Child Fatality Report

Report Identification Number: NY-21-132

Prepared by: New York City Regional Office

Issue Date: Jun 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: 9 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 12/09/2021
Initial Date OCFS Notified: 12/09/2021

Presenting Information

The initial and subsequent SCR reports alleged on 12/9/21, the nine-year-old subject child's (SC) school contacted the parents because the SC had suffered an asthma attack during school. The parents took the SC home and gave her asthma treatments at about 8:00PM, and 10:30PM, but the SC was still having difficulty breathing and then became unresponsive. The parents called 911. EMS responded to the home and found the SC in cardiac arrest. EMS gave the SC CPR and then transported her by ambulance to the hospital. The SC died during transport to the hospital. The preliminary cause of death was determined to be cardiac arrest due to her asthmatic condition. The time of death was 12:03AM on 12/9/21. The reports alleged the parents' delay in obtaining medical treatment for the SC resulted in her death. The reports further alleged the parents failed to provide a safe and sanitary living environment for all the children.

Executive Summary

This fatality report concerns the death of a nine-year-old female SC that occurred on 12/9/2021. The final autopsy report was pending as of the writing of this report.

At the time of the fatality, the SC resided with her mother, subject father (SF), and four SSs. The SF was the stepfather of the SC, the 11, and 12-yo SSs, and the biological father of the 5, and 3-yo SSs.

ACS' case documentation reflected at about 12:30PM on 12/9/21, the SC's school contacted the parents to pick the SC up from school because she was coughing. The mother responded to the school and took the SC home. At home the mother administered a double dose of breathing treatment via the SC's nebulizer. The SC engaged in normal activities after the treatment and went to sleep. At 10:00PM, the SC awoke and reported having difficulty breathing. The mother gave the SC another breathing treatment, but the symptoms did not subside. The SC was in distress and became unresponsive. The mother called EMS while the SF told the 12-yo surviving sibling to run to the nearby FDNY station for help. FDNY personnel responded and began CPR on the SC until EMS arrived. EMS continued CPR and then transported the SC to the hospital. The SC arrived at the hospital unresponsive and pulseless. The hospital staff was unable to resuscitate the SC and then pronounced her dead at 12:03AM.

ACS received the report and initiated the CPS fatality investigation in a timely manner. ACS reviewed the family's prior CPS records and made several collateral contacts including with the ME, LE, hospital staff, school staff, pediatrician, and the family. The ME, LE and hospital staff did not deem the SC's death suspicious and LE did not make an arrest. LE and ACS assessed the SSs and deemed them fine. The school staff and the pediatrician did not report any concerns for the family or the care they provided their children. The family reported the SC had a medical condition but did not experience any complications with the condition. They also denied any prior hospitalization for the SC.

ACS held a child safety conference (CSC) and the decision was made to not seek court intervention. The family declined services and stated they would obtain services on their own. There were no safety concerns for the SSs in care of the parents.

At the time of writing this report, ACS had not made a determination regarding the CPS investigation.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? N/A

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:
The case documentation reflected supervisory involvement at the prescribed time frames and at critical case decision making points. The staff consulted with the supervisor regarding possible safety issues and guidance was provided.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	ACS did not complete the 30-Day Safety Assessment in a timely manner. After the 12/15/21 safety assessment, ACS completed the next assessment form on 3/18/22.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Child Fatality Report

Date of Death: 12/09/2021 **Time of Death:** 12:03 AM

Date of fatal incident, if different than date of death: 12/08/2021
Time of fatal incident, if different than time of death: 10:40 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 10:58 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	9 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)

LDSS Response

On 12/9/21, the medical personnel reported the SC arrived at the hospital unresponsive and pulseless. The autopsy report was pending.

On 12/9/21, ACS visited the family. The family reported the SC had a history of a breathing condition, but she did not experience any complications or hospitalization prior to her death. They stated there was a delay in EMS' response, and they sought help from a nearby FDNY station, but the SC had died prior to FDNY's arrival. EMS performed CPR on the SC in the home and during transport to the hospital, but the medical team pronounced the SC dead upon her arrival at the

hospital. The parents reported that the SSs were at the MGM's home.

On 12/9/21, LE reported the SSs were assessed and deemed fine. The family's home did not pose any health or safety hazard. LE did not deem the SC's death suspicious and no arrest was made.

On 12/9/21, the family's neighbor did not report any concerns for the family or the children.

On 12/9/21, the hospital staff reported the SC was deemed a well child before her death. The SC was provided with a referral to a respiratory specialist, but there was no indication an appointment was made.

On 12/9/21, ACS assessed the SSs in the MGM's home. ACS did not document any concerns for the SSs at the time of the visit. The MGM reported the SC visited her home but denied the SC fell ill while in her care. The two older SSs provided an account of the incident which was the same as the information that was already known. The 6-yo SS was asleep at the time of the visit. The 4-yo SS was too young to be interviewed.

On 12/9/21, the SF's previous ACS worker did not report any concerns for the family.

On 12/10/21, the school staff did not report attendance, behavioral, or academic concerns for the SSs.

