Child Fatality Report

Report Identification Number: NY-22-004

Prepared by: New York City Regional Office

Issue Date: Jul 05, 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 | **Jurisdiction:** New York | **Date of Death:** 01/03/2022
Age: 1 month(s) | **Gender:** Female | **Initial Date OCFS Notified:** 01/03/2022

Presenting Information

The initial and duplicate SCR reports alleged at approximately 4:30PM on 1/3/22, the parents were caring for the 2-month-old SC. The parents noticed that the SC was limp and unresponsive. The BF called 911 but could not get through to them. The parents ran out of the home with the SC and got assistance from a police officer, who contacted EMS. EMS took the SC to the hospital where life saving measures were performed; however, she was pronounced dead at the hospital. The SC was an otherwise healthy child, and the parents did not have an explanation for her death. The SC had a bump and a semicircular mark above her right eyebrow. It was unknown how the SC sustained the injury.

Executive Summary

On 1/3/22, the one-month-old female SC died while in the care of her parents. The autopsy report was pending.

The parents of the SC and the 2-yo SS were present in the home when the incident occurred. The BF also had fourteen other children from various women. He was a Level 1 Child Sex Offender and on Parole at the time of the fatality. The 11-yo SS was visiting his father who resided at different address and did not witness the incident.

ACS' case documentation reflected at about 4:00PM on 1/3/22, the BM found the SC on her side and unresponsive under the BF's sweatshirt in a pack and play. The BM called 911 but did not get through. The family then ran out of the home with the SC, and the 2-yo SS and got help from a police officer (PO) who escorted them to the hospital in a patrol car. Minutes later, the PO flagged down an ambulance and sought their assistance. EMS started CPR on the SC and transported her to the hospital where the medical staff worked on the SC prior to pronouncing her dead at 4:30PM.

On 1/3/22, ACS received the report and initiated the CPS fatality investigation within the mandated timeframe. ACS obtained information through interviews with the family, LE, ME, medical providers, Family Court Legal Services (FCLS), and other collaterals. ACS conducted ongoing assessment of the SSs through virtual, school and home visits and deemed them safe. ACS also attempted to assess all the BF's other children; but was denied access by their respective mothers.

ACS held two separate child safety conferences (CSC) with the parents, and the 11-yo SS' father. The participants at the CSC agreed to seek court involvement against the BF. ACS was unable to file a petition in court due to an existing Criminal Court (full stay away) OP against the BF. The FCLS advised ACS to obtain and provide the BM with a copy of the existing OP. The FCLS also advised the BF to file a visitation petition in Family Court.

ACS offered the BM PPRS services, but she declined. The SSs remained safe in the BM's care. The 11-yo SS continued to spend time with his father, and there had been no concerns reported. The BF remained under the supervision of the Department of Parole and had been issued an ankle monitoring bracelet. The BM denied the BF had visited the home or contacted the children.

On 3/4/22, ACS SUB the allegation IG of the 2 children by the parents due to fair preponderance of evidence. The BF was a sex offender who was convicted for raping a minor. He was incarcerated and released on Parole in 2020. The conditions of the BF's Parole stated he was not allowed to be around children, including his biological children. During the investigation, the 11-yo SS disclosed that he and his siblings were left in the BF's care while the BM ran errands. He also

disclosed the BF resided in the home and would sleep over. The BM was aware of the BF's sex offender status, but she allowed him to have contact with her children. Also, interviews with the PGM and the BF's other children suggested that the BF visited his other children in the PGM's home.

ACS UNSUB the allegation DOA/FATL of the SC by the parents due to lack of fair preponderance of evidence. There was no evidence to support the parents' actions or lack thereof contributed to the SC's death. The ME reported there was no suspicion of abuse to the SC pending the results of other tests.

ACS gathered evidence to SUB the allegation IG against the parents as they excised poor judgement when they placed the SC to sleep in a pack and play that contained diapers, baby wipes, toys, stuffed animals, blankets, and clothing, which was an unsafe sleeping environment; however, ACS unfounded the report. Also, The BF was a sex offender who was not allowed to be around children, including his biological children. The BF resided in the home and provided care to the children. Additionally, the BM was aware of the BF's sex offender status, but she allowed him into the home.

