Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-076

Prepared by: New York City Regional Office

Issue Date: Jan 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		
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: 1 year(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 07/15/2021
Initial Date OCFS Notified: 07/16/2021

Presenting Information

The SCR report alleged on 7/14/21, the mother and male partner put the child to bed at approximately 9:00PM. On 7/15/21, at approximately 9:45 AM, the partner checked the child and found him unresponsive and blue in color. 911 was called and EMS responded to the case address. The child was pronounced dead, and the caretakers had no explanation.

Executive Summary

The SCR registered a report on 7/16/21, regarding the death of an eighteen-month-old male child who died while in the presence of the mother and her male partner.

ACS learned that the mother and child resided in another state and were visiting the partner when the incident occurred. They visited often and the partner was known as a person legally responsible for the SC. The mother and father had no other children; however, the partner had two minor children and one adult child who resided with their mother. They had not seen or visited the partner for days and were not aware of the death of the child. ACS assessed the minors and deemed them safe in a clean home environment.

According to ACS' investigation, the mother and her partner reported the child had a normal night prior to being put to bed. The mother fed the child and placed him in his crib in a supine position to sleep at approximately 9:00PM on 7/14/21. She explained that the child normally slept through the night and sometimes in the morning, so she thought nothing of it when he did not wake up at 9:30AM the following morning. At approximately 9:45 AM, the partner checked the SC and found him unresponsive and blue in color. He was found face down on a blanket in his crib. 911 was called and EMS responded to the case address where the child was observed in the crib. The ME removed the body from the home and performed an autopsy. There were no bruises or marks found on the child that indicated maltreatment or abuse. LE found no criminality. The ME had not identified any suspicion into the child's death.

ACS received information from the child's pediatrician that he was last examined on 5/25/21 for a routine visit. He had a developmental delay and a medical condition for which he was not prescribed medication. The parents were compliant with medications, treatments, and visits.

ACS learned from the father that the child was sick on 6/26 and 6/27/21 while in his care. The father took the child to the ER where he was treated and released. The father stated the physician told him the child did not have a medical condition and it was not uncommon for children of his age to experience those symptoms; however, there was a possibility a condition could develop. The father was advised to monitor the child closely and he was given medication that should be administered only as the symptoms occurred.

On 8/27/21 ACS unsubstantiated the allegations of DOA/fatality and IG of the child by the mother and the partner, citing a lack of credible evidence. ACS wrote that the child's medical appointments with pediatrician and the specialist had been maintained and the treatments adhered.

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

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:
There were no surviving siblings.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/15/2021 **Time of Death:** 09:00 AM (Approximate)

Time of fatal incident, if different than time of death: 09:45 AM

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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
How long before incident was the child last seen by caretaker? 12 Hours

At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☒ Asleep
- ☐ Absent
- ☐ 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	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Mother's Partner	Alleged Perpetrator	Male	40 Year(s)

LDSS Response

ACS initiated the investigation within the required timeframe by contacting LE and the ME. ACS learned the child was pronounced DOA, and the ME removed his body from the home. The ME reported no injuries were found on the child. There was no obvious disease or anything suspicious. The final autopsy was pending. LE found no criminality.

The ACS Specialist interviewed the mother and her partner and learned that in March 2021, the SC was sick and was taken to the hospital where tests were completed. The child was being routinely seen by his pediatrician and a medical specialist. All his appointments were kept as scheduled.

On 7/20/21, the Specialist interviewed the father who disclosed that when the child was at his home and on 6/26/21, he observed the child's "eyes roll back in his head and he foamed at the mouth." He took him to the ER, where the child was given medication; observed for five hours and discharged. The father took the child home and he monitored him by room sharing. During that night, the child had a fever and was shaking. On 6/27/21, while they were out, the symptoms reoccurred, and the father took the child back to the hospital where he was treated and released with medication. The medical staff advised that this was to be expected until the child was six years old.

ACS received information from the pediatrician on 7/20/21 that reflected the child's last medical occurred on 5/25/21. Based on medical records, the child was followed by his pediatrician as well as a specialist. The appointments were maintained, and the prescribed medication was to be used only if he had an episode that lasted longer than five minutes.

On 7/23/21, the Specialist visited the home where the incident occurred and observed the room the SC occupied. The room was in the back of the apartment, away from the room occupied by the partner. ACS documented the room was furnished to accommodate the child's safety. The Specialist documented that collaterals had no concerns regarding the partner or the mother.

ACS offered the mother burial assistance and she declined; however, she accepted assistance from the state in which she resided.

On 8/27/21, ACS unsubstantiated the DOA/Fatality and IG of the child by the mother and her partner due to a lack of credible evidence. At the time of determination, the ME reported the cause or manner of death were pending.

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: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059306 - Deceased Child, Male, 1 Yrs	059307 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
059306 - Deceased Child, Male, 1 Yrs	059307 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
059306 - Deceased Child, Male, 1 Yrs	059308 - Mother's Partner, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
059306 - Deceased Child, Male, 1 Yrs	059308 - Mother's Partner, Male, 40 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?	☒	☐	☐	☐

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:
ACS offered burial assistance and the SM declined; however, she accepted assistance from the state in which she resided.

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? N/A
Explain:
There were no other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother and her partner declined 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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/11/2021	Other Child - Partner's son, Male, 5 Years	Mother's Partner, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Partner's daughter, Female, 14 Years	Mother's Partner, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
On 1/11/21, the SCR registered a report that alleged the partner had an altercation with the mother of his children. The son intervened and was struck in his face causing injury. The allegations of the report were Fractures to the seventeen-year-old child and IG of the three children.

The investigation revealed that the minor children were in their rooms when the altercation began so they did not witness the actual fight; however, they emerged to observe the eldest brother on the ground bleeding from his nose. The investigation also revealed that the partner was arrested in connection with the incident. The partner relocated. There was an active OP against him.

Report Determination: Unfounded	**Date of Determination:** 03/12/2021

Basis for Determination:
On 3/12/21, ACS unsubstantiated the allegations of IG and Fractures of the alleged 17-year-old child citing he was an adult. ACS updated the information to reflect the accurate date of birth. The partner admitted he hit his son in self-defense. Additionally, ACS unsubstantiated the allegation of IG of the two minor children by the partner. ACS wrote that "the minor children stated they were not exposed to the altercation, they did not witness the beginning of the altercation, they were in their rooms; however, they observed their brother on the floor bleeding from his nose."

OCFS Review Results:
The documentation supports that an Assault occurred and the children were present and the effects of the altercation were negative. The children witnessed ongoing DV and the IG allegation should have been substantiated.

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

Issue:
Appropriateness of allegation determination

Summary:
The documentation supports that an Assault occurred and the children were present and the effects of the altercation were negative. The children witnessed ongoing DV and the IG allegation should have been substantiated.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

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.

[redacted]

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

Concerning the partner, he was involved in reports that alleged ongoing DV from 2010. One report was indicated for IG. The partner and the mother of his three children (2 minors) were involved in altercations in the presence of the children. The partner allegedly threatened, threw objects, and broke “things” on the mother, in the presence of the children. The report also alleged that the partner was an alcoholic.

On 3/2/2011, ACS documented there was credible evidence that the partner verbally abused the mother in the presence of children, based on the children's disclosure. The mother fled with the children from the home to escape the abuse and obtained an OP. ACS substantiated the allegation of IG against the partner.

Known CPS History Outside of NYS

ACS learned that the parents of the deceased child were the subjects in an open investigation dated 6/28/21, in the state in which they reside, due to DV. There were no additional details.

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