Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-002

Prepared by: New York City Regional Office

Issue Date: Jun 21, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 01/01/2022
Initial Date OCFS Notified: 01/11/2022

Presenting Information

OCFS was notified of the SC's death on 01/11/22 by the Purchased Preventive Rehabilitative Services (PPRS) agency. Per the notification, on 12/31/21 because the SC was vomiting and had a high fever, the BM and BF took the SC to the hospital. The SC was tested for Covid-19 and the result was positive. The SC had pre-existing health conditions and was diagnosed with other complications while in the hospital. The SC died in the hospital on 01/01/22.

Executive Summary

The fatality report concerns the death of a 1 yo male child (SC). Per documentation, the SC died as the result of an illness. OCFS requested a copy of the SC's Certificate of Death that has not been received to date. There was no SCR report relating to the SC's death, nor an investigation by CPS. The PPRS shared supporting documentation with OCFS that included medical information regarding the SC's death as recorded by hospital staff. The SC had been battling cold symptoms for over a week. On 12/31/21, because the SC was vomiting and had a high fever, the BM and BF took the SC to the hospital. The SC was tested for Covid-19 and the results were positive. The SC died in the hospital at 4:16 PM on 01/01/22. The BM and BF were offered counseling as well as clergy services by the hospital staff which they declined.

Although the SC died on 1/1/22, the BM did not inform the PPRS agency until 1/10/22. Upon learning about the fatality, the PPRS agency notified OCFS on 1/11/22.

The SC had pre-existing medical health conditions and had been receiving PPRS services from a program that serves families with medically-fragile children since 12/28/20. The CP conducted casework contacts with the family throughout the COVID-19 pandemic. At times, the contacts were virtually via videoconference or face-to-face home visits. In addition, some contacts occurred via phone. The agency documented that the BM was knowledgeable of the SC's medical conditions and treatment, kept up with the multiple service providers, and was available for casework contacts. The BF did not reside in the home. However, the BF frequently visited, as well as provided care and supervision to the SC.

The BM and BF were very young and raising a child with significant medical health complications. At no time during the services case did the agency assess the need for, or discuss family planning, personal goals either parent had, employment, or education.

Following the SC's death, there were no other children in the home under the BM's care. The services/PPRS case was appropriately closed on 3/04/22.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
There was no SCR report or CPS investigation in response to the SC's death.

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Unable to Determine
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Following the SC's death, the case was no longer eligible for PPRS in that there were no children in the family's composition. Thus, the decision to close the case was appropriate. The PPRS appropriately offered bereavement counseling to the BM. However, the PPRS did not offer similar services to the BF who was involved in the SC's care and supervision.

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: 01/01/2022 **Time of Death:** 04:16 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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: **with the child**

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	Aunt/Uncle	No Role	Male	24 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	23 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	22 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	15 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	1 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	50 Year(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)
Other Household 1	Father	No Role	Male	23 Year(s)

LDSS Response

On 1/10/22, the CP documented telephone contact with the BM to schedule a home visit. The BM informed the CP that the SC died in the hospital on 1/1/22. The BM stated she did not contact the CP because she thought one of the other service providers would. The CP expressed condolences and offered bereavement counseling to the BM who declined. The CP was unable to visit the home in person due to Covid-19 restrictions, and made multiple attempts to reach the BM by telephone and video conference.

The CP documented the information as received from collateral contacts such as the SC's primary care physician, the hospital where the SC died, the SC's vision therapist, Early Intervention program coordinator, and speech therapist.

The CP and supervisor contacted the BM on 1/10/22 to again offer condolences and inquire about the SC's funeral. Per the BM, the funeral was scheduled on 1/11/22. Due to Covid-19 protocols, agency staff was unable to attend but made arrangements to conduct a home visit for the same day. On 1/11/22, the CP contacted the BM to conduct a Covid-19 screening and visit the home. The BM stated she was not available; there had been exposure to Covid-19 in the home.

