Child Fatality Report

Report Identification Number: NY-21-057

Prepared by: New York City Regional Office

Issue Date: Nov 22, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 05/26/2021
Initial Date OCFS Notified: 05/26/2021

Presenting Information

The 5/26/21 SCR report alleged that on 5/20/21, while under the care of the SM, the SC became lethargic. At that time, it was strongly recommended that the SM take the SC for medical attention. The SC continued to be very lethargic for several days. The SM failed to seek medical care for the SC until 5/24/21. The SC died at 3:00AM on 5/26/21. The SC was an otherwise healthy child and the SM was unable to provide an explanation as to how the SC died. The father had an unknown role.

Executive Summary

This fatality report concerns the death of a 3-year-old male subject child (SC) that occurred on 5/26/21. As of the date of issuance of this report, NYCRO had not received a copy of the autopsy report. The SCR registered a report with allegations of DOA/Fatality, LMC, and IG of the SC by the SM. There are no surviving siblings or other children in the home.

ACS's investigation revealed over the period of a week beginning on 5/18/21, the SC had episodes of vomiting. The child then began to exhibit unsteady gait which manifested in physical imbalance; the SC began tilting first to one side then to the next as he walked. On 5/22/21, the SM took the SC to his doctor who prescribed medication and plenty of rest. Medication was administered as prescribed, beginning the day after the doctor's visit. The SC appeared fine, but on 5/24/21, the SC became pale, began to "wobble," and not move. The SM called 911 for emergency medical assistance. EMS responded to the home and transported the SC and the mother to the hospital. The SC was admitted and two days later he died.

On 5/26/21, a Heightened Oversight Process conference occurred. ACS staff visited the hospital and interviewed medical personnel who said the subject child presented with a medical condition and there were no signs of neglect or abuse.

During the investigation, ACS maintained contact with medical professionals including the medical examiner and learned there was no evidence of abuse or maltreatment, and no trauma to the body of the SC. From the medical examiner, ACS learned the final autopsy would not be available for at least six months.

On 7/23/21, ACS unsubstantiated allegations of DOA/Fatality, IG, and LMC of the SC by the SM as there was no credible evidence to substantiate the allegations. ACS documented the family had provided adequate food, clothing, shelter, and sleeping provisions for the SC. Collaterals also reported the mother had responded appropriately to the child's unfolding medical concern.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**

- **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
There were no SSs or other CHN in the SM's household.

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 documentation did not reflect that ACS interviewed EMS Liaison/Crew regarding the incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations 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: 05/26/2021 **Time of Death:** 02:10 AM

Date of fatal incident, if different than date of death: 05/24/2021
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: Unknown
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

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: **Child was in sight of the supervisor.**

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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Other Household 1	Father	No Role	Male	33 Year(s)

LDSS Response

ACS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACS established there were no surviving siblings or other children in the home. ACS also contacted medical personnel at the hospital.

On 5/26/21, LE said the SC was seen by the pediatrician as he was weak and lethargic. The SC was prescribed medication. There was no indication of the SC having any kind of injury. Based on the medical evaluation, there was no suspicion of foul play, abuse, or maltreatment.

On 5/27/21, the hospital confirmed the SC was admitted to the hospital on 5/24/21. Results of tests conducted at the time the SC was admitted, were all normal. Medical personnel said the mother responded appropriately to the situation.

On 5/27/21, ACS visited the SM's home to speak with the SM. The SM denied substance abuse in the home. The SM said the SC was diagnosed with a medical condition at two months old and she and the BF took him to his doctor. The SC had been receiving in-home services since October 2019. ACS provided the SM with information from the Clinical Health Consultant about support groups for families who had lost a child.

On 5/27/21, medical personnel said the SC was never brought to the pediatrician for head injury or trauma. The SM was very attentive to the SC's needs and always asked for services due to the SC's special needs. There were no signs of neglect or abuse. ACS learned that on 5/22/21, the SM brought the SC to the medical office and the SC was prescribed medication. SM was advised to give him lots of fluids and have him rest. The physician assistant stated that on 5/23/21, the SM was advised to decrease the medication and if the SC's condition worsened to contact them.

