Child Fatality Report

Report Identification Number: NY-20-082

Prepared by: New York City Regional Office

Issue Date: Mar 14, 2021

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: Kings
Date of Death: 09/13/2020
Age: 9 year(s)
Gender: Male
Initial Date OCFS Notified: 09/13/2020

Presenting Information

On 9/13/2020, the SCR registered 3 reports regarding the 9-yo SC. The reports alleged the SC was experiencing some medical problems since 9/11/2020. He had complained of abdominal pain accompanied with vomiting. The BM gave the SC medication but failed to seek medical attention for him. At about 11:00PM on 9/12/20, the SC was asleep in the bed with the BM and the younger SS. At approximately 2:00AM on 9/13/20, the SC returned to his bedroom. At 10:53AM, the adult SS found the SC unresponsive, face up in bed. The adult SS moved the SC’s body to the living room and then went next door to the MU’s home and alerted him the SC was not breathing. A call to 911 was made. EMS responded to the home and pronounced the SC deceased on the scene at 10:56AM. The SC was otherwise healthy, and the BM did not have any explanation for the SC's death.

Executive Summary

This report concerns the death of a nine-year old male child. The ME reported that the preliminary findings indicated the child's death appeared to be natural and related to a medical condition (Ketoacidosis/Diabetes). The final autopsy report was pending further studies.

On 9/13/2020, the adult SS found the SC unresponsive in the family’s home. According to the case records, the SC had not been feeling well since 9/11/2020. He complained of abdominal pain accompanied with vomiting. The SC was treated with home remedies and over-the-counter medication. He appeared to feel better and did not exhibit any concerns that required he be taken for medical care. At about 10:45AM on 9/13/20, the BM asked the adult SS to check on the SC. The adult checked the SC and found him not breathing. The adult SS alerted the MU who resided across the hall from the home and the MU called 911. EMS responded to the home and pronounced the SC deceased on the scene at 10:56AM.

At the time of the fatality, the SC resided with the BM, the adult SS and the 13-yo SS. The BF did not reside in the home and did not have any contact with his children in the four years prior to the fatality.

On 9/13/2020, ACS received the report and initiated the CPS investigation within the required timeframe. ACS obtained information from the family and relevant collaterals such as the medical providers, the ME, LE and the school staff. The information obtained did not reveal the SC’s death was indicative of abuse. Also, LE did not make any arrest. The family and the pediatrician did not report any preexisting medical condition for the SC and there were no other immediate concerns reported for the care of the SS. Following the incident, the BM and the SS relocated to the MA’s home. During the investigation, ACS assessed the SS for safety through home and school visits, interviews with the family, school staff and medical providers and deemed her safe. She was adequately cared for and did not report any concerns.

ACS held a child safety conference (CSC). The CSC did not seek court intervention for the family. The CSC referred the family for bereavement counseling and medical preventive services. The service provider confirmed the family engaged in services.

On 11/12/2020, ACS UNSUB the allegations of the report due to lack of credible evidence that indicated the BM’s actions or inaction resulted in the SC’s death. The ME reported that the preliminary cause of death was due to a medical condition. The family was referred to and was actively engaged in PPRS services.

The SS was being cared for appropriately by the BM and supported by the maternal family. The SS did not report or

exhibit any behavioral concerns. She received school-based services to cope with her loss. The family continued to reside in the MA's home for emotional support due to the trauma they experienced when the SC was found deceased in the home. During the investigation, ACS utilized language services to engage the BF and the MGM 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:**
    - **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?** Yes

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:
ACS UNSUB the allegations of the report and kept the case open for services. The family was already receiving services.

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: 09/13/2020 **Time of Death:** 10:56 AM

Office of Children and Family Services

Child Fatality Report

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 10:53 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:

- [x] 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 supervisor was:

- [ ] Drug Impaired
- [ ] Absent
- [ ] Alcohol Impaired
- [ ] Asleep
- [ ] Distracted
- [x] Impaired by illness
- [ ] Impaired by disability
- [ ] Other: Lupus

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	Adult Sibling	No Role	Male	19 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)

LDSS Response

On 9/13/2020, ACS contacted the BM and the younger SS via video conferencing. ACS did not observe the SS with any suspicious marks or bruises. She appeared to be adequately cared for and did not report any concerns. The BM repeated the account of events leading up to the SC’s death, which was consistent with the information that was already known. She denied any medical history or diagnosis for the children. ACS also contacted the ME and LE. They did not report any trauma to the SC's body and his death was not suspicious. The ME stated that preliminary findings indicated the SC’s death appeared to be natural and related to a medical condition. LE stated based on the interview with the family, no arrest was made.

