



Report Identification Number: NY-21-126

Prepared by: New York City Regional Office

Issue Date: May 18, 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: 4 month(s)

Jurisdiction: Bronx
Gender: Female

Date of Death: 11/23/2021
Initial Date OCFS Notified: 11/23/2021

Presenting Information

The 11/23/21 SCR report alleged, on 11/22/21, the SC was crying, not eating, and not sleeping all day. On that same day, the SM and SF took the SC to the doctor who examined and discharged the SC home with no need for medical treatment. The SC continued to cry, not eat or sleep, and the SM and SF kept the SC in their bed with them, both staying awake with the SC. At 12:36AM on 11/23/21, the SF called 911 because the SC's condition had deteriorated, and the SC was having difficulty breathing. EMS arrived at the residence at 12:44AM and transported the SC to the hospital by 1:03AM. At 5:04 AM, the SC was pronounced dead. The SC was an otherwise healthy CH who died of unknown causes and the SM and SF did not have an explanation for her death. The GM and the 6-yo CH had unknown roles.

The allegations of the 11/23/21 report were DOA/Fatality and Inadequate Guardianship of the SC by the parents.

Executive Summary

The 4-month-old female child (SC) died on 11/23/21. The ME reported that the SC's body was externally examined without an autopsy due to religious objections.

At the time of her death, the SC resided with her parents, a 6-yo male SS, and the MGM.

ACS' investigation revealed on 11/21/21, the SC cried incessantly, and was not eating. The parents contacted the pediatric clinic on 11/22/21 and sought medical assistance. The doctor examined the SC, and said the SC was fine. The SC laughed and played during the visit, and was discharged without medication. When the SC returned home, the SC was fussy and did not eat. At about 10:00PM the parents put the SC to bed; the SC slept for a short while, and then awoke again at about 11:00PM. Sometime after 11:00 PM, the SC vomited which prompted the parents to contact the after hours medical emergency line. The father was told to take the child to the ER. The father then called 911 and he and the SM accompanied the SC to the hospital. Upon arrival at the pediatric ER, medical personnel immediately began emergency procedures and preparation to transfer the SC to another hospital for more intensive care. While waiting for transfer, the SC died.

ACS contacted the ME on the same day and was told the SC's body was externally examined and was in excellent condition. The SC was free of marks and bruises, and was very clean. The ME also reported X-rays were completed and they reflected the SC had a medical condition. The ME further stated the SC died after her health declined during medical treatment. The ME added a review of the child's medical chart reflected the parents kept the SC's appointments and was always seen as healthy and well cared for.

EMS reported that upon arrival at the home the SC was pale and appeared to be working hard to breathe; her lips were blue. No trauma was noted on the child's body.

ACS convened a child safety conference and the decision was made that no family court intervention was necessary and that the family would be referred for community-based services, such as bereavement counseling.

ACS' contact with LE revealed their investigation was closed as the ME determined there was no foul play or negligence suspected in the SC's death.



On 1/21/22, ACS unsubstantiated the allegations of IG and DOA/Fatality by the SM and SF due to a lack of credible evidence. ACS supported their decision with information from medical personnel which reflected the child had a medical condition that was not previously discovered or diagnosed. ACS also documented the parents responded appropriately and sought appropriate medical care to address the SC’s illness and symptoms. There was no evidence of foul play according to LE.

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 make determination for all allegations.

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:

NA

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: 11/23/2021

Time of Death: 05:04 AM

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

11:00 PM

County where fatality incident occurred:

Bronx

Was 911 or local emergency number called?

Yes

Time of Call:

12:36 AM

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:

Sleeping

Working

Driving / Vehicle occupant

Playing

Eating

Unknown

Other: Child was sick.

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: **attentive to the SC**

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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)

LDSS Response

Upon receipt of the report, the Specialist contacted LE personnel who reported there would be no autopsy conducted based on the family's religious objections. LE stated the 6-yo SS appeared well and had no marks or bruises.

On 11/23/21, ACS visited the case address to interview the family. The parents denied they engaged in substance or alcohol use. The parents said they initially believed the SC had a stomach virus as she was not eating. The SC did not display any symptoms of being critically ill except for crying and the refusal to eat. The SC had no known pre-existing medical conditions.



The 6-yr SS said LE came to the home before ACS arrived. He said he knew ACS was in the home because the SC went to heaven. The family reported the SC usually slept on the bed, between the SM and SF, as that was their cultural norm.

On 11/23/21, the MA stated she was aware the SC was ill since 11/21/21. The documentation reflected that ACS attempted to interview the MGM during the initial home visit; however, the MGM was distraught and opted not to be interviewed.

On 11/29/21, ACS contacted the medical professionals at the clinic where the SC had been taken for urgent care on 11/22/21. The SC came in due to the SF concerns that the SC had difficulties feeding the previous night. On the day of the visit to the clinic, the SC drank two ounces of formula prior to going to the clinic. The Dr. said the SC was not irritable and seemed comfortable during the visit. The family was discharged with instructions to call for EMS if the SC's condition worsened. The Dr. confirmed the SF called the on-call doctor at about 11:00 PM, and was advised to go to the ER with the SC.

On 12/3/21, the treating Dr. at the ER said the SC presented to be very ill. Upon admission, the SC had a low-grade fever. A medical procedure was performed, and they realized the cause of the SC's illness was caused by a medical issue. While trying to get the SC stabilized for transfer to another hospital, the SC began to decompensate and went into cardiac arrest. After an hour of trying to resuscitate the SC, the SC was pronounced dead. The Dr. said he did not suspect non-accidental and non-natural causes of death, and they had no concerns for the parents.

On 12/17/21, ACS learned that the family had relocated to another borough.

Between 12/18/21 and 1/20/22, ACS continued to make contact with the family and assisted the family with obtaining medical appointments for the SS who had a medical episode. The Specialist confirmed the child was seen by a doctor and obtained copies of the child's medical discharge papers.

On 1/21/22, ACS unfounded the report after documenting there were no safety factors that placed the SS in immediate or impending danger of serious harm.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: From a medical cause

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 NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060170 - Deceased Child, Female, 4 Mons	060171 - Father, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
060170 - Deceased Child, Female, 4 Mons	060171 - Father, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated



Child Fatality Report

060170 - Deceased Child, Female, 4 Mons	060172 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
060170 - Deceased Child, Female, 4 Mons	060172 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Responders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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harm, were the safety interventions, including parent/caretaker actions adequate?				
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain:
 On 1/21/22, ACS opened a service case. On 3/14/22, the service case was closed. No FASPs were completed. The service case was created to document the family's referral for community-based services.

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Housing assistance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Mental health services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Foster care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Legal services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Homemaking Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Parenting Skills	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Domestic Violence Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Early Intervention	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Child Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Additional information, if necessary:
 The family was provided with referrals for community based services. According to ACS, on 3/4/22, ACS provided the family with referrals for outpatient clinical health services. The documentation also reflected ACS ordered a bed for the SS.

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? Yes

Explain:

ACS provided the family with referrals to community-based organizations for bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

ACS provided the family with referrals to community-based organizations for bereavement 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

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 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