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?** No

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:
ACS decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination

Summary:	ACS UNSUB the allegation IG against the parents who used poor judgement when they placed the SC to sleep in a pack and play that contained diapers, baby wipes, toys, stuffed animals, blankets, and clothing, which was an unsafe sleeping environment.
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 the action the agency will take or has taken to address the citations 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.
Issue:	Overall Completeness and Adequacy of Investigations
Summary:	The 2-yo SS was seen at the hospital earlier on the day of the incident because he had a bead in his right ear. ACS did not address the circumstances that led the SS putting the object in his ear.
Legal Reference:	SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or has taken to address the citations 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: 01/03/2022 **Time of Death:** 04:36 PM

Time of fatal incident, if different than time of death: 04:00 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 04:01 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

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: **Not Applicable**

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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	33 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	11 Year(s)

LDSS Response

On 1/3/22, the hospital staff reported the SC arrived at the hospital in cardiac arrest. The preliminary cause of death was cardiac arrest. The staff stated the 2-yo SS was seen at the hospital earlier that day because he had a bead in his right ear and was discharged to the BM.

The parents provided an account of the events prior to the fatality which was consistent with the information that was already known. They denied any medical issues for the SC. The BF denied he lived with the BM, and that he only came to the home to watch the SC while the BM took the 2-yo SS to the hospital.

On 1/3/22, the ER Dr. stated the SC had a small abrasion above her right eyebrow which possibly occurred during the SC's transport to the hospital. The SC was last seen on 12/21/21 for a well visit, and there were no concerns noted.

On 1/3/22, ACS assessed the 11-yo SS and deemed him safe with his father. The SS denied corporal punishment by his parents. The father stated he and the BM shared custody of the SS via a mutual arrangement. He did not have any concerns about the BM's parenting. LE reported the autopsy results were pending.

On 1/4/22, ACS assessed the 2-yo SS and deemed him safe in the MGF's home. The MGF and his partner did not report any concerns for the parents. They were willing to keep the SS for as long as was necessary.

On 1/4/22, ACS visited the mothers of the BF's other children in their respective homes. They denied ACS access to the children and declined to be interviewed.

On 1/4/22, LE reported concerns about the SC being placed to sleep in a pack and play which contained diapers, baby wipes, toys, stuffed animals, blankets, and clothing.

On 1/4/22, the 11-yo SS disclosed the BF resided in the home and cared for him and his siblings. He denied feeling afraid or uncomfortable around the BF. He did not make any disclosure of drugs or alcohol use in the home.

On 1/4/22, the BM stated she was aware of the BF's sex offender status but did not know the details. She denied the BF lived with her, and that the day of the incident was the only time the BF cared for the SC.

On 1/4/22, the father of the 11-yo SS reported he had heard rumors about the BF's sex offender status, but he always checked in with his son to keep him safe. He agreed to have the SS participate in a forensic interview.

On 1/5/22, the BF disclosed he was arrested for statutory rape in 2011 due to his involvement with a 14-yo female. He had

a son with the female. He reported he had other children but denied any contact with them or their mothers.

On 1/6/22, ACS held two separate child safety conferences with the parents, and the 11-yo SS' father. The decision at the CSC was to seek court involvement against the BF.

On 1/6/22, the ME reported that the initial findings did not reveal any trauma to the SC.

On 1/6/22, the female involved in the BF's 2011 sexual assault case reported the BF was the bio father of her son. She stated that her son was healthy and fine. She had an OP against the BF until 2031. The father of the female reported he shared custody of his grandson with his daughter. He said the BF was not involved with his grandson and would not allow ACS access to his daughter or grandson.

On 1/7/22, ACS was unable to file an Article 10 Petition in court due to an active criminal OP against the BF. ACS obtained a copy of the details of the BF's parole. The BF was not to be around children.

On 1/13/22, the 11-yo SS was interviewed at the Child Advocacy Center and did not make any disclosure.

Between 1/20/22 and 2/28/22, ACS made multiple casework contacts with the family and other collaterals. ACS assessed the two SSs virtually and during home visits and did not document any concerns for them. The BF was issued an ankle bracelet on 1/13/22, which barred him from children and 1,000 feet away from the home as a condition of his continued parole. The BM denied the BF had visited the home or contacted the children. The BM declined services.

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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060721 - Deceased Child, Female, 1 Mons	060722 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
060721 - Deceased Child, Female, 1 Mons	060722 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
060721 - Deceased Child, Female, 1 Mons	060723 - Father, Male, 33 Year(s)	DOA / Fatality	Unsubstantiated
060721 - Deceased Child, Female, 1 Mons	060723 - Father, Male, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
060724 - Sibling, Male, 11 Year(s)	060722 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated

060724 - Sibling, Male, 11 Year(s)	060723 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
060725 - Sibling, Male, 2 Year(s)	060722 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
060725 - Sibling, Male, 2 Year(s)	060723 - Father, Male, 33 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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

The BM did not have any prior ACS history. The BF had multiple prior SCR history from his previous relationships. The SC and the 2 SSs were not born at the time and were not listed in the household composition in the reports.

Known CPS History Outside of NYS

The family did not have any 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