Following this phone contact, the CP made multiple unsuccessful attempts to contact the BM. The CP attempted to contact the BF by telephone on 1/12/22 and left a voicemail message expressing condolences. Efforts to contact the BM, BF, and MGM continued to be unsuccessful until 1/19/22 when the CP spoke with the MGM via videoconference. The CP conducted home visits on 1/28/22 and 2/4/22 and met with MGM both times. During the home visits, the CP offered condolences and bereavement counseling to the family that were declined.
There were no children under the care of the BM in the home. Therefore, the services case was appropriately closed on 3/4/22.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in New York City.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
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?	☒	☐	☐	☐
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?	☐	☐	☒	☐
Explain: There was no SCR report in response to the SC's death; therefore, there was no CPS Investigation. The SC resided in a				

home with extended family members that included a 14 yo male maternal uncle (MU). There were no recorded safety concerns for the MU. The MU, along with the other adult relatives living at the case address, had no role in the care or supervision of the SC.

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:
The family refused the CP's offer for services after the SC's death.

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 no SCR report in response to the SC's death. There were no Safety Factors or concerns documented for the minor child (a 14 yo MU) living in the home. The PPRS services-recipient family comprised of the BM, BF and SC. There were no SS's and no children under the BM's care in the home.

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: The BM and BF were offered bereavement counseling but declined.							

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:
The SC did not have siblings. The SC resided at the case address with his mother and extended family members that included a 14 yo male maternal uncle (MU). During a casework contact after the fatality, the MU informed the CP he did not need services. The CP also spoke with with the MU's mother who did not indicate the 14 yo exhibited or engaged in behaviors that warranted services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Bereavement services were offered to the family and were declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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? Yes

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)
12/04/2020	Deceased Child, Male, 1 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
The SCR report was generated on 12/4/20. It alleged that the BM left the then eight-month-old SC at the PGM's home without notice, provisions, or supervision. Both the BM and BF denied the allegations and insisted the BF requested the BM bring SC to the home. The BF stated he was aware the BM had put the SC down for a nap before leaving, and that he was in a nearby room. CPS conducted a thorough investigation and the report was closed as UNF on 2/2/21.

Report Determination: Unfounded **Date of Determination:** 02/02/2021

Basis for Determination:
CPS interviewed the source of the report, BM and BF as well as extended family and collateral contacts. The SC was observed on multiple occasions and appeared to always be well taken care of by the parents.

OCFS Review Results:
The case documentation reflected that CPS conducted a detailed investigation and that the outcome was appropriate.

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

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

The family does not have any known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 12/28/2020

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 12/28/2020

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐

Did all service providers comply with mandated reporter requirements?	☐	☐	☒	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
The NYC LDSS contracts Preventive Services out to voluntary agencies to provide services to children and families. The SC received visiting nurse services from a community provider.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Eligibility for Preventive Services
Summary:	The PPRS case began during CPS' investigation of an SCR report that was UNF. No safety factors were identified, and assessed risk was low. The Protective program choice was inappropriate and should have been removed in the FASP completed by the PPRS.
Legal Reference:	18 NYCRR 423.3 and 430.9
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies regarding Program Choice Eligibility for its' contracted service providers. ACS must ensure that PPRS meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed and the action plan.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The PPRS agency did not adequately engage the BF or involve him in case planning despite his consistent role in the SC's life. The BF provided care and supervision for the SC, and was not assessed as a Secondary Caretaker or offered services.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies regarding Father Engagement and Case Planning for its' contracted service providers. ACS must ensure that PPRS meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed and the action plan.

Preventive Services History

The family was referred for PPRS services on 12/28/20 during CPS' investigation of a 12/4/20 SCR report. The report alleged that the BM left the 1 yo SC in the PGM's home without notifying the PGM or providing adequate supervision. The BM and BF denied the allegations and insisted that the BF requested the BM bring the SC to the home. That the BF was aware the SC had been placed down for a nap before the BM left the home. CPS conducted a thorough investigation and the report was UNF.
The family was referred to a medically fragile PPRS provider because the SC had multiple physical and developmental issues due to a health condition diagnosed at birth. The PPRS program provided casework counseling, a visiting nurse, advocacy with service providers, and referrals for supportive services to assist the very young, first-time parents with the SC's care.
Following the fatality, the services case was appropriately closed on 3/4/22.

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