Child Fatality Report

Report Identification Number: NY-22-030

Prepared by: New York City Regional Office

Issue Date: Oct 24, 2022

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

- [x] 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased **Jurisdiction:** Kings **Date of Death:** 04/25/2022
Age: 1 year(s) **Gender:** Female **Initial Date OCFS Notified:** 04/26/2022

Presenting Information

An SCR report was received which alleged that on 4/24/22, the one-year-old female subject child was in the care of her mother and grandparents, and that evening, developed a fever. The mother gave the child Tylenol around 7:00PM, and around midnight, the mother put the child in her crib to sleep. The mother then went to clean the kitchen. On 4/25/22, at 1:00AM, the mother went back to check on the child and found her unconscious. Paramedics were called and the child was transported to the hospital. While at the hospital, the child went into cardiac arrest and died. The father and sibling had unknown roles.

Executive Summary

This fatality report concerns the death of a one-year-old female subject child that occurred on 4/25/22. A report was registered with the SCR on 4/26/22 with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother, paternal grandmother, and paternal grandmother's husband (OA). The New York City Administration of Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; however, the official cause and manner of death remained pending at the time of this writing.

At the time of the child's death, she resided with her mother, two-year-old surviving sibling, paternal grandmother, and paternal grandmother's husband. The child's father did not live in the home, and at the time of the fatality, had not had any recent contact with the child. The investigation revealed that the subject child was diagnosed with sleep apnea and a seizure disorder, and in the days leading up to her death, she had a cough and a fever. At around 7:00PM on 4/25/22, the mother administered Tylenol to the subject child to alleviate her fever, and at 9:00PM, placed the child in her crib to sleep. The mother cleaned the house, and at 10:30PM, she and the surviving sibling went to bed. The mother next awoke around 1:15AM on 4/25/22 to check on the subject child and found her unresponsive in the crib. The mother picked up the child and carried her to the paternal grandmother's bedroom for help. The paternal grandmother's husband called emergency services and the mother began cardiopulmonary resuscitation. The child was transported to the hospital via ambulance where she was pronounced deceased at 2:12AM on 4/25/22.

ACS spoke with several collateral sources, including law enforcement, the medical examiner, hospital staff and the subject child's pediatrician. It was learned that the mother had another child who died in 2018 at the age of nine months due to natural causes. The medical examiner suspected that child's death and the subject child's death may have had a genetic component; however, testing for such was still pending. The medical examiner further noted there were no signs of abuse, trauma, or illness during autopsy. While there were no documented concerns surrounding the mother's care of the child, it was noted that ten medical appointments were missed from 9/2/21 to 3/22/22. The record did not reflect which, if any of those appointments were re-scheduled and attended, or if missing those appointments negatively impacted the subject child's health. It was noted that the subject child had been prescribed a sleep apnea machine in September 2021, but its use was recently discontinued by the prescribing doctor. The record did not reflect if ACS confirmed this information with the subject child's medical provider. There were no criminal charges brought against any of the caregivers in the home regarding the fatality, and the surviving sibling was deemed safe. ACS offered the family voluntary preventive services to further address ongoing concerns within the family, and they were accepted. ACS noted there was no evidence to support the subject child's death was due to any actions or inaction by the caregivers. The allegations against the mother, paternal grandmother, and the paternal grandmother's husband were unsubstantiated. The case was opened for services which remained ongoing at the time this report was issued.

PIP Requirement

ACS must meet with the staff involved in this fatality 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.

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?** — No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** — Unable to Determine

Explain:

The record did not reflect if the concerns surrounding missed medical appointments and medications were fully explored prior to the case determination. It remained unclear if the missed appointments negatively impacted SC's health, or if SC's medication was administered as prescribed.

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 record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source

Summary:	The record did not reflect if ACS spoke with medical providers about the impact of the numerous missed medical appointments, if SC no longer needed a sleep apnea machine, or if SM was properly administering SC's medications.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must meet with the staff involved in this fatality 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

Date of Death: 04/25/2022 **Time of Death:** 02:12 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 01:16 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

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 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Adult - PGM's Husband	Alleged Perpetrator	Male	50 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)

LDSS Response

On 4/26/22, ACS interviewed BF, who reported he was not present when the incident occurred. BF stated there was a stay away OP in place between himself and SM due to an incident from March 2022: BF said he and SM got into an argument, she hit him, and he hit her back. He explained he had no concerns surrounding SM's care of the CHN.

