Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-095

Prepared by: New York City Regional Office

Issue Date: Apr 03, 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
Age: 17 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 09/28/2020
Initial Date OCFS Notified: 10/02/2020

Presenting Information

The BM had her parental rights terminated with the SC and regained custody of him about a year ago. The SC was diagnosed with depression, morbid obesity and a significant eating disorder. The BM and the SC moved from shelter to shelter. At one point, the BM and the SC lived on an abandoned train and the SC begged for food in violent and unsafe areas. The BM failed to follow through with mental health or medical treatment for the SC. As a result, the SC gained about 220lbs. over the past year while in the care of the BM. In July 2020, the BM took the SC to the hospital due to a medical condition but signed the SC out of the hospital, against medical advice. On or about 9/28/2020, the SC had difficulty breathing, urinated on himself and foamed at the mouth. The BM turned on the air conditioner and failed to seek medical care in a timely manner for the SC. As a result, the SC was pronounced dead on 9/28/2020. The cause of death was a cardiac arrest.

Executive Summary

On 9/28/2020, the SC died while in the care of his BM. ACS case documentation reflected two days before his death, the SC did not feel well, and had trouble breathing. The BM did not seek medical assistance for the SC at the time. At about 9:00PM on 9/28/20, the SC was in distress and unresponsive in bed. The BM called 911 and gave the SC CPR. FDNY arrived at the family's shelter unit and took over CPR. LE later pronounced the SC dead on the scene at 10:40PM. The ME's initial findings indicated the cause of death was morbid obesity and the manner of death was natural pending toxicology results.

At the time of his death, the SC and the BM resided in a shelter. The BF resided out of state and was not involved with the family. He had waived his rights for the SC.

On 10/2/2020, ACS received the SCR report and initiated the CPS investigation in a timely manner. ACS obtained information from the family and relevant collaterals which revealed the SC struggled throughout his life with an eating disorder and medical conditions. The SC was in and out of care since the age of 4 due to being overweight. When in care, the foster care agency would monitor the SC's weight. When he was returned to his BM's care, the SC would gain a significant amount of weight which resulted in his return to foster care. On 3/4/14, Family Court terminated the BM's parental rights due to the SC's weight gain. As a result, the SC re-entered care and was freed for adoption. On 3/24/20, the SC went AWOL from a congregate care facility to reconnect with the BM. The SC weighed over 400 lbs. at the time. Since the SC's return to the BM's care, the BM failed to follow up with the SC's educational, medical and diet needs. He weighed over 600lbs when he died.

ACS referred the BM for bereavement counseling services and an outpatient treatment program because she admitted to alcohol use and had tested positive for marijuana. The BM did not follow through with the referral.

On 11/30/2020, ACS SUB the allegations IFCS, IG, and LMC against the BM due to credible evidence. The accounts obtained from collaterals and the BM's statement revealed the BM gave the SC inappropriate foods. Despite having knowledge of the SC's medical diagnosis as well as being counseled by medical professionals and service providers, the BM provided the SC with inappropriate food options on a regular basis. The shelter facility provided healthy meals for free, but the BM would bring unhealthy foods into the unit for the SC. Also, the family's shelter unit was unsanitary and a health hazard. The shelter staff often observed the SC in inappropriate clothing in the unit.

Additionally, the BM often left the SC unsupervised for hours at a time and/or overnight. The SC had significant health issues and had limited capacity to protect or advocate for himself.

The BM failed to provide the SC with adequate medical care. Two days before his death, the SC did not feel well, and was in respiratory distress. The BM did not seek medical assistance for the SC. The SC later died on 9/28/20. In July 2020, the SC was hospitalized following a medical visit. The BM would sneak in fast foods into the hospital for the SC. Upon discharge, the SC was provided with medications and medical equipment to aid his sleeping condition. He was also referred for Visiting Nurse Services and physical therapy. The hospital obtained transportation services for the SC to keep his appointments, but the BM did not keep the appointments and failed to reschedule them. The BM did not replace the SC's medical equipment.

ACS UNSUB the allegation DOA/FATL due to lack of credible evidence. The BM's actions/inactions did not contribute to the SC's death. The ME's initial findings suggested the SC's death was natural pending toxicology results.

During the investigation, ACS obtained information that the BM did not enroll the SC in school. ACS should have added and SUB the allegation ED/NG of the SC by the BM.

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?** No, sufficient information was gathered to determine some allegations only.
- **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:
There were no surviving children.

Required Actions Related to the Fatality

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

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	During the investigation, ACS obtained information that the BM did not enroll the SC in school. ACS should have added and SUB the allegation ED/NG of the SC by the BM.

Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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: 09/28/2020 **Time of Death:** 10:40 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 09:46 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: Laying in bed

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	Male	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Other Household 1	Father	No Role	Male	42 Year(s)

LDSS Response

On 10/2/2020, the facility staff, and the service provider reported the SC struggled with morbid obesity, an overeating disorder, depression, and anxiety. They also reported the BM often left the SC in the unit alone by himself unsupervised and returned with a large amount of food for the SC.

On 10/5/20, the BF reported concerns of marijuana and alcohol use by the BM and the SC. He stated he attempted to get the SC in his care, but Oneida County Department of Social Services (OCDSS) "wanted him to do so much."

On 10/5/2020, the adult half sibling stated the SC was not enrolled in school and would not go outside of the unit. The SC went hungry and thirsty which caused him to miss taking his medication. He was not on a diet and often ate unhealthy foods, and his weight increased. The BM smoked marijuana.