On 5/27/21, ACS interviewed the father who said he noticed the SC appeared to be lethargic and had a "water welt" on his forehead and "reed sores" around his mouth. The father said he asked the mother to take the SC to the hospital as the child

"could barely keep his body up."

On 5/28/21, the MU said the last time he saw the SC was on 5/23/21. He said the SC seemed "a little more fatigued than usual." He attributed it to him being ill, as the SM told him the doctor said he had a medical condition and gave him medication.

On 6/2/21, the SM's therapist told ACS she did not have any concerns regarding the SM's ability to care for the SC and would continue to provide therapy to the SM.

On 7/19/21, the pediatrician said that on 5/22/21, the SC was medically examined as the SM reported the SC vomited on 5/18/21 and again on 5/21/21, in addition to appearing lethargic. The physician stated throughout the SC's treatment there were no concerns regarding the SM not seeking assistance to meet the SC's medical needs.

On 7/23/21, ACS unsubstantiated the allegations of the report.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058445 - Deceased Child, Male, 3 Yrs	058446 - Mother, Female, 39 Year(s)	DOA / Fatality	Unsubstantiated
058445 - Deceased Child, Male, 3 Yrs	058446 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
058445 - Deceased Child, Male, 3 Yrs	058446 - Mother, Female, 39 Year(s)	Lack of Medical Care	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
The documentation did not reflect that ACS interviewed EMS Liaison/Crew regarding the incident.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The documentation reflected that on 6/23/21, ACS provided the SM with information for parents who lost a CH. In addition, ACS provided information regarding bereavement counseling. On 6/24/21, ACS provided the BF resources for bereavement counseling.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no SSs or other children in the SM's household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided the SM with information for parents who lost a child and provided information regarding bereavement counseling. On 6/24/21, ACS provided the BF resources for bereavement counseling.

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?	No
Were there any siblings ever placed outside of the home prior to this child's death?	N/A
Was the child acutely ill during the two weeks before death?	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)
05/24/2021	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Internal Injuries	Unsubstantiated	

Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Lacerations / Bruises / Welts	Unsubstantiated
Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
The 5/24/21 report alleged there was on-going concern for the SC while in the care of the SM. The SC had received two suspicious concussions while in the SM's care. The SM did not get the SC timely medical care. Also one of these concussions required on-going therapy. When the SC was 9 months old, the SC stopped cooing and smiling. The SM waited nine months before getting the SC an MRI and hearing test. On 5/21/21, the SC was abnormally uncoordinated and falling while running. The SM refused to bring him for medical care. On 5/22/21, the SC was abnormally sleeping. On 5/23/21, the SC had welts all over his body, almost like an allergic reaction, but he had no allergies.

Report Determination: Unfounded | **Date of Determination:** 07/23/2021

Basis for Determination:
There was no credible evidence to Sub the allegations. Home assessments were conducted and ACS saw there was food, clothing, shelter, and sleeping provisions for the SC. The SM provided adequate medical care for the SC. The Dr. said the SC was current with his immunizations and was due for a wellness check in December 2021. On 5/22/21, SM took the SC to the doctor due to the SC's vomiting on 5/18/21 and then again on 5/21/21. The SC was prescribed medication which the SM administered. On 5/24/21, SM called 911 when the SC's symptoms worsened.

OCFS Review Results:
The investigation was begun timely. ACS provided the parents with the notice of existence and made contact with the appropriate collaterals including medical personnel and family. There were no concerns noted by medical providers. There was evidence of supervisory consultation during the investigation.

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

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

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship

Date Filed:	Fact Finding Description:	Disposition Description:
03/04/2021	There was not a fact finding	There was not a disposition
Respondent:	None	

Comments:	The notes reflected a Custody/Visitation Proceeding regarding the petitioner (BF) against the respondent (SM). On 3/4/21, the BF filed a petition requesting an order awarding custody of the SC. The Court, on consent of both parties and their attorneys, ordered five visits between the BF and child.

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