On this same date, ACS interviewed SM. SM reported she lived with SC, SS, PGM, and OA. SM explained that on 4/22/22, SC had a cough, but was otherwise acting normally. SM stated she gave SC chamomile tea to soothe the cough; however, it persisted through the weekend. SM reiterated that despite this, SC was eating, drinking, and acting normally. SM stated that around 5:00PM on 4/24/22, SC felt warm, and SM assumed she had a fever. SM explained she could not take her temperature as the thermometer was broken. SM said she gave SC Tylenol at 7:00PM, and then at 9:00PM, she applied Vick's Vapor Rub to SC's back. SM stated eventually SC fell asleep in her crib, and then SM cleaned up the house. SM said at around 10:30PM, she put SS to bed, and SM went to sleep as well. At around 1:15AM on 4/25/22, SM woke up to check on SC and found her unresponsive. SM sought help from PGM, and OA called 911. SM said she administered a prescribed medication to SC, which was for emergencies only and given rectally. SM reported EMS arrived and SC was brought to the hospital. SM explained SC was diagnosed with sleep apnea and seizures and was prescribed 2 medications: 1 was taken every 12 hours, and the other was only given in the case of an emergency. SM reported that 3 weeks prior to SC's death, SC's Dr. said SC no longer needed a sleep apnea machine, and it was returned to the Dr.'s office. ACS also spoke with PGM at this visit, and PGM's account of what occurred corroborated what SM had reported. PGM denied any concerns for SM or her care of the CHN. ACS observed the home and found it to be appropriate. SS was also observed and deemed safe.

On 4/27/22, ACS spoke with the ME, who reported no concerns of abuse or trauma. The ME explained SM had a 9-month-old child that died in 2018 due to natural causes, and she was running various tests to see if there is a genetic condition which may have caused the deaths. The ME further stated that SC had no signs of illness, and her lungs were clear. She accessed SC's medical records and found she had one reported seizure in August 2021; however, was "not diagnosed with a seizure disorder." The ME stated SC was prescribed medication for a short time, but it was since discontinued. It was further noted that sleep apnea could not be seen via autopsy.

SC's pediatric records noted no ongoing medical concerns for SC; however, there were numerous missed or canceled medical appointments listed. On 5/19/22, ACS spoke with SC's Dr. who clarified SC was diagnosed with a seizure disorder, as well as sleep apnea and a large liver, and medication for the seizures was prescribed. The Dr. had no concerns regarding SM's care of SC. The record did not reflect if ACS explored the missed medical appointments or the large liver diagnosis with the Dr.

On 5/23/22, ACS interviewed OA, who reported he was asleep when SC was found unresponsive. OA denied any concerns regarding SM or her care of the CHN.

Throughout the investigation, ACS spoke with collateral sources and assessed the safety of SS. The OP against BF was amended to a refrain from order, and BF was allowed contact with SM and SS. By the close of the investigation, it remained unclear if the missed medical appointments had a negative impact on SC's health. The record did not reflect if ACS confirmed SC was given her medication as prescribed, when the last dose was administered, or if SC no longer needed a sleep apnea machine. ACS noted evidence was not found to support the allegations in the report. Therefore, the allegations against SM, PGM, and OA were unsubstantiated, and the case was opened for 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
Comments: This fatality investigation was conducted by the ACS MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061681 - Deceased Child, Female, 1 Yrs	061684 - Other Adult - PGM's Husband, Male, 50 Year(s)	DOA / Fatality	Unsubstantiated
061681 - Deceased Child, Female, 1 Yrs	061684 - Other Adult - PGM's Husband, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
061681 - Deceased Child, Female, 1 Yrs	061682 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
061681 - Deceased Child, Female, 1 Yrs	061682 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
061681 - Deceased Child, Female, 1 Yrs	061683 - Grandparent, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated
061681 - Deceased Child, Female, 1 Yrs	061683 - Grandparent, Female, 43 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?	☒	☐	☐	☐

Additional information:

ACS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered timely.

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	☒	☐	☐	☐
Explain: A voluntary preventive services case was opened following the death of the subject child.				

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:
The surviving sibling did not need to be removed as a result of the fatality.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Voluntary Preventive Services

Additional information, if necessary:
ACS provided the family with bereavement counseling referrals and assistance with funeral costs. A voluntary preventive services case was opened following the fatality.

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:
Grief and bereavement referrals were provided to the caregivers for the sibling. Voluntary preventive services were also opened.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief and bereavement referrals were provided to the caregivers. Voluntary preventive services were also opened to continue to address ongoing familial concerns.

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

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?
☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 03/01/2022	**To:** 09/22/2022
Explain: A full stay away order of protection was issued against the father after he physically assaulted the mother during an argument. This order was amended to a refrain from during the fatality investigation.	

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