interview the subject mother and paternal great-grandmother alone. The subject mother reported the day leading up to the subject child's death was uneventful. The subject mother was questioned regarding substance use and denied any alcohol or other substance use on the day of the subject child's death. ACS asked the subject mother to submit to a drug screen and she refused to do so. The paternal great-grandmother and the maternal grandmother disclosed no specific details related to the fatality; however, denied any concerns for the subject mother's care of the subject child.

ACS attempted contact with the biological father on multiple occasions through face-to-face visits, phone calls, and mail. The biological father did answer an initial phone call and told ACS that it was not a good time to speak. The father did not respond to any other attempts at contact throughout the case. The case record noted that a paternal uncle resided in the family's home at the time of the fatality. The paternal uncle was incorrectly added to the case composition as a collateral, despite residing in the home, and the record reflected no attempts made to contact or engage him with the investigation.

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 New York City 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
060207 - Deceased Child, Female, 6 Mons	060683 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated
060207 - Deceased Child, Female, 6 Mons	060683 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
060207 - Deceased Child, Female, 6 Mons	060683 - Mother, Female, 26 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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 made multiple attempts to contact EMS staff to question them regarding the fatality; however, EMS staff did not respond. ACS was unable to speak with the pediatrician as the subject mother refused to sign a release of information.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Bereavement services were provided to the subject mother and biological father. The paternal great-grandmother was identified as having a need for bereavement services; however, the record did not reflect any services were provided. ACS referred the subject mother and biological father for mental health services; however, the parents had not engaged by the time the investigation was closed.

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 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