Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-106

Prepared by: New York City Regional Office

Issue Date: Mar 29, 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: 2 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 10/05/2021
Initial Date OCFS Notified: 10/05/2021

Presenting Information

The SCR report alleged that at an unspecified time in the morning of 10/5/21, the mother awoke and found the child bluish purple in color, cold, and face up on the mother's bed. The mother called 911 at 9:54AM. The child was transported to the hospital where she was pronounced dead. The child was an otherwise healthy child and the mother did not have any explanation for the child's death.

Executive Summary

This fatality report concerns the death of a two-year-old female subject child (SC) that occurred on 10/5/2021 while in her mother's care. At the time of writing this report, the autopsy report was pending further tests; however, the ME's preliminary findings did not reveal any trauma to the SC.

At the time of the fatality, the mother and the SC resided with the grand-maternal uncle and his wife. The father resided outside of the country; however, the mother had ongoing contact with him. The parents did not have any other children.

On 10/5/2021, ACS received the report and commenced the CPS fatality investigation within the mandated timeframe. ACS' case documentation reflected on 9/28/21, the SC had flu-like symptoms. The mother took the SC to the doctor. The doctor informed the BM that the SC had a cold and advised the mother to give the SC over the counter medication if the SC became more irritable. The SC was fine after the doctor's visit. On 10/4/21, the SC developed a cough with phlegm. The mother gave the SC soup and rubbed the SC's chest with Vicks vapor rub ointment and then put her to sleep on the mother's twin-size bed. At 10:30PM, the mother left the home for work and the SC was supervised by the grand-maternal uncle and his wife. At about 1:50AM, the mother returned home from work and observed the SC alive. At 9:50AM on 10/5/21, the mother found the SC unresponsive in bed, sleeping on her stomach. The mother tried to wake the SC, but was unable to. The mother then called 911. EMS responded to the home and transported the SC to the hospital where medical staff declared her dead on arrival.

ACS contacted the medical providers, DC provider, LE, ME, family, friends, neighbors and other key collaterals regarding the cause and circumstances of the SC's death. The medical providers, the DC provider, friends, and family members did not report any concerns about the mother's parenting. The mother and several family members denied the SC displayed any concerning behavior prior to her death. The hospital staff and the ME denied the SC had any marks or bruises on her body. LE did not suspect any criminality and closed the criminal investigation.

On 1/24/2022, ACS unsubstantiated the allegations of the report due to lack of credible evidence. Although the autopsy report was pending, the ME and hospital staff denied any trauma to the SC. LE did not suspect any criminality and did not make any arrest. Additionally, collaterals contacted by ACS did not report any concerns regarding the BM's parenting.

ACS contacted the BF after his arrival into the United States. He reported a great relationship with the BM. ACS provided the parents with referrals for bereavement counseling services. ACS provided the family with a working smoke detector. ACS utilized language services to interview the grand-maternal uncle's wife and the father who had limited proficiency in English language.

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:
ACS's decision to close the case was appropriate. There were no surviving siblings or any other children in the home.

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: 10/05/2021 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 09:50 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 09:54 AM
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	Aunt/Uncle	No Role	Female	29 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	38 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Father	No Role	Male	33 Year(s)

LDSS Response

Upon receipt of the report, ACS contacted law enforcement (LE) and other collaterals. LE did not suspect any criminality pending the autopsy and did not report any concerns for the home.

On 10/5/2021, ACS interviewed the mother at the case address. The mother's statement was consistent with the SC experiencing flu-like symptoms on 9/28/21. The mother took the SC to the doctor and was advised to give the SC over the counter medication for cold. The SC was fine after the visit to the doctor. On 10/4/21, the SC developed a "wet cough." The mother gave the SC soup and rubbed the SC with Vicks vapor rub ointment and sent her to bed. The following morning, the mother found the SC purplish blue, and her body was stiff. The mother contacted 911 and the SC was pronounced dead. The mother denied the SC displayed any odd behavior prior to her death.

On 10/5/2021, the GMU, his wife, the BM's friends, and neighbors did not report any concern regarding the care the mother gave to the SC. They described the mother as an amazing mother and a great parent. They reported the SC was very well cared for and always appeared neat and tidy.

On 10/5/2021, ACS contacted the ME and learned the autopsy had not been performed; however, there was no evidence of foul play. Two days later the ME stated the final cause and manner of death were pending further studies.

On 10/6/2021, LE reported there was no suspicions of criminality pending the autopsy report.

On 10/29/2021, the pediatrician reported that at the times the mother brought the child in for medical visits, the mother appeared to be very nurturing and involved with the SC. The SC was a well child and there were no concerns about the care she received.

On 11/30/2021, the daycare provider reported the mother was a very attentive parent. She always called throughout the day to check on the SC.

On 11/30/2021, LE reported that the criminal investigation was closed. There was no evidence of foul play and no criminality was suspected.

On 1/11/2022, ACS visited the family. The father reported he had a great relationship with the mother. The mother reported she was doing much better dealing with the death of the SC. ACS provided the parents with resources for grief counseling services. The parents accepted the referral.

On 1/24/2022, ACS UNSUB the allegations of the report.

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
059886 - Deceased Child, Female, 2 Yrs	059887 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
059886 - Deceased Child, Female, 2 Yrs	059887 - Mother, Female, 22 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	☐	☐	☐	☐	☐	☒	☐

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 surviving siblings.

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

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

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