On 9/13/2020, the PA reported she last saw the children about 5 years prior to the fatality, and she did not have any concerns for the children at the time. She stated the parents had not been together for a long time and the BF was not involved with the children.

On 9/13/2020, ACS interviewed the BF. The BF denied knowledge of how the SC died. The BF spoke positively about the BM and her ability to care for the children.

On 9/14/2020, the ME reported that the autopsy was pending additional findings.

On 9/14/2020, the adult SS confirmed he found the SC not breathing in the home and alerted the MU across the hall from the home. He did not alert the BM because the BM was not feeling well at the time. He denied substance use or any mental health concerns.

On 9/14/2020, the BM stated at the time of the incident, she asked the adult SS to check on the SC because the SC had been in the same position for a while. When the adult SS noticed that the SC was not breathing, he screamed and then gave the SC CPR. The adult SS' screaming alerted the MU who came over from his apartment across the home and called 911. The BM stated she was in the bathroom throwing up at the time, as she was not feeling well due to a medical condition. The MA stated the BM and the SS would be staying with her for a long time. The MA denied any medical history for the SC and stated the SC was a healthy child.

On 9/16/2020, the EMS staff stated upon arrival on the scene, the SC was in rigor mortis. There was blood observed in the SC's airway, but there was no injuries or abnormal findings on the SC.

On 9/16/2020, the BF reported lack of contact with the children due to the BM denying him access to the children. He did not report any concerns for the BM caring for the children. He denied any medical concerns for the children.

On 9/16/2020, the pediatrician did not report any preexisting medical condition for the SC and the SS. The children were current with their immunizations and were seen for regular medical appointments.

On 9/18/2020, ACS held a child safety conference (CSC). The CSC referred the family for bereavement counseling and medical preventive services.

On 9/24/2020 and 11/12/2020, ACS made several casework contacts with the family, and collaterals. The family, the ME and LE did not provide any new information regarding the fatality. The family continued to do well in the MA' s home. ACS assessed the home to be safe and appropriate for the SS. The SS was attending school regularly via remote learning and received weekly counseling sessions. The school did not report any academic or behavioral concerns for the SS. The service provider confirmed the BM officially accepted services. The BF declined services because of his job schedule.

On 11/12/2020, ACS unsubstantiated the allegations of the report and kept the case open 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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

056358 - Deceased Child, Male, 9 Yrs	056359 - Mother, Female, 44 Year(s)	DOA / Fatality	Unsubstantiated
056358 - Deceased Child, Male, 9 Yrs	056359 - Mother, Female, 44 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?	☐	☒	☐	☐
Other	☐	☒	☐	☐
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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Medical preventive 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? No
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

Between 12/17/07 and 01/07/16, the family had 9 CPS reports. Five (5) of the reports were indicated, 2 were unfounded and 2 were suspended. The BM and the stepparent were the subjects of the reports. The pattern of the indicated cases was IG, ED/NG, LS, L/B/W, and LMC of the older children by the parents. The SC was listed as having “No Role” or “Unknown Role” in the reports.

Known CPS History Outside of NYS

The family did not have any known CPS History outside of New York State.

Preventive Services History

On 12/10/10, an FSS stage was opened for the family due to the now adult SS being left alone without an authorized person to pick him up from the school bus drop off. Also, there were concerns of corporal punishment and truancy issues regarding the now adult sister (not part of the household composition at the time of the fatality) who was truant in school and failing as a result. The family received parenting skills training, childcare monitoring, education assistance, mental health services and monitoring of service compliance. The family was compliant with services. The children were observed to be free from abuse or neglect during home visits casework contacts. The family was stable, and the BM continued to provide for her family.

On 7/16/12, the family's case was closed.

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