On 12/10/21 and 12/13/21, ACS visited the case address. The SF declined to be interviewed and advised ACS to obtain any needed information from the collaterals the family had spoken to. He also declined ACS's offer of services to the family.

On 12/22/21, ACS visited the family. The family declined services. The SF stated ACS had not allowed the family to grieve since the SC's death and that the family would no longer speak to ACS about the SC's death. There were no concerning conditions in the home at the time of the visit.

On 12/22/21, the FDNY staff reported the oldest SS came to the station and requested help for the SC. The FDNY staff advised ACS to submit a written request for the full report from the 911 record.

On 12/23/21, ACS held a child safety conference (CSC). The decision was not to seek court intervention. The family would be offered services.

On 1/14/22 and 1/27/22, ACS visited the family and assessed the SSs for safety. ACS did not document any concerns for the SSs during the visits.

On 2/8/22, the ME reported based on the preliminary findings, the SC tested positive for an upper respiratory passaging infection, which was related to asthma. The final autopsy was pending further tests.

Between 2/11/22 and 3/28/22, ACS made casework contacts with the family and other collaterals. ACS did not obtain any new information regarding the SC's death. The family continued to decline services; there were no safety concerns for the SSs.

As of the writing of this report, the investigation remained open.

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
060542 - Deceased Child, Female, 9 Yrs	060543 - Father, Male, 41 Year(s)	Lack of Medical Care	Pending
060542 - Deceased Child, Female, 9 Yrs	060544 - Mother, Female, 31 Year(s)	Lack of Medical Care	Pending
060542 - Deceased Child, Female, 9 Yrs	060544 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Pending
060542 - Deceased Child, Female, 9 Yrs	060544 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060542 - Deceased Child, Female, 9 Yrs	060543 - Father, Male, 41 Year(s)	DOA / Fatality	Pending
060542 - Deceased Child, Female, 9 Yrs	060543 - Father, Male, 41 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060542 - Deceased Child, Female, 9 Yrs	060543 - Father, Male, 41 Year(s)	Inadequate Guardianship	Pending
060542 - Deceased Child, Female, 9 Yrs	060544 - Mother, Female, 31 Year(s)	DOA / Fatality	Pending
060546 - Sibling, Female, 5 Year(s)	060543 - Father, Male, 41 Year(s)	Inadequate Guardianship	Pending
060546 - Sibling, Female, 5 Year(s)	060543 - Father, Male, 41 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060546 - Sibling, Female, 5 Year(s)	060544 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060546 - Sibling, Female, 5 Year(s)	060544 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Pending
060547 - Sibling, Male, 3 Year(s)	060544 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Pending
060547 - Sibling, Male, 3 Year(s)	060543 - Father, Male, 41 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060547 - Sibling, Male, 3 Year(s)	060544 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060547 - Sibling, Male, 3 Year(s)	060543 - Father, Male, 41 Year(s)	Inadequate Guardianship	Pending
060548 - Sibling, Male, 12 Year(s)	060544 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Pending

060548 - Sibling, Male, 12 Year(s)	060544 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060548 - Sibling, Male, 12 Year(s)	060543 - Father, Male, 41 Year(s)	Inadequate Food / Clothing / Shelter	Pending
060548 - Sibling, Male, 12 Year(s)	060543 - Father, Male, 41 Year(s)	Inadequate Guardianship	Pending

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?	☒	☐	☐	☐
Explain: ACS did not complete the 30-Day Safety Assessment.				

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? 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)
10/31/2019	Sibling, Female, 16 Years	Father, Male, 39 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Sibling, Female, 16 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 16 Years	Father, Male, 39 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 9 Years	Father, Male, 39 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Male, 9 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Male, 10 Years	Father, Male, 39 Years	Excessive Corporal Punishment	Unsubstantiated
Sibling, Male, 10 Years	Father, Male, 39 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
On 10/30/19, as a means of discipline, the BF grabbed his 16-yo daughter by her arms and threw her to the ground. As a result of BF's actions, the child had a bruise on her upper left arm and possibly an injury to her leg. The BF's action was because he found something on the child's phone and/or computer that he did not like. The BF used corporal punishment in the home. He had punched the ten and nine-year-old children in the back of their heads. The BF's actions were excessive. It was unknown if either child had been injured.

Report Determination: Unfounded | **Date of Determination:** 12/30/2019

Basis for Determination:
The BF reported the child smoked marijuana and could be very disrespectful when spoken to; but he denied he physically disciplined the child. ACS interviewed the children in the home and at school and did not observe any laceration, bruises, and welts on the children. The children denied the BF used corporal punishment as form of discipline. The school staff denied the children had any marks or bruises on their bodies. The children's physicals and immunizations were up to date. There was enough food provision in the home.

OCFS Review Results:
ACS initiated the investigation in a timely manner. ACS visited the home, interviewed the family, and the children at school. Also, ACS made the appropriate collateral contacts. ACS sought and received the assistance of the mental health consultant. NYCRO agrees with the case determination of UNF due to lack of credible evidence to support the allegations of the report. ACS kept the case open in the FSS stage pending the mental health consultant's recommendations. On 1/24/20, ACS provided the family with the recommendations and closed the FSS stage.

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 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