On 10/5/2020, the BM provided an account of events that led to the incident which was consistent with the SC being ill two days prior to his death. The SC saw doctors once a month and was hospitalized in July 2020 following a regular check-up. The BM denied any mental health issues.

On 10/8/2020, the MA stated the SC reported physical abuse by his godmother while in care and sexual abuse by a staff member at the group home which caused him to go AWOL from the facility.

Also on 10/8/2020, the family's CP reported ongoing efforts to work with the BM regarding the SC's weight issues and lack of supervision by the BM. The CP was working with the BM to enroll the SC in school. The BM stated the SC could not come out of the unit due to his medical condition and COVID-19. The CP would provide the BM with resources to deal with her loss.

On 10/9/2020, the ME reported the cause of death was morbid obesity and the manner of death was natural. The ME's preliminary findings indicated hypertensive cardiovascular disease, enlarged heart, enlarged fatty liver, and a body mass index of 85.3. Other results were pending.

On 10/9/2020, the SC's school reported multiple behavioral incidents for the SC in the previous school year. He had an IEP classification of depression with conduct disorder and compulsive eating disorder. The SC did not receive school-based services.

On 10/13/2020, the adult sibling denied the SC drank alcohol or used drugs. He stated the SC went AWOL from the group home because he "was not treated right."

On 10/16/2020, ACS received the SC's medical records. The SC had multiple chronic medical conditions and prior hospitalizations. The BM was not compliant with appointments and treatment plan for the SC. She also failed to adhere to the dietician's recommended calorie diet to assist the SC with weight loss.

On 10/19/2020, ACS received the results of the BM's drug test. She was positive for marijuana metabolite.

On 10/22/2020, the BM reported she no longer resided at the family shelter and had moved in with relatives. She was receptive to the offer of bereavement services.

On 10/23/2020, the SC's primary Dr. confirmed the BM was not compliant with appointments for the SC. She failed to follow up with visiting nurse service for the SC. The SC was provided medical equipment to aid his mobility and sleep.

On 10/28/20, LE stated the ME did not deem the SC's suspicious pending other results.

On 10/28/2020, EMS reported the responding team found the SC unresponsive and face up on the scene. He did not have a pulse and could not be revived. He did not have any obvious signs of injuries on his body.

On 11/4/2020, ACS mailed bereavement counseling and substance use outpatient treatment information to the BM.

On 11/9/2020, the family's former service provider stated the BM did not comply with shelter rules or appointments. She

frequently left the SC unattended, and broke curfew. The family's unit was unsanitary and a health hazard.

On 11/13/2020, the ME stated the final autopsy was pending further studies.

On 11/30/2020, ACS SUB the allegations IFCS, IG, and LMC against the BM. ACS UNSUB the allegation DOA/FATL.

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)?No

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in New York City.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055302 - Deceased Child, Male, 17 Yrs	055303 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
055302 - Deceased Child, Male, 17 Yrs	055303 - Mother, Female, 40 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
055302 - Deceased Child, Male, 17 Yrs	055303 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Substantiated
055302 - Deceased Child, Male, 17 Yrs	055303 - Mother, Female, 40 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
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

Between 3/23/05 and 3/6/2014, the BM had nine prior CPS reports. ACS and Orange County DSS investigated allegations of the reports. Seven of the nine reports were indicated against the BM for the SC and his now adult sibling. The patterns and themes of the indicated reports were IG, ED/NG, LS, LMC, and IFCS. The BM was neglectful of the health concerns and supervision of the SC. She failed to assure that the SC utilized the medical equipment that was necessary to manage his sleep apnea. She also failed to monitor the SC's diet. As a result, the SC was removed from the BM's care and placed into foster care on four occasions; from March 2007 to March 2008, July 2008 to October 2009, September 2009 to December 2011, and March 2014 to March 26, 2020. Each time the SC was back in the BM's care, he gained large amounts of weight and the BM's neglectful parenting continued. On 3/4/14, the Family Court terminated the BM's parental rights.

The case records also reflected the BF was in and out of the SC's life. The BF's absences were due to spells of incarceration, unstable living conditions, and extreme discord between him and the BM. Also, the BF had limited financial resources and did not have a home of his own. He was very inconsistent with visits with his son and maintaining contact with the service providers. On 12/16/15, the BF appeared in Utica Family court to surrender his paternal rights for the SC.

Known CPS History Outside of NYS

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

Preventive Services History

Between 5/31/07 and 5/24/16, an FSS stage was opened for the family regarding the removal and placement of the SC and the supervision of his now adult sibling. The BM stated she was not provided services during the period. However,

between 3/2/2007 and 11/13/2013, the SC received psychological counseling services for depression, eating disorder and 24 Hour supervision while in congregate care.

Foster Care Placement History

Between 3/2/2007 and 11/13/2013, the SC was in and out of foster care due to being significantly overweight and his medical conditions. During the period, the SC had weekend visits with the BM; however, there were ongoing concerns about the BM's lack of compliance and follow through with the SC's nutritional and medical recommendations. Consequently, the SC was placed in a boarding home in Albany at the time.

On 11/13/13, the SC was placed back in the BM's care and weighed 216lbs. at the time. While in the BM's care, the SC gained additional weight and became obese. He had trouble breathing, walking, and had a medical condition as a result. The BM did not monitor the SC's diet, and he was falling asleep in school. On 3/4/14, the boarding home filed a petition in Family Court to terminate the BM's parental rights. The court granted the petition and the SC re-entered care and was freed for adoption. On 3/24/20, the SC went AWOL from the boarding home to reunite with the BM.

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